

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)

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

7
8 **BE IT ENACTED** by the Senate and General Assembly of the State
9 of New Jersey:

10
11 1. (New section) P.L. , c. (C.) (pending before the
12 Legislature as this bill) shall be known, and may be cited, as the
13 “Improved Suicide Prevention, Response, and Treatment Act.”

14
15 2. (New section) As used in P.L. , c. (C.) (pending
16 before the Legislature as this bill):

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

22 “Care transition” means the transfer or transition of a patient
23 from one health care or behavioral health care provider to another.

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

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

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

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

42 “Psychiatric facility” means a State psychiatric hospital listed in
43 R.S.30:1-7, a county psychiatric hospital or the psychiatric unit of a
44 county hospital, a short-term care facility, a special psychiatric
45 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 thus is new matter.

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

3 “Rapid referral” means the taking of appropriate steps by a
4 psychiatric facility, prior to an at-risk patient’s discharge from
5 inpatient care, to facilitate the at-risk patient’s immediate access to
6 an appropriate outpatient treatment appointment as soon as is
7 practicable, and preferably within 48 hours, after discharge; or the
8 taking of appropriate steps by an outpatient treatment provider to
9 facilitate an at-risk patient’s immediate access to an appointment
10 with another outpatient treatment provider or an inpatient
11 psychiatric facility as soon as is practicable, and preferably within
12 48 hours, after referral thereto.

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

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

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

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

42

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 c. If the patient refuses to be admitted to the hospital's
27 psychiatric ward, the attending emergency room physician shall
28 effectuate the warm hand-off of the patient to a screening service or
29 mental health screener to determine whether involuntary
30 commitment to treatment, as provided by P.L.1987, c.116 (C.30:4-
31 27.1 et seq.), is necessary to address the patient's suicidal ideations
32 behaviors, and tendencies or associated mental health issues.

33
34 5. (New section) The Commissioner of Human Services shall
35 require each suicide hotline and crisis hotline in the State,
36 including, but not limited to, the NJ Hopeline and each community-
37 based suicide hotline established pursuant to section 2 of P.L.1985,
38 c.195 (C.30:9A-13), to identify callers to the hotline who are or
39 may be suicidal, provide immediate suicide prevention counseling
40 to each such caller, and ensure that a sufficient number of suicide
41 prevention counselors are available on staff, at all times during the
42 hotline's operation, to provide such counseling.

43
44 6. (New section) a. Any suicide prevention counselor or other
45 staff member employed by a psychiatric facility, outpatient
46 treatment provider, or suicide or crisis hotline, and any other health
47 care professional, when interacting with an at-risk patient, shall:

- 1 (1) treat the at-risk patient with the same dignity and respect
- 2 that is shown to other patients;
- 3 (2) adopt a stance that reflects empathy, compassion, and an
- 4 understanding of the ambivalence the at-risk patient may feel in
- 5 relation to the patient's desire to die;
- 6 (3) treat the at-risk patient in an age-appropriate manner and
- 7 using methods of communication that the patient can understand;
- 8 (4) attempt to engender confidence in the at-risk patient that
- 9 there is an alternative to suicide, and encourage the patient to use all
- 10 available services and resources to empower the patient to choose
- 11 such an alternative;
- 12 (5) not engage in activities or communication methods that may
- 13 result in the increased traumatization or re-traumatization of the at-
- 14 risk patient;
- 15 (6) with the exception of suicide assessments performed
- 16 pursuant to P.L. , c. (C.) (pending before the Legislature as
- 17 this bill), not engage in the psychological testing of a patient who is
- 18 in crisis or who has recently been lifted out of a crisis situation; and
- 19 (7) not engage in behavior that discriminates against or
- 20 stigmatizes the patient.
- 21 b. A psychiatric facility or outpatient treatment provider shall
- 22 require and facilitate the biennial training of all staff on the
- 23 following issues:
- 24 (1) the fundamentals of the facility's or provider's suicide
- 25 prevention policies and protocols;
- 26 (2) the particular suicide care policies and protocols that are
- 27 relevant to each staff member's role and responsibilities;
- 28 (3) the signs and symptoms that can be used by both clinical and
- 29 non-clinical staff to identify existing patients who may be
- 30 developing new suicidal ideations, behaviors, or tendencies;
- 31 (4) the importance of, and methods and principles to be used in,
- 32 ensuring the safe and responsible discharge and care transition of
- 33 at-risk patients; and
- 34 (5) the respectful treatment of, effective communication with,
- 35 and de-stigmatization of, at-risk patients.
- 36
- 37 7. (New section) a. If either the Commissioner of Health or
- 38 the Commissioner of Human Services has reason to believe that a
- 39 facility or provider under its jurisdiction, or any staff member
- 40 employed thereby, is failing to comply with the provisions of
- 41 P.L. , c. (C.) (pending before the Legislature as this bill) or
- 42 any of the internal suicide care policies or protocols adopted
- 43 pursuant thereto, the commissioner shall order the facility or
- 44 provider, as appropriate, to undertake corrective action, within a
- 45 reasonable timeframe, as may be deemed by the commissioner to be
- 46 necessary to ensure future compliance with P.L. , c. (C.)
- 47 (pending before the Legislature as this bill) or the suicide
- 48 prevention policies and protocols adopted pursuant thereto, as the

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

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

12 c. Any staff member of a psychiatric facility or outpatient
13 treatment provider who violates the provisions of paragraph (4) of
14 subsection b. of section 3 of P.L. , c. (C.) (pending before
15 the Legislature as this bill), and any staff member of a psychiatric
16 facility, staff member of an outpatient treatment provider, staff
17 member of a suicide or crisis hotline, or other health care
18 professional who violates the provisions of subsection a. of section
19 6 of P.L. , c. (C.) (pending before the Legislature as this
20 bill), shall be liable to pay a civil penalty of not more than \$500 for
21 a first offense, not more than \$1,000 for a second offense, and not
22 more than \$2,500 for a third or subsequent offense, to be collected
23 in a summary proceeding in accordance with the "Penalty
24 Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).
25 Any such person shall also be subject to: (1) potential criminal
26 liability and civil lawsuits, including lawsuits for punitive damages,
27 for any injury that is proximately caused thereby; (2) the suspension
28 or revocation of the person's professional license or certification;
29 (3) the revocation of the person's mental health accreditation; and
30 (4) the termination of the person's employment.

31

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

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

39 c. As used in this section:

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

46

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

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

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

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

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

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

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

30
31 10. (New section) a. The governing body of each county shall
32 appoint a suicide prevention response coordinator to facilitate and
33 coordinate the deployment of qualified suicide prevention
34 counselors to emergency scenes involving persons who are or may
35 be suicidal.

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

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

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

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

8 (3) immediately link the person who is or may be suicidal to
9 appropriate treatment facilities, programs, and services, through the
10 use of warm hand-offs and supportive contacts, as deemed by the
11 suicide prevention counselor to be appropriate based on the results
12 of the on-site suicide risk assessment. If the suicide prevention
13 counselor concludes that inpatient psychiatric treatment may be
14 necessary to address and mitigate the person's suicidal risk and
15 tendencies, the suicide prevention counselor, in cooperation with
16 the on-site law enforcement officer, as appropriate, shall effectuate
17 the person's voluntary admission and warm hand-off to a
18 psychiatric facility as soon as is practicable after the immediate
19 crisis is resolved. If such person refuses to be admitted to a
20 psychiatric facility, the suicide prevention counselor, in cooperation
21 with the on-site law enforcement officer, as appropriate, shall
22 effectuate the warm hand-off of the person to a screening service or
23 mental health screener to determine whether involuntary
24 commitment to treatment, as provided by P.L.1987, c.116 (C.30:4-
25 27.1 et seq.), is necessary to address the person's suicidal ideations,
26 behaviors, and tendencies or associated mental health issues.

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

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

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

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

46

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

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

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

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

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

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

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

28

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

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

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

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

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

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

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

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

30 (1) The configuration of, and requirements for, the enhanced 9-
31 1-1 network. The office with the approval of the commission and
32 the Chief Technology Officer, in consultation with the council, only
33 as provided herein, and assistance and advice of the Office of
34 Information Technology in but not of the Department of the
35 Treasury is empowered to enter into contracts for the provision of
36 this network.

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

41 (3) Technical and operational standards for the establishment of
42 public safety answering points (PSAPs) which utilize enhanced 9-1-
43 1 network features in accordance with the provisions of this act and
44 in alignment with the Next Generation 9-1-1 Planning by the
45 National 9-1-1 Office within the United States Department of
46 Transportation, National Highway Traffic Safety Administration.
47 Those entities having responsibility for the creation and
48 management of PSAPs shall conform to these standards in the

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

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

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

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

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

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

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

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

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

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

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

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

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

14 f. The office, after review and approval by the commission and
15 the Chief Technology Officer, only as provided herein, shall submit
16 a report to the Senate Revenue, Finance and Appropriations
17 Committee and the Assembly Appropriations Committee, or their
18 successors, not later than February 15 of each year, concerning its
19 progress in carrying out the provisions of this act and the
20 expenditure of moneys appropriated thereto and appropriated for the
21 purposes of installation of the Statewide enhanced 9-1-1 network
22 and the New Jersey Interoperable Communications System.
23 (cf: P.L.2011, c.4, s.2)

24
25 13. a. The Commissioner of Human Services and the
26 Commissioner of Health, in consultation with each other, shall
27 adopt rules and regulations applicable to the facilities or providers
28 under each commissioner's respective jurisdiction, pursuant to the
29 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
30 seq.), as may be necessary to implement the provisions of sections 1
31 through 7 of P.L. , c. (C. through C.) (pending before
32 the Legislature as this bill).

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

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

44
45 14. This act shall take effect immediately, and section 8 of this
46 act shall apply to all health benefits plans that are in effect in the
47 State, are delivered, issued, executed, or renewed in this State, or
48 are approved for issuance or renewal in this State by the

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

3

4

5

STATEMENT

6

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

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

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

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

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

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

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

40 The bill provides that, whenever a law enforcement officer is
41 dispatched in response to a request for emergency services that
42 involves a person who is or may be suicidal, the police dispatcher
43 will be responsible for notifying the local suicide prevention
44 response coordinator, appointed by the county's governing body
45 under the bill, and the suicide prevention response coordinator will
46 be responsible for ensuring the contemporaneous deployment of a
47 suicide prevention counselor to the scene of the emergency. A 9-1-
48 1 call-taker is to determine whether each request for emergency

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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