30:4-27.1

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2009 **CHAPTER:** 112

NJSA: 30:4-27.1 (Establishes involuntary commitment to outpatient treatment for person in need of involuntary commitment to treatment)

BILL NO: S735 (Substituted for A1618)

SPONSOR(S) Codey and Others

DATE INTRODUCED: January 8, 2008

COMMITTEE: **ASSEMBLY:** Human Services

SENATE: Health, Human Services and Senior Citizens
Budget and Appropriations

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** June 25, 2009

SENATE: June 25, 2009

DATE OF APPROVAL: August 11, 2009

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (Second reprint enacted)

S735

SPONSOR'S STATEMENT: (Begins on page 25 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: Yes 12-8-08 (Health)
6-22-09 (Budget)

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: Yes

LEGISLATIVE FISCAL NOTE: Yes 2-9-09
7-8-09

A1618

SPONSOR'S STATEMENT: (Begins on page 25 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: No

FLOOR AMENDMENT STATEMENT: Yes

(continued)

LEGISLATIVE FISCAL NOTE:	Yes	2-9-09 7-8-09
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GOVERNOR'S PRESS RELEASE ON SIGNING:	Yes	8-11-09

FOLLOWING WERE PRINTED:

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REPORTS:	No
HEARINGS:	No
NEWSPAPER ARTICLES:	Yes

"Corzine signs mental-health treatment bill," The Record, 8-12-09, p. A04
"Law's goal is treating mentally ill," The Star Ledger, 8-12-09, p. 20
"Slain boy's mom finishes mission," Courier Post, 8-12-09, p. 1A
"Bill offers option for mental health," Courier News, 8-12-09
"Corzine approves measure allowing involuntary mental health treatment," The Press, 8-12-09, p. C1
"Governor Corzine signs mental health treatment bill," NewJerseyNewsroom.com, 8-2-09, http://www.newjerseynewsroom.com/healthquest/governor-corzine-signs-mental-health-treatment-bill

LAW/RWH

§9 - C.30:4-27.8a
§17 –
C.30:4-27.15a
§22 –
C.30:4-27.18a
§23 - T&E
§§24 to 26 - Notes
to §§1-22

P.L. 2009, CHAPTER 112, ***approved August 11, 2009***
Senate, No. 735 ***(Second Reprint)***

AN ACT concerning involuntary commitment to treatment and amending and supplementing chapter 4 of Title 30 of the Revised Statutes and amending P.L.1991, c.270.

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

1. Section 1 of P.L.1987, c.116 (C.30:4-27.1) is amended to read as follows:

1. The Legislature finds and declares that:

a. The State is responsible for providing care, treatment and rehabilitation services to mentally ill persons who are disabled and cannot provide basic care for themselves or who are dangerous to themselves, **[**to**]** others or **[**to**]** property; and because some of these mentally ill persons do not seek treatment or are not able to benefit from voluntary treatment provided on an outpatient basis, it is necessary that State law provide for the voluntary admission and the involuntary commitment to treatment of these persons as well as for the public services and facilities necessary to fulfill these responsibilities.

b. Because involuntary commitment to treatment entails certain deprivations of liberty, it is necessary that State law balance the basic value of liberty with the need for safety and treatment, a balance that is difficult to effect because of the limited ability to predict behavior; and, therefore, it is necessary that State law provide clear standards and procedural safeguards that ensure that only those persons who are dangerous to themselves, **[**to**]** others or **[**to**]** property, are involuntarily committed to treatment.

c. It is the policy of this State that persons in the public mental health system receive inpatient treatment and rehabilitation services in the least restrictive environment in accordance with the highest professional standards and which will enable those **[**hospitalized**]**

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.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Assembly AHU committee amendments adopted June 8, 2009.
[2]Assembly floor amendments adopted June 18, 2009.

persons committed to treatment to return to full autonomy in their community as soon as it is clinically appropriate. In addition, it is the policy of this State to ensure that appropriate outpatient treatment services are readily available to all persons with mental illness, such that involuntary commitment to treatment is rarely required; but that persons with mental illness who are determined to be dangerous to themselves, others or property should be subject to involuntary treatment in the least restrictive environment possible, in an inpatient or outpatient setting clinically appropriate to their condition.

Further, it is the policy of this State that the public mental health system shall be developed in a manner which protects individual liberty and provides advocacy and due process for persons receiving treatment and insures that treatment is provided in a manner consistent with a person's clinical condition.

d. It is the policy of this State to encourage each county or designated mental health service area to develop a screening service, outpatient treatment provider and [a] short-term care facility which will meet the needs for evaluation and [acute care] treatment of mentally ill persons in the county or service area. The State encourages the development of screening services as the public mental health system's entry point in order to provide accessible crisis intervention, evaluation and referral services to mentally ill persons in the community; to offer mentally ill persons clinically appropriate alternatives to inpatient care, if any; and, when necessary, to provide a means for involuntary commitment to treatment. Similarly, the State encourages the development of community-based outpatient treatment providers and short-term care facilities to enable a mentally ill person to receive outpatient or acute, inpatient care [in a facility] near the person's community. Development and use of screening services, outpatient treatment providers and short-term care facilities throughout the State are necessary to strengthen the Statewide community mental health system, lessen inappropriate hospitalization and reliance on psychiatric institutions and enable State and county facilities to provide the rehabilitative care needed by some mentally ill persons following their receipt of acute care.

(cf: P.L.1987, c.116, s.1)

2. Section 2 of P.L.1987, c.116 (C.30:4-27.2) is amended to read as follows:

2. As used in [this act] P.L.1987, c.116 (C.30:4-27.1 et seq.) and P.L. , c. (pending before the Legislature as this bill):

a. "Chief executive officer" means the person who is the chief administrative officer of an institution or psychiatric facility.

b. "Clinical certificate" means a form prepared by the division and approved by the Administrative Office of the Courts, that is

completed by the psychiatrist or other physician who has examined the person who is subject to commitment within three days of presenting the person for [admission to a facility for treatment] involuntary commitment to treatment, and which states that the person is in need of involuntary commitment to treatment. The form shall also state the specific facts upon which the examining physician has based his conclusion and shall be certified in accordance with the Rules of the Court. A clinical certificate may not be executed by a person who is a relative by blood or marriage to the person who is being screened.

c. "Clinical director" means the person who is designated by the director or chief executive officer to organize and supervise the clinical services provided in a screening service, short-term care or psychiatric facility. The clinical director shall be a psychiatrist, however, those persons currently serving in the capacity will not be affected by this provision. This provision shall not alter any current civil service laws designating the qualifications of such position.

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

e. "County counsel" means the chief legal officer or advisor of the governing body of a county.

f. "Court" means the Superior Court or a municipal court.

g. "Custody" means the right and responsibility to ensure the provision of care and supervision.

h. "Dangerous to self" means that by reason of mental illness the person has threatened or attempted suicide or serious bodily harm, or has behaved in such a manner as to indicate that the person is unable to satisfy his need for nourishment, essential medical care or shelter, so that it is probable that substantial bodily injury, serious physical [debilitation] harm or death will result within the reasonably foreseeable future; however, no person shall be deemed to be unable to satisfy his need for nourishment, essential medical care or shelter if he is able to satisfy such needs with the supervision and assistance of others who are willing and available. This determination shall take into account a person's history, recent behavior and any recent act, threat or serious psychiatric deterioration.

i. "Dangerous to others or property" means that by reason of mental illness there is a substantial likelihood that the person will inflict serious bodily harm upon another person or cause serious property damage within the reasonably foreseeable future. This determination shall take into account a person's history, recent behavior and any recent act [or], threat or serious psychiatric deterioration.

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

k. "Director" means the chief administrative officer of a screening service, [a] short-term care facility or [a] special psychiatric hospital.

l. "Division" means the Division of Mental Health Services in the Department of Human Services.

m. "In need of involuntary commitment" or "in need of involuntary commitment to treatment" means that an adult with mental illness, whose mental illness causes the person to be dangerous to self or dangerous to others or property and who is unwilling to [be admitted to a facility voluntarily for care] accept appropriate treatment voluntarily after it has been offered, [and who] needs outpatient treatment or inpatient care at a short-term care[,] or psychiatric facility or special psychiatric hospital because other services are not appropriate or available to meet the person's mental health care needs.

n. "Institution" means any State or county facility providing inpatient care, supervision and treatment for persons with developmental disabilities; except that with respect to the maintenance provisions of Title 30 of the Revised Statutes, institution also means any psychiatric facility for the treatment of persons with mental illness.

o. "Mental health agency or facility" means a legal entity which receives funds from the State, county or federal government to provide mental health services.

p. "Mental health screener" means a psychiatrist, psychologist, social worker, registered professional nurse or other individual trained to do outreach only for the purposes of psychological assessment who is employed by a screening service and possesses the license, academic training or experience, as required by the commissioner pursuant to regulation; except that a psychiatrist and a State licensed clinical psychologist who meet the requirements for mental health screener shall not have to comply with any additional requirements adopted by the commissioner.

q. "Mental hospital" means, for the purposes of the payment and maintenance provisions of Title 30 of the Revised Statutes, a psychiatric facility.

r. "Mental illness" means a current, substantial disturbance of thought, mood, perception or orientation which significantly impairs judgment, capacity to control behavior or capacity to recognize reality, but does not include simple alcohol intoxication, transitory reaction to drug ingestion, organic brain syndrome or developmental disability unless it results in the severity of impairment described herein. The term mental illness is not limited to "psychosis" or "active psychosis," but shall include all conditions that result in the severity of impairment described herein.

s. "Patient" means a person over the age of 18 who has been admitted to, but not discharged from a short-term care or

psychiatric facility, or who has been assigned to, but not discharged from an outpatient treatment provider.

t. "Physician" means a person who is licensed to practice medicine in any one of the United States or its territories, or the District of Columbia.

u. "Psychiatric facility" means a State psychiatric hospital listed in R.S.30:1-7, a county psychiatric hospital, or a psychiatric unit of a county hospital.

v. "Psychiatrist" means a physician who has completed the training requirements of the American Board of Psychiatry and Neurology.

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

x. "Psychologist" means a person who is licensed as a psychologist by the New Jersey Board of Psychological Examiners.

y. "Screening certificate" means a clinical certificate executed by a psychiatrist or other physician affiliated with a screening service.

z. "Screening service" means a public or private ambulatory care service designated by the commissioner, which provides mental health services including assessment, emergency and referral services to persons with mental illness in a specified geographic area.

aa. "Screening outreach visit" means an evaluation provided by a mental health screener wherever the person may be when clinically relevant information indicates the person may need involuntary commitment to treatment and is unable or unwilling to come to a screening service.

bb. "Short-term care facility" means an inpatient, community based mental health treatment facility which provides acute care and assessment services to a person with mental illness whose mental illness causes the person to be dangerous to self or dangerous to others or property. A short-term care facility is so designated by the commissioner and is authorized by the commissioner to serve persons from a specified geographic area. A short-term care facility may be a part of a general hospital or other appropriate health care facility and shall meet certificate of need requirements and shall be licensed and inspected by the Department of Health and Senior Services pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) and in accordance with standards developed jointly with the Commissioner of Human Services.

cc. "Special psychiatric hospital" means a public or private hospital licensed by the Department of Health and Senior Services to provide voluntary and involuntary mental health services,

including assessment, care, supervision, treatment and rehabilitation services to persons with mental illness.

dd. "Treatment team" means one or more persons, including at least one psychiatrist or physician, and may include a psychologist, social worker, nurse and other appropriate services providers. A treatment team provides mental health services to a patient of a screening service, outpatient treatment provider, or short-term care or psychiatric facility.

ee. "Voluntary admission" means that adult with mental illness, whose mental illness causes the person to be dangerous to self or dangerous to others or property and is willing to be admitted to a facility voluntarily for care, needs care at a short-term care or psychiatric facility because other facilities or services are not appropriate or available to meet the person's mental health needs. A person may also be voluntarily admitted to a psychiatric facility if his mental illness presents a substantial likelihood of rapid deterioration in functioning in the near future, there are no appropriate community alternatives available and the psychiatric facility can admit the person and remain within its rated capacity.

ff. "County adjuster" means the person appointed pursuant to R.S.30:4-34.

gg. "Least restrictive environment" means the available setting and form of treatment that appropriately addresses a person's need for care and the need to respond to dangers to the person, others or property and respects, to the greatest extent practicable, the person's interests in freedom of movement and self-direction.

hh. "Outpatient treatment" means clinically appropriate care based on proven or promising treatments directed to wellness and recovery, provided by a member of the patient's treatment team to a person not in need of inpatient treatment. Outpatient treatment may include, but shall not be limited to, day treatment services, case management, residential services, outpatient counseling and psychotherapy, and medication treatment.

ii. "Outpatient treatment provider" means a community-based provider, designated as an outpatient treatment provider pursuant to section 8 of P.L.1987, c.116 (C.30:4-27.8), that provides or coordinates the provision of outpatient treatment to persons in need of involuntary commitment to treatment.

jj. "Plan of outpatient treatment" means a plan for recovery from mental illness approved by a court pursuant to section 17 of P.L. , c. (C.)(pending before the Legislature as this bill) that is to be carried out in an outpatient setting and is prepared by an outpatient treatment provider for a patient who has a history of responding to treatment. The plan may include medication as a component of the plan; however, medication shall not be involuntarily administered in an outpatient setting.

kk. "Reasonably foreseeable future" means a time frame that may be beyond the immediate or imminent, but not longer than a time frame as to which reasonably certain judgments about a person's likely behavior can be reached.

(cf: P.L.2005, c.55, s.1)

3. Section 3 of P.L.1987, c.116 (C.30:4-27.3) is amended to read as follows:

3. The standards and procedures in this act apply to all adults involuntarily committed to treatment, including those assigned to an outpatient treatment provider or admitted to a short-term care facility, psychiatric facility or special psychiatric hospital and all adults voluntarily admitted from a screening service to a short-term care facility or psychiatric facility. The standards and procedures in this act shall not apply to adults voluntarily admitted to psychiatric units in general hospitals or special psychiatric hospitals, except as provided in section 11 or 20 of [this amendatory and supplementary act] P.L.1987, c.116 (C.30:4-27.11 or C.30:4-27.20).

(cf: P.L.1987, c.116, s.3)

4. Section 4 of P.L.1987, c.116 (C.30:4-27.4) is amended to read as follows:

4. The commissioner, in consultation with the appropriate county mental health board and consistent with the approved county mental health plan, shall designate one or more mental health agencies or facilities in each county or multi-county region in the State as a screening service. The commissioner shall so designate an agency or facility only with the approval of the agency's or facility's governing body. In designating the screening services, the commissioner shall ensure that screening services are accessible to all persons in the State who need these services and that screening service evaluation is the preferred process for entry into outpatient treatment, short-term care facilities or psychiatric facilities so that appropriate consideration is given to less restrictive treatment alternatives.

(cf: P.L.1987, c.116, s.4)

5. Section 5 of P.L.1987, c.116 (C.30:4-27.5) is amended to read as follows:

5. The commissioner shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) regarding a screening service and its staff that effectuate the following purposes and procedures:

a. A screening service shall serve as the facility in the public mental health care treatment system wherein a person believed to be in need of involuntary commitment to outpatient treatment, a short-term care facility, psychiatric facility or special psychiatric

hospital undergoes an assessment to determine what mental health services are appropriate for the person and where those services may be most appropriately provided in the least restrictive environment.

The screening service may provide emergency and consensual treatment to the person receiving the assessment and may transport the person or detain the person up to 24 hours for the purposes of providing the treatment and conducting the assessment.

b. When a person is assessed by a mental health screener and involuntary commitment to treatment seems necessary, the screener shall provide, on a screening document prescribed by the division, information regarding the person's history and available alternative facilities and services that are deemed inappropriate for the person. When appropriate and available, and as permitted by law, the screener shall make reasonable efforts to gather information from the person's family or significant others for the purposes of preparing the screening document. If a psychiatrist, in consideration of this document and in conjunction with the psychiatrist's own complete assessment, concludes that the person is in need of commitment to treatment, the psychiatrist shall complete the screening certificate. The screening certificate shall be completed by a psychiatrist except in those circumstances where the division's contract with the screening service provides that another physician may complete the certificate.

Upon completion of the screening certificate, screening service staff shall determine', in consultation with the psychiatrist or another physician, as appropriate,' the least restrictive environment for the appropriate [facility in] treatment to which the person shall be [placed] assigned or admitted, taking into account the person's prior history of hospitalization and treatment and the person's current mental health condition. Screening service staff shall designate:

(1) inpatient treatment for the person if he is immediately or imminently dangerous or if outpatient treatment is deemed inadequate to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future; and

(2) outpatient treatment for the person when outpatient treatment is deemed sufficient to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future.

If the screening service staff determines that the person is in need of involuntary commitment to outpatient treatment, the screening service staff shall consult with an outpatient treatment provider to arrange, if possible, for an appropriate interim plan of outpatient treatment in accordance with section 9 of P.L. , c. (C.) (pending before the Legislature as this bill).

If a person has been admitted three times or has been an inpatient for 60 days at a short-term care facility during the preceding 12

months, consideration shall be given to not placing the person in a short-term care facility.

The person shall be admitted to the appropriate facility or assigned to the appropriate outpatient treatment provider, as appropriate for treatment, as soon as possible. Screening service staff are authorized to coordinate initiation of outpatient treatment or transport the person or arrange for transportation of the person to the appropriate facility.

c. If the mental health screener determines that the person is not in need of assignment or commitment to an outpatient treatment provider, or admission or commitment to a short-term care facility, psychiatric facility or special psychiatric hospital, the screener shall refer the person to an appropriate community mental health or social services agency or appropriate professional or inpatient care in a psychiatric unit of a general hospital.

d. A mental health screener shall make a screening outreach visit if the screener determines, based on clinically relevant information provided by an individual with personal knowledge of the person subject to screening, that the person may need involuntary commitment to treatment and the person is unwilling or unable to come to the screening service for an assessment.

e. If the mental health screener pursuant to this assessment determines that there is reasonable cause to believe that a person is in need of involuntary commitment to treatment, the screener shall so certify the need on a form prepared by the division.

(cf: P.L.1987, c.116, s.5)

6. Section 6 of P.L.1987, c.116 (C.30:4-27.6) is amended to read as follows:

6. A State or local law enforcement officer shall take custody of a person and take the person immediately and directly to a screening service if:

a. On the basis of personal observation, the law enforcement officer has reasonable cause to believe that the person is in need of involuntary commitment to treatment;

b. A mental health screener has certified on a form prescribed by the division that based on a screening outreach visit the person is in need of involuntary commitment to treatment and has requested the person be taken to the screening service for a complete assessment; **[**or**]**

c. The court orders that a person subject to an order of conditional discharge issued pursuant to subsection c. of section 15 of **[**this act**]** P.L.1987, c.16 (C.30:4-27.15) who has failed to follow the conditions of the discharge be taken to a screening service for an assessment; or

d. An outpatient treatment provider has certified on a form prescribed by the division that the provider has reasonable cause to

believe the person is in need of evaluation for commitment to treatment.

The involvement of the law enforcement authority shall continue at the screening [center] service as long as necessary to protect the safety of the person in custody and the safety of the community from which the person was taken.

(cf: P.L.1987, c.116, s.6)

7. Section 7 of P.L.1987, c.116 (C.30:4-27.7) is amended to read as follows:

7. a. A law enforcement officer, screening service, outpatient treatment provider or short-term care facility designated staff person or their respective employers, acting in good faith pursuant to [this act] P.L.1987, c.116 (C.30:4-27.1 et seq.) and P.L. , c. (pending before the Legislature as this bill) who takes reasonable steps to assess, take custody of, detain or transport an individual for the purposes of mental health assessment or treatment is immune from civil and criminal liability.

b. An emergency services or medical transport person or their respective employers, acting in good faith pursuant to this act and pursuant to the direction of a person designated in subsection a. of this section, who takes reasonable steps to take custody of, detain or transport an individual for the purpose of mental health assessment or treatment is immune from civil and criminal liability.

For the purposes of this subsection, "emergency services or medical transport person" means a member of a first aid, ambulance, rescue squad or fire department, whether paid or volunteer, auxiliary police officer or paramedic.

(cf: P.L.1992, c.152, s.1)

8. Section 8 of P.L.1987, c.116 (C.30:4-27.8) is amended to read as follows:

8. a. The commissioner, in consultation with the Commissioner of Health and Senior Services, shall designate one or more mental health agencies or facilities in each county or multi-county region in the State as short-term care facilities. The commissioner shall so designate an agency or facility only with the approval of the agency's or facility's governing body.

b. The commissioner shall designate one or more mental health agencies in each county or multi-county region in the State as an outpatient treatment provider, and shall authorize the designated outpatient treatment provider to provide services to persons from a specified geographic area. The commissioner shall so designate an agency only with the approval of the agency's governing body.

(cf: P.L.1987, c.116, s.8)

9. (New section) a. An outpatient treatment provider shall develop a plan of outpatient treatment, in cooperation with screening service or short term care facility staff or the court, as applicable, for patients committed and assigned to outpatient treatment by screening service staff or order of a court, or both. When appropriate and available, and as permitted by law, the provider shall make reasonable efforts to gather information from the patient's family or significant others for the purposes of developing the plan of outpatient treatment.

b. During the time a patient is assigned to the outpatient treatment provider for services pursuant to a commitment to outpatient treatment, the outpatient treatment provider shall provide and coordinate the provision of care consistent with the plan of outpatient treatment.

c. If a patient fails to materially comply with the plan of outpatient treatment during the time the patient is assigned by a screening service to the outpatient treatment provider for services pursuant to a commitment to outpatient treatment, or if the outpatient treatment provider determines that the plan of outpatient treatment is inadequate to meet the patient's mental health needs, the provider shall notify the screening service of the material noncompliance or plan inadequacy, as applicable, and the patient shall be referred to a screening service for an assessment to determine what mental health services are appropriate and where those services may be provided, in accordance with section 5 of P.L.1987, c.116 (C.30:4-27.5). In such a case, the patient shall be afforded the protections and procedures provided for in P.L.1987, c.116 and P.L. , c. (pending before the Legislature as this bill).

d. If a patient fails to materially comply with the plan of outpatient treatment during the time the patient is assigned by a court to the outpatient treatment provider for services pursuant to a commitment to outpatient treatment, or if the outpatient treatment provider determines that the plan of outpatient treatment is inadequate to meet the patient's mental health needs, the provider shall notify the court and screening service of the material noncompliance or plan inadequacy, as applicable, and the patient shall be referred to a screening service for an assessment to determine what mental health services are appropriate and where those services may be provided, in accordance with section 5 of P.L.1987, c.116 (C.30:4-27.5). In such a case, the patient shall be afforded the protections and procedures provided for in P.L.1987, c.116 and P.L. , c. (pending before the Legislature as this bill).

e. If an outpatient treatment provider determines that a plan of outpatient treatment is inadequate and needs to be modified, but referral to a screening service is not necessary, the provider shall seek court approval for such modification and shall notify the court,

the patient's attorney and the county adjuster of the request for court approval of such modification.

10. Section 9 of P.L.1987, c.116 (C.30:4-27.9) is amended to read as follows:

9. **[**Short-term**]** Outpatient treatment providers, short-term care facilities, psychiatric facilities and special psychiatric hospitals shall effectuate the following purposes and procedures:

a. An outpatient treatment provider to which a person has been assigned pursuant to an order of continued involuntary commitment to treatment pursuant to section 15 of P.L.1987, c.116 (C.30:4-27.15) shall maintain the plan of outpatient treatment approved by the court pursuant to section 17 of P.L. , c. (C.)(pending before the Legislature as this bill), and shall notify the court, the person's attorney and the county adjuster of any material non-compliance with the plan by the person and of the inadequacy of the plan of outpatient treatment to meet the person's mental health needs, if applicable, and seek court approval for a modification to a plan of outpatient treatment, as provided for in section 9 of P.L. , c. (C.) (pending before the Legislature as this bill).

The director or chief executive officer of a short-term care facility, psychiatric facility or special psychiatric hospital shall have custody of a person while that person is detained in the facility and shall notify:

(1) appropriate public or private agencies to arrange for the care of any dependents and to ensure the protection of the person's property; and (2) appropriate ambulatory mental health providers for the purposes of beginning discharge planning.

If a person is admitted to a psychiatric facility, the chief executive officer of the facility shall promptly notify the county adjuster of the person's county of residence that the person has been admitted to the facility.

The facility is authorized to provide assessment, treatment and rehabilitation services and shall provide discharge planning services as required pursuant to section 18 of **[**this act**]** P.L.1987, c.116 (C.30:4-27.18).

The facility is authorized to detain persons involuntarily committed to the facility.

b. A person shall not be involuntarily committed to **[**a**]** treatment at an outpatient treatment provider, short-term care or psychiatric facility, or special psychiatric hospital unless the person is **[**mentally ill and that mental illness causes the person to be dangerous to self or dangerous to others or property, and appropriate facilities or services are not otherwise available**]** in need of involuntary commitment to treatment.

The person shall be assigned involuntarily to an outpatient treatment provider or admitted involuntarily to a facility only by

referral from a screening service or temporary court order. The person may be admitted voluntarily to a short-term care or psychiatric facility or special psychiatric hospital only after the person has been advised orally and in writing of the discharge provisions established pursuant to [this act] P.L.1987, c.116 (C.30:4-27.1 et seq.) and P.L. , c. (C.) (pending before the Legislature as this bill) and of the subsequent possibility that the facility may initiate involuntary commitment proceedings for the person.

c. A short-term care or psychiatric facility, or special psychiatric hospital may detain a person, admitted to the facility involuntarily by referral from a screening service without a temporary court order, for no more than 72 hours from the time the screening certificate was executed. During this period of time the facility shall initiate court proceedings for the involuntary commitment of the person pursuant to section 10 of [this act] P.L.1987, c.116 (30:4-27.10).

d. A person shall not be assigned to an outpatient treatment provider by referral from a screening service without a temporary court order, for more than 72 hours from the time the screening certificate was executed. During this period of time the provider shall initiate court proceedings for the involuntary commitment of the person pursuant to section 10 of P.L.1987, c.116 (C.30:4-27.10.

(cf: P.L.1987, c.116, s.9)

11. Section 10 of P.L.1987, c.116 (C.30:4-27.10) is amended to read as follows:

10. a. (1) A short-term care or psychiatric facility or a special psychiatric hospital shall initiate court proceedings for involuntary commitment to inpatient or outpatient treatment by submitting to the court a clinical certificate completed by a psychiatrist on the patient's treatment team and the screening certificate which authorized admission of the patient to the facility; provided, however, that both certificates shall not be signed by the same psychiatrist unless the psychiatrist has made a reasonable but unsuccessful attempt to have another psychiatrist conduct the evaluation and execute the certificate.

(2) A screening service or outpatient treatment provider shall initiate court proceedings for commitment to outpatient treatment by submitting to the court a clinical certificate completed by a psychiatrist on the patient's treatment team and the screening certificate which authorized assignment of the patient to outpatient treatment with the outpatient treatment provider; provided, however, that both certificates shall not be signed by the same psychiatrist unless the psychiatrist has made a reasonable but unsuccessful attempt to have another psychiatrist conduct the evaluation and execute the certificate.

b. Court proceedings for the involuntary commitment to treatment of any person not referred by a screening service may be initiated by the submission to the court of two clinical certificates, at least one of which is prepared by a psychiatrist. The person shall not be involuntarily committed before the court issues a temporary court order.

c. A court proceeding for involuntary commitment to treatment of an inmate who is scheduled for release upon expiration of a maximum term of incarceration shall be initiated by the Attorney General or county prosecutor by submission to the court of two clinical certificates, at least one of which is prepared by a psychiatrist.

d. The Attorney General, in exercise of the State's authority as parens patriae, may initiate a court proceeding for the involuntary commitment to treatment of any person in accordance with the procedures set forth in subsection a. or b. of this section. When the Attorney General determines that the public safety requires initiation of a proceeding pursuant to subsection b. of this section, the Attorney General may apply to the court for an order compelling the psychiatric evaluation of the person. The court shall grant the Attorney General's application if the court finds that there is reasonable cause to believe that the person may be in need of involuntary commitment to treatment. The Attorney General may delegate the authority granted pursuant to this subsection, on a case by case basis, to the county prosecutor.

e. Any person who is a relative by blood or marriage of the person being screened who executes a clinical certificate, or any person who signs a clinical certificate for any purpose or motive other than for purposes of care, treatment and confinement of a person in need of involuntary commitment to treatment, shall be guilty of a crime of the fourth degree.

f. Upon receiving these documents the court shall immediately review them in order to determine whether there is probable cause to believe that the person is in need of involuntary commitment to treatment.

g. If the court finds that there is probable cause to believe that the person, other than a person whose commitment is sought pursuant to subsection c. of this section, is in need of involuntary commitment to treatment, it shall issue a temporary order authorizing the assignment of the person to an outpatient treatment provider or the admission to or retention of the person in the custody of the facility, that is both appropriate to the person's condition and is the least restrictive environment, pending a final hearing.

h. If the court finds that there is probable cause to believe that a person whose commitment is sought pursuant to subsection c. of this section is in need of involuntary commitment to treatment, it

shall issue an order setting a date for a final hearing and authorizing the Commissioner of the Department of Corrections to arrange for temporary commitment pursuant to section 2 of P.L.1986, c.71 (C.30:4-82.2) to the Ann Klein Forensic **[**Psychiatric Hospital**]** Center in Trenton or other facility designated for the criminally insane pending the final hearing and prior to the expiration of the person's term. The order shall specifically provide for transfer of custody to the Ann Klein Forensic **[**Psychiatric Hospital**]** Center in Trenton or other facility designated for the criminally insane if the person's maximum term will expire prior to the final hearing.

i. In the case of a person committed to treatment at a short-term care facility or special psychiatric hospital, after the facility's treatment team conducts a mental and physical examination, administers appropriate treatment and prepares a discharge assessment, the facility may transfer the patient to a psychiatric facility prior to the final hearing; provided that: (1) the patient, his family and his attorney are given 24 hours' advance notice of the pending transfer; and (2) the transfer is accomplished in a manner which will give the receiving facility adequate time to examine the patient, become familiar with his behavior and condition and prepare for the hearing. In no event shall the transfer be made less than five days prior to the date of the hearing unless an unexpected transfer is dictated by a change in the person's clinical condition.

(cf: P.L.1994, c.134, s.6)

12. Section 11 of P.L.1987, c.116 (C.30:4-27.11) is amended to read as follows:

11. A patient admitted to a short-term care or psychiatric facility or special psychiatric hospital either on a voluntary or involuntary basis, or assigned to an outpatient treatment provider has the following rights:

a. The right to have examinations and services provided in the patient's primary means of communication including, as soon as possible, the aid of an interpreter if needed because the patient is of limited English-speaking ability or suffers from a speech or hearing impairment;

b. The right to a verbal explanation of the reasons for admission to the facility or assignment to the provider, as applicable, the availability of an attorney and the rights provided in **[**this act**]** P.L.1987, c.116 (C.30:4-27.1 et seq.) and P.L. , c. (pending before the Legislature as this bill); and

c. The right to be represented by an attorney and, if unrepresented or unable to afford an attorney, the right to be provided with an attorney paid for by the appropriate government agency. An attorney representing a patient has the right to inspect and copy the patient's clinical chart.

The clinical director of the facility, or the outpatient treatment provider, as appropriate, shall ensure that a written statement of the rights provided in [this act] P.L.1987, c.116 (C.30:4-27.1 et seq. and P.L. , c. (pending before the Legislature as this bill) is provided to patients at the time of admission or assignment, as applicable, as soon as possible thereafter, and to patients and their families upon request.
(cf: P.L.1987, c.116, s.11)

13. Section 12 of P.L.1987, c.116 (C.30:4-27.12) is amended to read as follow:

12. a. A patient who is involuntarily committed to treatment and assigned to [a] an outpatient treatment provider or involuntarily committed to treatment and admitted to a short-term care or psychiatric facility or special psychiatric hospital shall receive a court hearing with respect to the issue of [continuing] continued need for involuntary commitment within 20 days from initial [inpatient admission to the facility] commitment unless the patient has been administratively discharged [from the facility] pursuant to section 17 of P.L.1987, c.116 (C.30:4-27.17). However, if a person is involuntarily committed pursuant to subsection c. or d. of section 10 of P.L.1987, c.116 (C.30:4-27.10), that person immediately shall be committed to the Ann Klein Forensic [Psychiatric Hospital] Center in Trenton or other facility designated for the criminally insane for the duration of the 20 day waiting period.

b. Except as provided in subsection c. of this section, the assigned county counsel is responsible for presenting the case for the patient's involuntary commitment to the court, unless the county adjuster is licensed to practice law in this State, in which case the county adjuster shall present the case for the patient's involuntary commitment to the court.

c. Notwithstanding the provisions of subsection b. of this section and upon notice to the county adjuster:

(1) The Attorney General, or the county prosecutor acting at the request of the Attorney General, may supersede the county counsel or county adjuster and assume responsibility for presenting any case for involuntary commitment to treatment or may elect to participate with the county counsel or county adjuster in presenting any such case; and

(2) The county prosecutor may supersede the county counsel or county adjuster and assume responsibility for presenting any case for involuntary commitment to treatment initiated by the county prosecutor pursuant to subsection c. of section 10 of P.L.1987, c.116 (C.30:4-27.10) or may elect to participate with the county counsel in the presentation of any such case.

d. A patient subject to involuntary commitment to treatment shall have counsel present at the hearing and shall not be permitted to appear at the hearing without counsel.
(cf: P.L.1994, c.134, s.7)

14. Section 13 of P.L.1987, c.116 (C.30:4-27.13) is amended to read as follows:

13. a. At least 10 days prior to a court hearing, the county adjuster of the admitting county or the Attorney General or county prosecutor if presenting the case for the patient's involuntary commitment to treatment, shall cause notice of the court hearing to be served upon the patient, the patient's guardian if any, the patient's next-of-kin, the patient's attorney, the director, chief executive officer, or other individual who has custody of the patient, the county adjuster of the county in which the patient has legal settlement and any other individual specified by the court. The notice shall contain the date, time and location of the court hearing. The patient and the patient's attorney shall also receive copies of the clinical certificates and supporting documents, the temporary court order and a statement of the patient's rights at the court hearing.

b. A psychiatrist on the patient's treatment team who has conducted a personal examination of the patient as close to the court hearing date as possible, but in no event more than five calendar days prior to the court hearing, shall testify at the hearing to the clinical basis for the need for involuntary commitment to treatment. Other members of the patient's treatment team and any other witness with relevant information offered by the patient or the persons presenting the case for civil commitment shall also be permitted to testify at the hearing.

c. The patient's next-of-kin may attend and testify at the court hearing if the court so determines.

d. The court shall transcribe the court hearing and arrange for the payment of expenses related thereto in the same manner as for other court proceedings.
(cf: P.L.1994, c.134, s.8)

15. Section 14 of P.L.1987, c.116 (C.30:4-27.14) is amended to read as follows:

14. A person subject to involuntary commitment to treatment has the following rights at a court hearing and any subsequent review court hearing:

a. The right to be represented by counsel or, if indigent, by appointed counsel;

b. The right to be present at the court hearing unless the court determines that because of the person's conduct at the court hearing

the proceeding cannot reasonably continue while the person is present;

c. The right to present evidence;

d. The right to cross examine witnesses; and

e. The right to a hearing in camera.

(cf: P.L.1987, c.116, s.14)

16. Section 15 of P.L.1987, c.116 (C.30:4-27.15) is amended to read as follows:

15. a. If the court finds by clear and convincing evidence that the patient needs continued involuntary commitment to treatment, it shall issue an order authorizing the involuntary commitment of the patient and the assignment or admission of the patient pursuant to section 17 of P.L. , c. (C.)(pending before the Legislature as this bill) and shall schedule a subsequent court hearing in the event the patient is not administratively discharged pursuant to section 17 of P.L.1987, c.116 (C.30:4-27.17) prior thereto.

b. If the court finds that the patient does not need continued involuntary commitment to treatment, the court shall so order. A patient who is serving a term of incarceration shall be returned to the appropriate State, county or local authority to complete service of the term of incarceration imposed until released in accordance with law, and any other patient shall be discharged by the facility within 48 hours of the court's verbal order or by the end of the next working day, whichever is longer, with a discharge plan prepared pursuant to section 18 of P.L.1987, c.116 (C.30:4-27.18).

c. (1) The court may discharge the patient subject to conditions, if the court finds that the person does not need involuntary or continued involuntary commitment to treatment and the court finds:

(a) that the patient's history indicates a high risk of rehospitalization because of the patient's failure to comply with discharge plans; or

(b) that there is substantial likelihood that by reason of mental illness the patient will be dangerous to himself, others or property if the patient does not receive other appropriate and available services that render involuntary commitment to treatment unnecessary.

(2) Conditions imposed pursuant to this section shall include those recommended by the facility and mental health agency and developed with the participation of the patient. Conditions imposed on the patient shall be specific and their duration shall not exceed 90 days unless the court determines, in a case in which the Attorney General or a county prosecutor participated, that the conditions should be imposed for a longer period. If the court imposes conditions for a period exceeding six months, the court shall provide for a review hearing on a date the court deems appropriate but in no event later than six months from the date of the order.

The review hearing shall be conducted in the manner provided in this section, and the court may impose any order authorized pursuant to this section.

(3) The designated mental health agency staff person shall notify the court if the patient fails to meet the conditions of the discharge plan, and the court shall issue an order directing that the person be taken to a screening service for an assessment. The court shall determine, in conjunction with the findings of a screening service, if the patient needs to be rehospitalized and, if so, the patient shall be returned to the facility. The court shall hold a hearing within 20 days of the day the patient was returned to the facility to determine if the order of conditional discharge should be vacated.

d. Notwithstanding subsection a. of this section, or any provision of section 16, 17 or 18 of P.L.1987, c.116 (C.30:4-27.16, 30:4-27.17 or 30:4-27.18), no person committed while serving a term of incarceration shall be discharged by the court or administratively discharged prior to the date on which the person's maximum term would have expired had he not been committed. If the person is no longer in need of involuntary commitment <u>to treatment</u>, the person shall be returned to the appropriate State, county or local authority to complete service of the term of incarceration imposed until released in accordance with law, and the person shall be given day for day credit for all time during which the person was committed.

e. Notwithstanding subsection a. of this section, or any provision of section 16, 17 or 18 of P.L.1987, c.116 (C.30:4-27.16, 30:4-27.17 or 30:4-27.18), no person committed pursuant to N.J.S.2C:4-8 concerning acquittal of a criminal charge by reason of insanity or pursuant to N.J.S.2C:4-6 concerning lack of mental competence to stand trial shall be discharged by the court or administratively discharged unless the prosecuting attorney in the case receives prior notice and an opportunity to be heard.

(cf: P.L.1996, c.133, s.4)

17. (New section) a. The court shall determine whether a patient who has been found to need continued involuntary commitment to treatment pursuant to section 15 of P.L.1987, c.116 (C.30:4-27.15) should be assigned to an outpatient setting or admitted to an inpatient setting for treatment, and shall issue the order authorizing such placement pursuant to section 15 of P.L.1987, c.116 (C.30:4-27.15), in accordance with this section. In determining the commitment placement, the court shall consider the least restrictive environment for the patient to receive clinically appropriate treatment that would ameliorate the danger posed by the patient and provide the patient with appropriate treatment.

b. If the court determines that the least restrictive environment for the patient to receive clinically appropriate treatment would be

in an outpatient setting and that there is a likelihood of the patient responding to outpatient treatment, the court shall obtain from a designated outpatient treatment provider a proposed plan of outpatient treatment for the patient which the court shall review. The plan of outpatient treatment shall be approved by the court.

c. If the court determines that the least restrictive environment for the patient to receive clinically appropriate treatment would be in an inpatient setting, the court shall issue an order for admission to a psychiatric facility.

d. Between the time periods for periodic court review hearings pursuant to section 16 of P.L.1987, c.116 (C.30:4-27.16), the chief executive officer of a psychiatric facility may recommend changing the placement of the patient from an inpatient to outpatient setting, in order to ensure that the patient receives clinically appropriate treatment in the least restrictive environment. The chief executive officer of the facility shall notify the court of the recommendation for the change in placement.

e. At the time the court sets the date for a hearing on the change in placement, notice of the hearing shall be served upon the patient, the patient's guardian, if any, the patient's next-of-kin, the patient's attorney and the county adjuster of the county in which the patient has legal settlement.

f. The provisions of section 14 of P.L.1987, c.116 (C.30:4-27.14) concerning patient rights at a hearing shall apply to the hearing pursuant to this subsection.

18. Section 16 P.L.1987, c.116 (C.30:4-27.16) is amended to read as follows:

16. a. A patient committed pursuant to a court order who is not administratively discharged pursuant to section 17 of **[**this act**]** P.L.1987, c.116 (C.30:4-27.17) shall be afforded periodic court review hearings of the need for involuntary commitment to treatment and of the least restrictive environment for that commitment. The review hearing shall be conducted in the manner provided in section 15 of **[**this act**]** P.L.1987, c.116 (C.30:4-27.15). If the court determines at a review hearing that involuntary commitment to treatment shall be continued, it shall execute a new order.

[The**]** In the case of a patient who has been admitted to a facility, the court shall conduct the first review hearing three months from the date of the first hearing, the next review hearing nine months from the date of the first hearing and subsequent review hearings 12 months from the date of the first hearing and annually thereafter. The court may schedule additional review hearings but, except in extraordinary circumstances, not more often than once every 30 days.

In the case of a patient who has been assigned to an outpatient treatment provider, the court shall conduct the first review hearing six months from the date of the first hearing, the next review hearing nine months from the date of the first hearing and subsequent review hearings 12 months from the date of the first hearing and annually thereafter. The court may schedule additional review hearings but, except in extraordinary circumstances, not more often than once every 30 days.

b. At a court review hearing, when the advanced age of the patient or the cause or nature of the mental illness renders it appropriate and when it would be impractical to obtain the testimony of a psychiatrist as required in section 13 of [this act] P.L.1987, c.116 (C.30:4-27.13), the court may permit a physician on the patient's treatment team, who has personally conducted an examination of the patient as close to the hearing date as possible, but in no event more than five days prior to the hearing date, to testify at the hearing to the clinical basis for the need for involuntary commitment to treatment.

(cf: P.L.1987, c.116, s.16)

19. Section 17 of P.L.1987, c.116 (C.30:4-27.17) is amended to read as follows:

17. a. The treatment team at [a] an outpatient treatment provider, short-term care or psychiatric facility or special psychiatric hospital shall, subject to the limitations set forth in subsections b. and c. of this section, administratively discharge a patient from involuntary commitment status if the treatment team determines that the patient no longer needs involuntary commitment to treatment. If a discharge plan has not been developed pursuant to section 18 of [this act] P.L.1987, c.116 (C.30:4-27.18), it shall be developed forthwith.

b. If the patient is confined pursuant to an order entered under section 15 of P.L.1987, c.116 (C.30:4-27.15) in a case in which the Attorney General or a county prosecutor participated, the treatment team shall, no less than 10 days prior to the proposed date of administrative discharge, provide written notice to the committing court and to the person or persons who presented the case for involuntary commitment to treatment. If, within five days of receipt of such notice, a person who presented the case for commitment files a request for a hearing on the issue of [continuing] continued need for commitment and serves notice of that request, in accordance with the provisions of section 13 of P.L.1987, c.116 (C.30:4-27.13), the treatment team shall delay the administrative discharge and the court shall schedule a hearing on the issue. The hearing shall be conducted in the manner provided in section 15 of P.L.1987, c.116 (C.30:4-27.15).

c. If the patient is confined pursuant to an order entered under N.J.S.2C:4-8 concerning acquittal of a criminal charge by reason of insanity or under N.J.S.2C:4-6 concerning lack of mental competence to stand trial, the treatment team shall, no less than 10 days prior to the proposed date of administrative discharge, provide written notice to the committing court and to the prosecutor. If, within five days of receipt of such notice, the prosecutor files a request for a hearing on the issue of **[**continuing**]** continued need for commitment and serves notice of that request, in accordance with the provisions of section 13 of P.L.1987, c.116 (C.30:4-27.13), the treatment team shall delay the administrative discharge and the court shall schedule a hearing on the issue. The hearing shall be conducted in the manner provided in section 15 of P.L.1987, c.116 (C.30:4-27.15).

(cf: P.L.1996, c.133, s.5)

20. Section 18 of P.L.1987, c.116 (C.30:4-27.18) is amended to read as follows:

18. A person discharged either by the court or administratively from **[**a**]** an outpatient treatment provider, short-term care or psychiatric facility or special psychiatric hospital shall have a discharge plan prepared by the treatment team at the facility or provider, as appropriate, pursuant to this section. The treatment team shall give the patient an opportunity to participate in the formulation of the discharge plan.

In the case of patients committed to treatment at short-term care or psychiatric facilities, a community agency designated by the commissioner shall participate in the formulation of the plan. The facility shall advise the mental health agency of the date of the patient's discharge. The mental health agency shall provide follow-up care to the patient pursuant to regulations adopted by the commissioner.

In the case of patients assigned to outpatient treatment providers, the outpatient treatment provider shall participate in the formulation of the plan.

This section does not preclude discharging a patient to an appropriate professional.

Psychiatric facilities shall give notice of the discharge to the county adjuster of the county in which the patient has legal settlement.

(cf: P.L.1987, c.116, s.18)

21. Section 1 of P.L.1991, c.270 (C.2A:62A-16) is amended to read as follows:

1. a. Any person who is licensed in the State of New Jersey to practice psychology, psychiatry, medicine, nursing, clinical social work or marriage counseling, whether or not compensation is

received or expected, is immune from any civil liability for a patient's violent act against another person or against himself unless the practitioner has incurred a duty to warn and protect the potential victim as set forth in subsection b. of this section and fails to discharge that duty as set forth in subsection c. of this section.

b. A duty to warn and protect is incurred when the following conditions exist:

(1) The patient has communicated to that practitioner a threat of imminent, serious physical violence against a readily identifiable individual or against himself and the circumstances are such that a reasonable professional in the practitioner's area of expertise would believe the patient intended to carry out the threat; or

(2) The circumstances are such that a reasonable professional in the practitioner's area of expertise would believe the patient intended to carry out an act of imminent, serious physical violence against a readily identifiable individual or against himself.

c. A licensed practitioner of psychology, psychiatry, medicine, nursing, clinical social work or marriage counseling shall discharge the duty to warn and protect as set forth in subsection b. of this section by doing any one or more of the following:

(1) Arranging for the patient to be admitted voluntarily to a psychiatric unit of a general hospital, a short-term care facility, a special psychiatric hospital or a psychiatric facility, under the provisions of P.L.1987, c.116 (C.30:4-27.1 et seq.);

(2) Initiating procedures for involuntary commitment <u>to treatment</u> of the patient to <u>an outpatient treatment provider,</u> a short-term care facility, a special psychiatric hospital or a psychiatric facility, under the provisions of P.L.1987, c.116 (C.30:4-27.1 et seq.);

(3) Advising a local law enforcement authority of the patient's threat and the identity of the intended victim;

(4) Warning the intended victim of the threat, or, in the case of an intended victim who is under the age of 18, warning the parent or guardian of the intended victim; or

(5) If the patient is under the age of 18 and threatens to commit suicide or bodily injury upon himself, warning the parent or guardian of the patient.

d. A practitioner who is licensed in the State of New Jersey to practice psychology, psychiatry, medicine, nursing, clinical social work or marriage counseling who, in complying with subsection c. of this section, discloses a privileged communication, is immune from civil liability in regard to that disclosure.

(cf: P.L.1991, c.270, s.1)

22. (New section) Whenever, in any rule, regulation, order, contract, document, judicial or administrative proceeding or otherwise, reference is made to "in need of involuntary

commitment" that term shall mean "in need of involuntary commitment to treatment" as defined in section 2 of P.L.1987, c.116 (C.30:4-27.2).

23. (New section) a. The Commissioner of Human Services shall monitor and evaluate the implementation of involuntary 2[outpatient]2 commitment 2to outpatient treatment2 established pursuant to P.L. , c. (pending before the Legislature as this bill) and report to the Governor and, pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), to the Legislature 2[two] four2 years after the effective date of P.L. , c. (pending before the Legislature as this bill) and again 2[four] six2 years after the effective date, on the implementation of involuntary 2[outpatient]2 commitment 2to outpatient treatment2. Specifically, the commissioner shall evaluate:

(1) how screening services, courts and mental health professionals apply the standard for determining whether a person is dangerous within the reasonably foreseeable future to self, others or property;

(2) the effect of involuntary 2[outpatient]2 commitment to 2outpatient2 treatment on persons with severe mental illness;

(3) the rate and geographic distribution of court orders for involuntary 2[outpatient]2 commitment to 2outpatient2 treatment;

(4) the responses of patients who have been committed to involuntary 2[outpatient]2 commitment to 2outpatient2 treatment to such treatment;

(5) the extent to which the use of involuntary 2[outpatient]2 commitment to 2outpatient2 treatment affects the rates of institutionalization and incarceration;

(6) whether sufficient treatment services are available to persons who have been involuntarily committed to outpatient treatment;

(7) whether persons who have been involuntarily committed to outpatient treatment are receiving the mental health treatment services necessary for recovery; and

(8) the effect of involuntary 2[outpatient]2 commitment to 2outpatient2 treatment on the availability of services to voluntary consumers with severe mental illness.

To carry out the purposes of this subsection, the commissioner may contract with an individual or entity with expertise in the field of evaluating mental health programs.

b. The commissioner shall include in his reports such recommendations for statutory changes as he deems necessary, including whether or not the provision for involuntary 2[outpatient]2 commitment 2to outpatient treatment2 as established pursuant to P.L. , c. (pending before the Legislature as this bill) shall be continued or revised.

[2]24. a. The Commissioner of Human Services shall phase in implementation of involuntary commitment to outpatient treatment established pursuant to P.L. , c. (pending before the Legislature as this act) over a three-year period. The commissioner shall select seven counties in the State to implement the act in the first year after the effective date of this act, seven additional counties to implement the act in the second year after the effective date of this act, and the remaining seven counties to fully implement the act Statewide in the third year after the effective date of this act.

b. For the three-year phase-in period, the commissioner shall monitor the implementation of involuntary commitment to outpatient treatment and report annually to the Governor and, pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), to the Legislature. The commissioner shall include in his reports such recommendations for administrative and statutory changes as he deems necessary. The annual reports shall address the following:

(1) the number of new patients who were involuntarily committed to outpatient treatment as compared to the number of patients committed to outpatient treatment who had previously been committed to inpatient treatment; and

(2) whether sufficient treatment services are available in the respective counties to serve persons who have been involuntarily committed to outpatient treatment and whether persons who have been involuntarily committed to outpatient treatment are receiving the mental health treatment services necessary for recovery.[2]

[2][24.] 25.[2] a. The Commissioner of Human Services, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations necessary to effectuate the purposes of this act.

b. The Supreme Court of New Jersey may adopt court rules to effectuate the purposes of this act.

[2][25.] 26.[2] This act shall take effect one year after the date of enactment [2]and the provisions of this act shall be subject to the phased-in implementation as provided in section 24 of this act[2], but the Commissioner of Human Services may take such anticipatory administrative action in advance [2]thereof[2] as shall be necessary for the implementation of the act.

Establishes involuntary commitment to outpatient treatment for person in need of involuntary commitment to treatment.

(3) the rate and geographic distribution of court orders for involuntary outpatient commitment to treatment;

(4) the responses of patients who have been committed to involuntary outpatient commitment to treatment to such treatment;

(5) the extent to which the use of involuntary outpatient commitment to treatment affects the rates of institutionalization and incarceration;

(6) whether sufficient treatment services are available to persons who have been involuntarily committed to outpatient treatment;

(7) whether persons who have been involuntarily committed to outpatient treatment are receiving the mental health treatment services necessary for recovery; and

(8) the effect of involuntary outpatient commitment to treatment on the availability of services to voluntary consumers with severe mental illness.

To carry out the purposes of this subsection, the commissioner may contract with an individual or entity with expertise in the field of evaluating mental health programs.

b. The commissioner shall include in his reports such recommendations for statutory changes as he deems necessary, including whether or not the provision for involuntary outpatient commitment as established pursuant to P.L. , c. (pending before the Legislature as this bill) shall be continued or revised.

24. a. The Commissioner of Human Services, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations necessary to effectuate the purposes of this act.

b. The Supreme Court of New Jersey may adopt court rules to effectuate the purposes of this act.

25. This act shall take effect one year after the date of enactment, but the Commissioner of Human Services may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act.

SPONSORS STATEMENT

This bill amends the State's civil commitment laws (N.J.S.A.30:4-27.1 et seq.) to allow for involuntary commitment to outpatient treatment of persons who are "in need of involuntary commitment to treatment." The bill defines this term to mean that "an adult with mental illness, whose mental illness causes the person to be dangerous to self or dangerous to others or property and who is unwilling to accept appropriate treatment voluntarily after it has been offered, needs outpatient treatment or inpatient care

at a short-term care or psychiatric facility or special psychiatric hospital because other services are not appropriate or available to meet the person's mental health care needs."

Involuntary commitment to treatment of persons with mental illness is one of the most intrusive exercises of power by the State. New Jersey's involuntary commitment system currently only permits commitment to inpatient care for persons who are established to be dangerous within the reasonably foreseeable future to themselves, others or property. The bill defines "reasonably foreseeable future" to mean a time frame that may be beyond the immediate or imminent, but not longer than a time frame as to which reasonably certain judgments about a person's likely behavior can be reached. In most cases, the small minority of persons with mental illness who present a danger within the reasonably foreseeable future to themselves, others or property, do so because they do not voluntarily engage in treatment. In this regard, the bill recognizes the State's responsibility to make available appropriate voluntary services in the community and clarifies or modifies New Jersey's civil commitment law as described below.

As the treatment for people with mental illness has advanced, many successful treatments are entirely outpatient. For this reason and others, the bill shifts the sense of involuntary commitment from commitment to an inpatient facility to commitment to clinically appropriate treatment, which may be inpatient care, outpatient care, or a combination of inpatient and outpatient care. The finding that a person is in need of involuntary commitment to treatment, then, will result in an order of commitment to appropriate treatment, rather than commitment to a facility.

The treatment provided after the entry of an order of involuntary commitment to treatment will be governed by the principle of least restrictive environment. The commitment process, then, will have two steps: it will first be determined whether by clear and convincing evidence a person's condition meets the dangerousness standard; then the treatment to which the person is committed will be determined by considering the least restrictive treatment setting appropriate to ameliorate the danger presented and appropriate to provide services directed to the wellness and recovery of the person.

In addition, the bill amends N.J.S.A. 30:4-27.9 to clarify, but not change, the standard for civil commitment and therefore make terminology uniform throughout the law so that the statute provides that a person shall not be involuntarily committed to treatment unless the person is "in need of involuntary commitment to treatment," as that term is defined in N.J.S.A. 30:4-27.2.

The bill also amends the definition of "dangerous to self" to replace the term "serious physical debilitation" with the term "serious physical harm," and make the definition of "dangerous to

self" parallel to the definition of "dangerous to others or property" by including language from the latter, that the determination of dangerousness take into account a person's history, recent behavior and any recent acts or threat. The bill also adds to both definitions that the determination of dangerousness shall take into account a person's "serious psychiatric deterioration."

With respect to screening services, the bill amends N.J.S.A.30:4-27.5 to provide that when appropriate and available, and as permitted by law, screening staff shall make reasonable efforts to gather information from the person's family or significant others in preparing screening documents. Upon completion of a screening certificate, screening service staff would determine the least restrictive environment for the appropriate treatment for the person, taking into account the person's prior history and current mental health condition. "Least restrictive environment" is defined in the bill as "the available setting and form of treatment that appropriately addresses a person's need for care and the need to respond to dangers to the person, others or property and respects, to the greatest extent practicable, the person's interests in freedom of movement and self-direction."

The bill specifies that screening service staff shall designate inpatient treatment for the person if that person is immediately or imminently dangerous or when outpatient treatment is deemed inadequate to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future. Screening service staff shall designate outpatient treatment for the person when outpatient treatment is deemed sufficient to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future.

If the screening service staff determines that the person is in need of involuntary commitment to outpatient treatment, staff must consult with an outpatient treatment provider to arrange, if possible, for an appropriate interim plan of treatment. The Commissioner of Human Services is required to designate one or more mental health agencies in each county or multi-county region in the State as an outpatient treatment provider, and authorizes the provider to provide services to persons from a specified geographic area. The designation would only be made with the approval of the agency's governing body.

In the case of patients committed and assigned to outpatient treatment by screening service staff or order of the court, or both, the bill provides that an outpatient treatment provider shall develop the plan of outpatient treatment in cooperation with screening service staff, short-term care facility staff or the court, as applicable. When appropriate and available, and as permitted by law, the provider shall make reasonable efforts to gather information from the patient's family or significant others for the

purposes of developing the plan of outpatient treatment. The bill defines "plan of outpatient treatment" as a plan for recovery from mental illness approved by a court that is to be carried out in an outpatient setting and is prepared by an outpatient treatment provider for a patient who has a history of responding to treatment. The plan may include medication as a component of the plan; however, medication shall not be involuntarily administered in an outpatient setting.

During the time a patient is assigned to the outpatient treatment provider for services pursuant to a commitment to outpatient treatment, the outpatient treatment provider must provide and coordinate the provision of care consistent with the plan of outpatient treatment.

If a patient fails to materially comply with the plan of outpatient treatment during the time the patient is assigned by a screening service to the outpatient treatment provider for services pursuant to a commitment to outpatient treatment or if the outpatient treatment provider determines that the plan is inadequate to meet the patient's mental health needs, the provider must notify the screening service of this material noncompliance or plan inadequacy. Similarly, if a patient fails to materially comply with the plan during the time the patient is assigned by a court to the provider or if the plan is inadequate, the provider must notify the court and screening service of this material noncompliance or plan inadequacy. In both cases, the patient would be referred to a screening service for an assessment to determine what services are available and where those services may be provided. The patient would be afforded the protections and procedures provided for in the State's civil commitment laws. The bill also provides that if a provider determines that a plan of outpatient treatment is inadequate and needs to be modified, but referral to a screening service is not necessary, the provider shall seek court approval for such modification and shall notify the court, patient's attorney and the county adjuster of the request for court approval of the modification.

Similar to procedures for admission to inpatient treatment, the bill:

- allows a screening service or outpatient treatment provider to initiate court proceedings for commitment to outpatient treatment, and also allows the same psychiatrist to execute the certificate after there has been a reasonable but unsuccessful attempt to have another psychiatrist conduct the evaluation and execute the certificate; and
- provides that a patient who is involuntarily committed and assigned to an outpatient treatment provider would receive a court hearing with respect to the need for continued involuntary commitment within 20 days from initial

commitment, unless administratively discharged by the outpatient treatment provider.

If the court finds by clear and convincing evidence that the patient needs continued involuntary commitment to treatment under N.J.S.A.30:4-27.15, it would issue an order authorizing the commitment as well as the placement of the patient in an outpatient or inpatient setting for treatment.

In determining the commitment placement, the court would consider the least restrictive environment for the patient to receive clinically appropriate treatment that would ameliorate the danger posed by the patient and provide the patient with appropriate treatment. If the court determines that the least restrictive environment for the patient to receive clinically appropriate treatment would be in an outpatient setting and that there is a likelihood of the patient responding to outpatient treatment, the court would obtain from a designated outpatient treatment provider a proposed plan of outpatient treatment for the patient, which the court shall review. The plan must be approved by the court.

Between the time period for periodic court review hearings pursuant to N.J.S.A.30:4-27.16, the chief executive officer of the psychiatric facility may recommend (to the court) changing the placement of a patient from an inpatient to outpatient setting, in order to ensure that the patient receives clinically appropriate treatment in the least restrictive environment. At the time the court sets the date for a hearing on the change in placement, notice would be provided to the patient, the patient's guardian, if any, the patient's next of kin, the patient's attorney and the county adjuster. The patient rights provided under N.J.S.A.30:4-27.14 would apply to the hearing.

The bill also requires the Commissioner of Human Services to monitor and evaluate the implementation of involuntary outpatient commitment and report to the Governor and the Legislature two and four years after the bill's effective date on the implementation of involuntary outpatient commitment. The commissioner may contract with an individual or entity for the evaluation. The evaluation would include specific criteria enumerated in the bill in section 23. The commissioner shall also include in his reports such recommendations for statutory changes as he deems necessary, including whether or not the provision for involuntary outpatient commitment established in this bill should be continued or revised.

The bill also amends:

-- N.J.S.A.30:4-27.6 to authorize State or local law enforcement officers to take custody of and take to a screening service a patient who needs to be referred to the service, upon certification by an outpatient treatment provider that the provider has reasonable cause to believe the patient is in need of evaluation for commitment to treatment;

-- N.J.S.A.2A:62A-16 and N.J.S.A.30:4-27.7 to add outpatient treatment providers to the list of professionals granted immunity under these sections of law;

-- N.J.S.A.30:4-27.11 to provide that patients assigned to an outpatient treatment provider have the same patient rights under this section of law as are provided to patients admitted to a short-term care or psychiatric facility or special psychiatric hospital;

-- N.J.S.A.30:4-27.16 concerning periodic court hearings to provide that if a patient has been assigned to an outpatient treatment provider, the court would conduct the first review hearing six months from the date of the first hearing, the next hearing nine months from the date of the first hearing and subsequent hearings 12 months from the date of the first hearing and annually thereafter;

-- N.J.S.A.30:4-27.17 to provide for an outpatient treatment provider to administratively discharge a patient; and

-- N.J.S.A.30:4-27.18 to provide for an outpatient treatment provider to participate in the formulation of a discharge plan.

Lastly, the bill takes effect one year after enactment.

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

STATEMENT TO

SENATE, No. 735

STATE OF NEW JERSEY

DATED: DECEMBER 8, 2008

The Senate Health, Human Services and Senior Citizens Committee reports favorably Senate Bill No. 735.

This bill amends the State's civil commitment laws (N.J.S.A.30:4-27.1 et seq.) to allow for involuntary commitment to outpatient treatment of persons who are "in need of involuntary commitment to treatment." The bill defines this term to mean that "an adult with mental illness, whose mental illness causes the person to be dangerous to self or dangerous to others or property and who is unwilling to accept appropriate treatment voluntarily after it has been offered, needs outpatient treatment or inpatient care at a short-term care or psychiatric facility or special psychiatric hospital because other services are not appropriate or available to meet the person's mental health care needs."

Involuntary commitment to treatment of persons with mental illness is one of the most intrusive exercises of power by the State. New Jersey's involuntary commitment system currently only permits commitment to inpatient care for persons who are established to be dangerous within the reasonably foreseeable future to themselves, others or property. The bill defines "reasonably foreseeable future" to mean a time frame that may be beyond the immediate or imminent, but not longer than a time frame as to which reasonably certain judgments about a person's likely behavior can be reached. In most cases, the small minority of persons with mental illness who present a danger within the reasonably foreseeable future to themselves, others or property, do so because they do not voluntarily engage in treatment. In this regard, the bill recognizes the State's responsibility to make available appropriate voluntary services in the community and clarifies or modifies New Jersey's civil commitment law as described below.

As the treatment for people with mental illness has advanced, many successful treatments are entirely outpatient. For this reason and others, the bill shifts the sense of involuntary commitment from commitment to an inpatient facility to commitment to clinically appropriate treatment, which may be inpatient care, outpatient care, or a combination of inpatient and outpatient care. The finding that a person is in need of involuntary commitment to treatment, then, will

result in an order of commitment to appropriate treatment, rather than commitment to a facility.

The treatment provided after the entry of an order of involuntary commitment to treatment will be governed by the principle of least restrictive environment. The commitment process, then, will have two steps: it will first be determined whether by clear and convincing evidence a person's condition meets the dangerousness standard; then the treatment to which the person is committed will be determined by considering the least restrictive treatment setting appropriate to ameliorate the danger presented and appropriate to provide services directed to the wellness and recovery of the person.

In addition, the bill amends N.J.S.A. 30:4-27.9 to clarify, but not change, the standard for civil commitment and therefore make terminology uniform throughout the law so that the statute provides that a person shall not be involuntarily committed to treatment unless the person is "in need of involuntary commitment to treatment," as that term is defined in N.J.S.A. 30:4-27.2.

The bill also amends the definition of "dangerous to self" to replace the term "serious physical debilitation" with the term "serious physical harm," and make the definition of "dangerous to self" parallel to the definition of "dangerous to others or property" by including language from the latter, that the determination of dangerousness take into account a person's history, recent behavior and any recent acts or threat. The bill also adds to both definitions that the determination of dangerousness shall take into account a person's "serious psychiatric deterioration."

With respect to screening services, the bill amends N.J.S.A.30:4-27.5 to provide that when appropriate and available, and as permitted by law, screening staff shall make reasonable efforts to gather information from the person's family or significant others in preparing screening documents. Upon completion of a screening certificate, screening service staff would determine the least restrictive environment for the appropriate treatment for the person, taking into account the person's prior history and current mental health condition. "Least restrictive environment" is defined in the bill as "the available setting and form of treatment that appropriately addresses a person's need for care and the need to respond to dangers to the person, others or property and respects, to the greatest extent practicable, the person's interests in freedom of movement and self-direction."

The bill specifies that screening service staff shall designate inpatient treatment for the person if that person is immediately or imminently dangerous or when outpatient treatment is deemed inadequate to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future. Screening service staff shall designate outpatient treatment for the person when outpatient treatment is deemed sufficient to render the person unlikely

to be dangerous to self, others or property within the reasonably foreseeable future.

If the screening service staff determines that the person is in need of involuntary commitment to outpatient treatment, staff must consult with an outpatient treatment provider to arrange, if possible, for an appropriate interim plan of treatment. The Commissioner of Human Services is required to designate one or more mental health agencies in each county or multi-county region in the State as an outpatient treatment provider, and authorizes the provider to provide services to persons from a specified geographic area. The designation would only be made with the approval of the agency's governing body.

In the case of patients committed and assigned to outpatient treatment by screening service staff or order of the court, or both, the bill provides that an outpatient treatment provider shall develop the plan of outpatient treatment in cooperation with screening service staff, short-term care facility staff or the court, as applicable. When appropriate and available, and as permitted by law, the provider shall make reasonable efforts to gather information from the patient's family or significant others for the purposes of developing the plan of outpatient treatment. The bill defines "plan of outpatient treatment" as a plan for recovery from mental illness approved by a court that is to be carried out in an outpatient setting and is prepared by an outpatient treatment provider for a patient who has a history of responding to treatment. The plan may include medication as a component of the plan; however, medication shall not be involuntarily administered in an outpatient setting.

During the time a patient is assigned to the outpatient treatment provider for services pursuant to a commitment to outpatient treatment, the outpatient treatment provider must provide and coordinate the provision of care consistent with the plan of outpatient treatment.

If a patient fails to materially comply with the plan of outpatient treatment during the time the patient is assigned by a screening service to the outpatient treatment provider for services pursuant to a commitment to outpatient treatment or if the outpatient treatment provider determines that the plan is inadequate to meet the patient's mental health needs, the provider must notify the screening service of this material noncompliance or plan inadequacy. Similarly, if a patient fails to materially comply with the plan during the time the patient is assigned by a court to the provider or if the plan is inadequate, the provider must notify the court and screening service of this material noncompliance or plan inadequacy. In both cases, the patient would be referred to a screening service for an assessment to determine what services are available and where those services may be provided. The patient would be afforded the protections and procedures provided for in the State's civil commitment laws. The bill also provides that if a provider determines that a plan of outpatient treatment is inadequate

and needs to be modified, but referral to a screening service is not necessary, the provider shall seek court approval for such modification and shall notify the court, patient's attorney and the county adjuster of the request for court approval of the modification.

Similar to procedures for admission to inpatient treatment, the bill:

(1) allows a screening service or outpatient treatment provider to initiate court proceedings for commitment to outpatient treatment, and also allows the same psychiatrist to execute the certificate after there has been a reasonable but unsuccessful attempt to have another psychiatrist conduct the evaluation and execute the certificate; and

(2) provides that a patient who is involuntarily committed and assigned to an outpatient treatment provider would receive a court hearing with respect to the need for continued involuntary commitment within 20 days from initial commitment, unless administratively discharged by the outpatient treatment provider.

If the court finds by clear and convincing evidence that the patient needs continued involuntary commitment to treatment under N.J.S.A.30:4-27.15, it would issue an order authorizing the commitment as well as the placement of the patient in an outpatient or inpatient setting for treatment.

In determining the commitment placement, the court would consider the least restrictive environment for the patient to receive clinically appropriate treatment that would ameliorate the danger posed by the patient and provide the patient with appropriate treatment. If the court determines that the least restrictive environment for the patient to receive clinically appropriate treatment would be in an outpatient setting and that there is a likelihood of the patient responding to outpatient treatment, the court would obtain from a designated outpatient treatment provider a proposed plan of outpatient treatment for the patient, which the court shall review. The plan must be approved by the court.

Between the time period for periodic court review hearings pursuant to N.J.S.A.30:4-27.16, the chief executive officer of the psychiatric facility may recommend (to the court) changing the placement of a patient from an inpatient to outpatient setting, in order to ensure that the patient receives clinically appropriate treatment in the least restrictive environment. At the time the court sets the date for a hearing on the change in placement, notice would be provided to the patient, the patient's guardian, if any, the patient's next-of-kin, the patient's attorney and the county adjuster. The patient rights provided under N.J.S.A.30:4-27.14 would apply to the hearing.

The bill also requires the Commissioner of Human Services to monitor and evaluate the implementation of involuntary outpatient commitment and report to the Governor and the Legislature two and four years after the bill's effective date on the implementation of involuntary outpatient commitment. The commissioner may contract

with an individual or entity for the evaluation. The evaluation would include specific criteria enumerated in section 23 of the bill. The commissioner shall also include in his reports such recommendations for statutory changes as he deems necessary, including whether or not the provision for involuntary outpatient commitment established in this bill should be continued or revised.

The bill also amends:

-- N.J.S.A.30:4-27.6 to authorize State or local law enforcement officers to take custody of and take to a screening service a patient who needs to be referred to the service, upon certification by an outpatient treatment provider that the provider has reasonable cause to believe the patient is in need of evaluation for commitment to treatment;

-- N.J.S.A.2A:62A-16 and N.J.S.A.30:4-27.7 to add outpatient treatment providers to the list of professionals granted immunity under these sections of law;

-- N.J.S.A.30:4-27.11 to provide that patients assigned to an outpatient treatment provider have the same patient rights under this section of law as are provided to patients admitted to a short-term care or psychiatric facility or special psychiatric hospital;

-- N.J.S.A.30:4-27.16 concerning periodic court hearings to provide that if a patient has been assigned to an outpatient treatment provider, the court would conduct the first review hearing six months from the date of the first hearing, the next hearing nine months from the date of the first hearing and subsequent hearings 12 months from the date of the first hearing and annually thereafter;

-- N.J.S.A.30:4-27.17 to provide for an outpatient treatment provider to administratively discharge a patient; and

-- N.J.S.A.30:4-27.18 to provide for an outpatient treatment provider to participate in the formulation of a discharge plan.

The bill takes effect one year after enactment.

This bill is identical to Assembly Bill No.1618 (McKeon), which is pending before the Assembly Human Services Committee.

This bill was pre-filed for introduction in the 2008-2009 session pending technical review. As reported, the bill includes the changes required by technical review, which has been performed.

FISCAL NOTE
SENATE, No. 735
STATE OF NEW JERSEY
213th LEGISLATURE

DATED: FEBRUARY 9, 2009

SUMMARY

Synopsis: Establishes involuntary outpatient commitment to treatment for persons in need of involuntary commitment to treatment.

Type of Impact: **Division of Mental Health Services** (DMHS). The DMHS appropriation already includes funds for mental health services that may be required by individuals in need of involuntary commitment to outpatient treatment. Additional costs related to education and training regarding the new law, and related to the provision of residential services may be incurred if DMHS is unable to reallocate existing funds to address these areas.

Judiciary. Although the Judiciary indicates that it may incur additional costs based on increased volume of involuntary commitment hearings, it is likely that the increase in the number of involuntary commitment hearings will be minimal.

Agencies Affected: Department of Human Services, DMHS. The Judiciary.

Executive and Judiciary Estimates

Fiscal Impact	Year 1	Year 2	Year 3
Office of Management and Budget	Unspecified increase in "outpatient treatment costs."	Same as Year 1.	Same as Year 1.
JUDICIARY	$56,700- $233,400	$58,900 - $237,800	$61,300 - $242,500

Office of Legislative Services Estimate

Fiscal impact **Years 1 -3**

DMHS. FY 2009 State appropriations provide sufficient funds to provide necessary services. **However, if DMHS is unable to reallocate existing funds to meet any additionl costs the legislation may entail, additional monies may be required.**

JUDICIARY. Minimal, as the Judiciary already incurs costs associated with the initial involuntary commitment hearings and follow-up hearings for those individuals who have been involuntarily committed.

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-OLS-

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- The FY 2009 appropriations act provides additional funding recommended by the Governor's Task Force on Mental Health, including monies to expand the capabilities and services of mental health screening centers and to provide special case management to individuals who are resistant to mental health treatment services. DMHS is also in the process of awarding $7.0 million to develop Intensive Outpatient Treatment and Support Services Programs for individuals whose mental health services needs are similar to those of individuals in need of involuntary outpatient commitment.

- DMHS may have to reallocate funds among various mental health service components to provide services to individuals committed to outpatient treatment, and the criteria as to who can receive certain mental health services may have to be revised to accommodate the mental health service needs of such individuals. Contracted mental health provider agencies already prioritize services to individuals with serious mental illness or who are resistant to mental health treatment services; the mental health services needs of these individuals are similar to those of individuals who may be subject to outpatient commitment.

- The availability of an involuntary commitment to outpatient treatment option may reduce the number of admissions to State and county psychiatric hospitals and other facilities. A reduction in the number of admissions to such facilities could reduce the operating costs of such facilities.

- The number of initial involuntary commitment hearings varies from year to year, and the establishment of an involuntary commitment to outpatient treatment option should have little impact on the total number of initial commitment hearings that are conducted. Similarly, compliance and treatment hearings conducted as part of the involuntary commitment to outpatient treatment option are not significantly different than follow-up involuntary commitment hearings that are now conducted when an individual is committed to an institution.

- If an involuntary commitment to outpatient treatment option is established, the possibility exists that there may be an increase in the overall percentage of individuals subject to initial commitment hearings who are involuntarily committed, since this option provides for a less restrictive means of requiring that a person access mental health services. Even if there is an increase in the percentage of individuals who are involuntarily committed, however, since many of the individuals are already involved in the mental health system and may already be receiving services, there should not be a net increase in the number of persons accessing services.

BILL DESCRIPTION

Senate Bill No. 735 of 2008 amends the State's civil commitment laws to allow for the involuntary commitment to outpatient treatment of an individual. Under current law, involuntary commitment to treatment of an individual is permitted only to a State or county psychiatric hospital or to other designated inpatient facilities such as a Short Term Care Facility. Commitment to outpatient treatment would be subject to court review as is currently required under the inpatient commitment law.

The legislation makes various technical changes with respect to definitions concerning involuntary commitment. Further, the legislation requires the Commissioner of Human Services to designate one or more mental health agencies in each county or multi-county region as the outpatient treatment provider for individuals assigned to involuntary commitment to outpatient treatment, subject to the agency's approval of the designation.

FISCAL ANALYSIS

EXECUTIVE BRANCH

The Office of Management and Budget has not provided any specific fiscal information outside of noting that the legislation "is expected to result in increased outpatient treatment costs within DMHS."

JUDICIAL BRANCH

The Judiciary has provided a range of estimates depending on the number of "involuntary commitment to outpatient treatment" hearings that may be held, as follows:

Number of Cases	Year One	Year Two	Year Three
400	$56,700	$58,900	$61,300
800	$68,700	$70,900	$73,300
1,600	$92,700	$94,900	$97,300
3,200	$185,400	$189,800	$194,500
4,800	$233,400	$237,800	$242,500

(Amounts have been rounded off to the nearest one hundred dollars.)

OFFICE OF LEGISLATIVE SERVICES

There are minimal additional costs associated with the involuntary commitment to outpatient treatment legislation, as discussed below.

DMHS. It is generally acknowledged that the overall community mental health system may not be adequately funded to meet the mental health needs of all State residents in need of services. Provider agencies have testified about their ongoing operational difficulties, particularly with respect to recruitment and retention of personnel. These funding limitations may result in individuals not being able to receive all the mental health services they require or the intensity of services they require. The comments below regarding the legislation are not intended to address the overall funding issue affecting community mental health services.

The FY 2009 appropriations act includes $323.5 million to DMHS for community mental health services provided by nearly 130 agencies. In addition to State appropriations, provider agencies obtain significant revenues from third parties such as Medicare and Medicaid, and receive fees, donations and other grants to supplement the State appropriation.

Included within the $323.5 million State appropriation were new monies to implement recommendations of the Governor's Mental Health Task Force to enhance the capacity of screening services to provide services to individuals being assessed for involuntary commitment,

and to provide case management services to individuals who are resistant to receiving mental health services. Also, during FY 2009, DMHS issued a Request for Proposal and is in the process of awarding up to $7.0 million in funds to develop Intensive Outpatient Treatment and Support Services to individuals whose mental health services needs are similar to those who may need involuntary commitment to outpatient treatment.

The State appropriation, along with other monies available to the various mental health agencies, is used to provide various mental health services which range from services provided on a 24/7 basis such as Integrated Case Management services (ICMS), Program for Assertive Community Treatment (PACT) and Screening Services, to services of lesser intensity such as outpatient, partial care and residential care, to services that are self-directed or episodic such as job training, legal assistance and self-help centers.

The availability of mental health services varies, depending on the needs of an individual. Screening services are available to all individuals who may require involuntary commitment; ICMS and PACT are generally available to individuals being discharged from an institutional setting and are not available to individuals who have not been hospitalized; and other mental health services are available to all individuals in need of such services, although priority may be given to individuals who have been institutionalized or to individuals who might otherwise be involuntarily committed to an institution.

Although sufficient funds are available to DMHS to implement the legislation, to the extent that DMHS is unable to reallocate existing monies to meet education and training costs associated with the new legislation and to provide residential services to individuals in need of outpatient commitment without adversely affecting residential services currently being provided to individuals, additional funding may be required by DMHS. Such costs cannot be determined until the legislation is implemented.

The availability of an involuntary commitment to outpatient treatment option, as an alternative to involuntary commitment to a State or county hospital or other inpatient facility, should have little impact on the total number of individuals being screened for possible involuntary commitment, since the standard for involuntary commitment is the same regardless of whether the individual is committed to inpatient or outpatient treatment. Further, as service planning and the provision of services to individuals being screened are already required by regulation, the development of "an appropriate interim plan of treatment" and the provision of services to individuals involuntarily committed to outpatient treatment should not represent a significant workload increase.

It is possible that individuals involuntarily committed to outpatient treatment may require ICMS or PACT services that are now usually available only to individuals discharged from an institutional setting. Thus, DMHS may have to broaden eligibility for such programs to include individuals in need of involuntary commitment to outpatient treatment. However, as such individuals would be eligible for ICMS or PACT upon discharge from an institution, the provision of ICMS or PACT is more a matter of when services are provided as opposed to providing a service that would otherwise not be available. As the case of other mental health services individuals committed to outpatient treatment may need, provider agencies may be required to give priority to these individuals over other persons with mental illness.

The establishment of an involuntary outpatient commitment classification could result in a reduction in the number of persons admitted to State and county hospitals. Over time, a reduction in the number of admissions to State and county hospitals could result in a reduction in the operating costs of the facilities.

It is noted, however, that there is a possibility that there may be an overall increase in the percentage of individuals subject to initial commitment hearings who are involuntarily committed, if an "involuntary commitment to outpatient services" option is established. At

present, a judge may decide not to involuntarily commit an individual to an institution even though the individual may require intensive mental health services. The establishment of the less restrictive outpatient commitment option may result in judges selecting this option as a way to ensure that mental health services are provided to an individual. However, until the legislation is implemented, it cannot be determined whether there will be an increase in the overall percentage of individuals involuntarily committed. Even if there is an increase in the percentage of commitments, many of the individuals subject to commitment are already involved in the mental health system and may already be receiving outpatient services.

The **Judiciary** already incurs costs associated with involuntary commitment hearings. The legislation should not result in an increase in the number of initial commitment hearings since the standard for outpatient commitment to treatment is the same as for inpatient commitment to treatment.

While there would be continued court involvement in instances where an individual is noncompliant with the terms and conditions of outpatient commitment to treatment, this requirement is not significantly different than the ongoing court involvement for individuals who are involuntarily committed to a State or county hospital or other inpatient facility. Thus, the availability of an involuntary outpatient commitment option for persons in need of involuntary commitment should have little impact on the Judiciary's overall costs related to involuntary commitment proceedings.

Section:	*Human Services*
Analyst:	*Jay A. Hershberg* *Principal Fiscal Analyst*
Approved:	*David J. Rosen* *Legislative Budget and Finance Officer*

This fiscal note has been prepared pursuant to P.L.1980, c.67 (C. 52:13B-1 et seq.).

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

SENATE, No. 735

STATE OF NEW JERSEY

DATED: FEBRUARY 26, 2009

The Senate Budget and Appropriations Committee reports favorably Senate Bill No. 735.

The bill amends the State's civil commitment laws (N.J.S.A.30:4-27.1 et seq.) to allow for involuntary commitment to outpatient treatment of persons who are "in need of involuntary commitment to treatment." The bill defines this term to mean that "an adult with mental illness, whose mental illness causes the person to be dangerous to self or dangerous to others or property and who is unwilling to accept appropriate treatment voluntarily after it has been offered, needs outpatient treatment or inpatient care at a short-term care or psychiatric facility or special psychiatric hospital because other services are not appropriate or available to meet the person's mental health care needs."

Involuntary commitment to treatment of persons with mental illness is one of the most intrusive exercises of power by the State. New Jersey's involuntary commitment system currently only permits commitment to inpatient care for persons who are established to be dangerous within the reasonably foreseeable future to themselves, others or property. The bill defines "reasonably foreseeable future" to mean a time frame that may be beyond the immediate or imminent, but not longer than a time frame as to which reasonably certain judgments about a person's likely behavior can be reached. In most cases, the small minority of persons with mental illness who present a danger within the reasonably foreseeable future to themselves, others or property, do so because they do not voluntarily engage in treatment. In this regard, the bill recognizes the State's responsibility to make available appropriate voluntary services in the community and clarifies or modifies New Jersey's civil commitment law as described below.

As the treatment for people with mental illness has advanced, many successful treatments are entirely outpatient. For this reason and others, the bill shifts the sense of involuntary commitment from commitment to an inpatient facility to commitment to clinically appropriate treatment, which may be inpatient care, outpatient care, or a combination of inpatient and outpatient care. The finding that a person is in need of involuntary commitment to treatment, then, will result in an order of commitment to appropriate treatment, rather than commitment to a facility.

The treatment provided after the entry of an order of involuntary commitment to treatment will be governed by the principle of least restrictive environment. The commitment process, then, will have two steps: it will first be determined whether by clear and convincing evidence a person's condition meets the dangerousness standard; then the treatment to which the person is committed will be determined by considering the least restrictive treatment setting appropriate to ameliorate the danger presented and appropriate to provide services directed to the wellness and recovery of the person.

In addition, the bill amends N.J.S.A.30:4-27.9 to clarify, but not change, the standard for civil commitment and therefore make terminology uniform throughout the law so that the statute provides that a person shall not be involuntarily committed to treatment unless the person is "in need of involuntary commitment to treatment," as that term is defined in N.J.S.A.30:4-27.2.

The bill also amends the definition of "dangerous to self" to replace the term "serious physical debilitation" with the term "serious physical harm," and make the definition of "dangerous to self" parallel to the definition of "dangerous to others or property" by including language from the latter, that the determination of dangerousness take into account a person's history, recent behavior and any recent acts or threat. The bill also adds to both definitions that the determination of dangerousness shall take into account a person's "serious psychiatric deterioration."

With respect to screening services, the bill amends N.J.S.A.30:4-27.5 to provide that when appropriate and available, and as permitted by law, screening staff shall make reasonable efforts to gather information from the person's family or significant others in preparing screening documents. Upon completion of a screening certificate, screening service staff would determine the least restrictive environment for the appropriate treatment for the person, taking into account the person's prior history and current mental health condition. "Least restrictive environment" is defined in the bill as "the available setting and form of treatment that appropriately addresses a person's need for care and the need to respond to dangers to the person, others or property and respects, to the greatest extent practicable, the person's interests in freedom of movement and self-direction."

The bill specifies that screening service staff shall designate inpatient treatment for the person if that person is immediately or imminently dangerous or when outpatient treatment is deemed inadequate to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future. Screening service staff shall designate outpatient treatment for the person when outpatient treatment is deemed sufficient to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future.

If the screening service staff determines that the person is in need of involuntary commitment to outpatient treatment, staff must consult with an outpatient treatment provider to arrange, if possible, for an appropriate interim plan of treatment. The Commissioner of Human Services is required to designate one or more mental health agencies in each county or multi-county region in the State as an outpatient treatment provider, and authorizes the provider to provide services to persons from a specified geographic area. The designation would only be made with the approval of the agency's governing body.

In the case of patients committed and assigned to outpatient treatment by screening service staff or order of the court, or both, the bill provides that an outpatient treatment provider shall develop the plan of outpatient treatment in cooperation with screening service staff, short-term care facility staff or the court, as applicable. When appropriate and available, and as permitted by law, the provider shall make reasonable efforts to gather information from the patient's family or significant others for the purposes of developing the plan of outpatient treatment. The bill defines "plan of outpatient treatment" as a plan for recovery from mental illness approved by a court that is to be carried out in an outpatient setting and is prepared by an outpatient treatment provider for a patient who has a history of responding to treatment. The plan may include medication as a component of the plan; however, medication shall not be involuntarily administered in an outpatient setting.

During the time a patient is assigned to the outpatient treatment provider for services pursuant to a commitment to outpatient treatment, the outpatient treatment provider must provide and coordinate the provision of care consistent with the plan of outpatient treatment.

If a patient fails to materially comply with the plan of outpatient treatment during the time the patient is assigned by a screening service to the outpatient treatment provider for services pursuant to a commitment to outpatient treatment or if the outpatient treatment provider determines that the plan is inadequate to meet the patient's mental health needs, the provider must notify the screening service of this material noncompliance or plan inadequacy. Similarly, if a patient fails to materially comply with the plan during the time the patient is assigned by a court to the provider or if the plan is inadequate, the provider must notify the court and screening service of this material noncompliance or plan inadequacy. In both cases, the patient would be referred to a screening service for an assessment to determine what services are available and where those services may be provided. The patient would be afforded the protections and procedures provided for in the State's civil commitment laws. The bill also provides that if a provider determines that a plan of outpatient treatment is inadequate and needs to be modified, but referral to a screening service is not necessary, the provider shall seek court approval for such modification

and shall notify the court, patient's attorney and the county adjuster of the request for court approval of the modification.

Similar to procedures for admission to inpatient treatment, the bill:

(1) allows a screening service or outpatient treatment provider to initiate court proceedings for commitment to outpatient treatment, and also allows the same psychiatrist to execute the certificate after there has been a reasonable but unsuccessful attempt to have another psychiatrist conduct the evaluation and execute the certificate; and

(2) provides that a patient who is involuntarily committed and assigned to an outpatient treatment provider would receive a court hearing with respect to the need for continued involuntary commitment within 20 days from initial commitment, unless administratively discharged by the outpatient treatment provider.

If the court finds by clear and convincing evidence that the patient needs continued involuntary commitment to treatment under N.J.S.A.30:4-27.15, it would issue an order authorizing the commitment as well as the placement of the patient in an outpatient or inpatient setting for treatment.

In determining the commitment placement, the court would consider the least restrictive environment for the patient to receive clinically appropriate treatment that would ameliorate the danger posed by the patient and provide the patient with appropriate treatment. If the court determines that the least restrictive environment for the patient to receive clinically appropriate treatment would be in an outpatient setting and that there is a likelihood of the patient responding to outpatient treatment, the court would obtain from a designated outpatient treatment provider a proposed plan of outpatient treatment for the patient, which the court shall review. The plan must be approved by the court.

Between the time period for periodic court review hearings pursuant to N.J.S.A.30:4-27.16, the chief executive officer of the psychiatric facility may recommend (to the court) changing the placement of a patient from an inpatient to outpatient setting, in order to ensure that the patient receives clinically appropriate treatment in the least restrictive environment. At the time the court sets the date for a hearing on the change in placement, notice would be provided to the patient, the patient's guardian, if any, the patient's next-of-kin, the patient's attorney and the county adjuster. The patient rights provided under N.J.S.A.30:4-27.14 would apply to the hearing.

The bill also requires the Commissioner of Human Services to monitor and evaluate the implementation of involuntary outpatient commitment and report to the Governor and the Legislature two and four years after the bill's effective date on the implementation of involuntary outpatient commitment. The commissioner may contract with an individual or entity for the evaluation. The evaluation would include specific criteria enumerated in section 23 of the bill. The

commissioner shall also include in his reports such recommendations for statutory changes as he deems necessary, including whether or not the provision for involuntary outpatient commitment established in this bill should be continued or revised.

The bill takes effect one year after enactment.

FISCAL IMPACT:

There are minimal additional costs associated with the involuntary commitment to outpatient treatment legislation, as discussed below.

Division of Mental Health Services (DMHS). The FY 2009 appropriations act includes $323.5 million to DMHS for community mental health services provided by nearly 130 agencies. In addition to State appropriations, provider agencies obtain significant revenues from third parties such as Medicare and Medicaid, and receive fees, donations and other grants to supplement the State appropriation.

Included within the $323.5 million State appropriation were new monies to implement recommendations of the Governor's Mental Health Task Force to enhance the capacity of screening services to provide services to individuals being assessed for involuntary commitment, and to provide case management services to individuals who are resistant to receiving mental health services. Also, during FY 2009, DMHS issued a Request for Proposal and is in the process of awarding up to $7.0 million in funds to develop Intensive Outpatient Treatment and Support Services to individuals whose mental health services needs are similar to those who may need involuntary commitment to outpatient treatment. The State appropriation, along with other monies available to the various mental health agencies, is used to provide various mental health services.

Although sufficient funds are available to DMHS to implement the legislation, to the extent that DMHS is unable to reallocate existing monies to meet education and training costs associated with the new legislation and to provide residential services to individuals in need of outpatient commitment without adversely affecting residential services currently being provided to individuals, additional funding may be required by DMHS. Such costs cannot be determined until the legislation is implemented.

The availability of an involuntary commitment to outpatient treatment option, as an alternative to involuntary commitment to a State or county hospital or other inpatient facility, should have little impact on the total number of individuals being screened for possible involuntary commitment, since the standard for involuntary commitment is the same regardless of whether the individual is committed to inpatient or outpatient treatment. Further, as service planning and the provision of services to individuals being screened are already required by regulation, the development of "an appropriate interim plan of treatment" and the provision of services to individuals

involuntarily committed to outpatient treatment should not represent a significant workload increase.

It is possible that individuals involuntarily committed to outpatient treatment may require certain services, such as Integrated Case Management Services (ICMS) or Program for Assertive Community Treatment (PACT) services, that are now usually available only to individuals discharged from an institutional setting. Thus, DMHS may have to broaden eligibility for such programs to include individuals in need of involuntary commitment to outpatient treatment. However, as such individuals would be eligible for ICMS or PACT upon discharge from an institution, the provision of ICMS or PACT is more a matter of when services are provided as opposed to providing a service that would otherwise not be available. Provider agencies may be required to give priority to these individuals over other persons with mental illness.

The establishment of an involuntary outpatient commitment classification could result in a reduction in the number of persons admitted to State and county hospitals. Over time, a reduction in the number of admissions to State and county hospitals could result in a reduction in the operating costs of the facilities.

It is noted, however, that there is a possibility that there may be an overall increase in the percentage of individuals subject to initial commitment hearings who are involuntarily committed, if an "involuntary commitment to outpatient services" option is established. At present, a judge may decide not to involuntarily commit an individual to an institution even though the individual may require intensive mental health services. The establishment of the less restrictive outpatient commitment option may result in judges selecting this option as a way to ensure that mental health services are provided to an individual. However, until the legislation is implemented, it cannot be determined whether there will be an increase in the overall percentage of individuals involuntarily committed. Even if there is an increase in the percentage of commitments, many of the individuals subject to commitment are already involved in the mental health system and may already be receiving outpatient services.

The Judiciary. The Judiciary already incurs costs associated with involuntary commitment hearings. The legislation should not result in an increase in the number of initial commitment hearings since the standard for outpatient commitment to treatment is the same as for inpatient commitment to treatment.

While there would be continued court involvement in instances where an individual is noncompliant with the terms and conditions of outpatient commitment to treatment, this requirement is not significantly different than the ongoing court involvement for individuals who are involuntarily committed to a State or county hospital or other inpatient facility. Thus, the availability of an

involuntary outpatient commitment option for persons in need of involuntary commitment should have little impact on the Judiciary's overall costs related to involuntary commitment proceedings.

However, it is noted that the Judiciary indicates that it may incur additional costs depending on the number of "involuntary commitment to outpatient treatment hearings that may be held, as follows:

# of Cases	Year One	Year Two	Year Three
400	$56,700	$58,900	$61,300
800	$68,700	$70,900	$73,300
1,600	$92,700	$94,900	$97,300
3,200	$185,400	$189,800	$194,500
4,800	$233,400	$237,800	$242,500

ASSEMBLY HUMAN SERVICES COMMITTEE

STATEMENT TO

SENATE, No. 735

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 8, 2009

The Assembly Human Services Committee reports favorably and with committee amendments, Senate Bill No. 735.

As amended by the committee, this bill amends the State's civil commitment laws (N.J.S.A.30:4-27.1 et seq.) to allow for involuntary commitment to outpatient treatment of persons who are "in need of involuntary commitment to treatment." The bill defines this term to mean that "an adult with mental illness, whose mental illness causes the person to be dangerous to self or dangerous to others or property and who is unwilling to accept appropriate treatment voluntarily after it has been offered, needs outpatient treatment or inpatient care at a short-term care or psychiatric facility or special psychiatric hospital because other services are not appropriate or available to meet the person's mental health care needs."

Involuntary commitment to treatment of persons with mental illness is one of the most intrusive exercises of power by the State. New Jersey's involuntary commitment system currently only permits commitment to inpatient care for persons who are established to be dangerous within the reasonably foreseeable future to themselves, others or property. The bill defines "reasonably foreseeable future" to mean a time frame that may be beyond the immediate or imminent, but not longer than a time frame as to which reasonably certain judgments about a person's likely behavior can be reached. In most cases, the small minority of persons with mental illness who present a danger within the reasonably foreseeable future to themselves, others or property, do so because they do not voluntarily engage in treatment. In this regard, the bill recognizes the State's responsibility to make available appropriate voluntary services in the community and clarifies or modifies New Jersey's civil commitment law as described below.

As the treatment for people with mental illness has advanced, many successful treatments are entirely outpatient. For this reason and others, the bill shifts the sense of involuntary commitment from commitment to an inpatient facility to commitment to clinically appropriate treatment, which may be inpatient care, outpatient care, or a combination of inpatient and outpatient care. The finding that a

person is in need of involuntary commitment to treatment, then, will result in an order of commitment to appropriate treatment, rather than commitment to a facility.

The treatment provided after the entry of an order of involuntary commitment to treatment will be governed by the principle of least restrictive environment. The commitment process, then, will have two steps: it will first be determined whether by clear and convincing evidence a person's condition meets the dangerousness standard; then the treatment to which the person is committed will be determined by considering the least restrictive treatment setting appropriate to ameliorate the danger presented and appropriate to provide services directed to the wellness and recovery of the person.

In addition, the bill amends N.J.S.A. 30:4-27.9 to clarify, but not change, the standard for civil commitment and therefore make terminology uniform throughout the law so that the statute provides that a person shall not be involuntarily committed to treatment unless the person is "in need of involuntary commitment to treatment," as that term is defined in N.J.S.A. 30:4-27.2.

The bill also amends the definition of "dangerous to self" to replace the term "serious physical debilitation" with the term "serious physical harm," and make the definition of "dangerous to self" parallel to the definition of "dangerous to others or property" by including language from the latter, that the determination of dangerousness take into account a person's history, recent behavior and any recent acts or threat. The bill also adds to both definitions that the determination of dangerousness shall take into account a person's "serious psychiatric deterioration."

With respect to screening services, the bill amends N.J.S.A.30:4-27.5 to provide that when appropriate and available, and as permitted by law, screening staff shall make reasonable efforts to gather information from the person's family or significant others in preparing screening documents. Upon completion of a screening certificate, screening service staff, in consultation with the psychiatrist or another physician, as appropriate, who completed the certificate, would determine the least restrictive environment for the appropriate treatment for the person, taking into account the person's prior history and current mental health condition. "Least restrictive environment" is defined in the bill as "the available setting and form of treatment that appropriately addresses a person's need for care and the need to respond to dangers to the person, others or property and respects, to the greatest extent practicable, the person's interests in freedom of movement and self-direction."

The bill specifies that screening service staff shall designate inpatient treatment for the person if that person is immediately or imminently dangerous or when outpatient treatment is deemed inadequate to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future. Screening

service staff shall designate outpatient treatment for the person when outpatient treatment is deemed sufficient to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future.

If the screening service staff determines that the person is in need of involuntary commitment to outpatient treatment, staff must consult with an outpatient treatment provider to arrange, if possible, for an appropriate interim plan of treatment. The Commissioner of Human Services is required to designate one or more mental health agencies in each county or multi-county region in the State as an outpatient treatment provider, and authorizes the provider to provide services to persons from a specified geographic area. The designation would only be made with the approval of the agency's governing body.

In the case of patients committed and assigned to outpatient treatment by screening service staff or order of the court, or both, the bill provides that an outpatient treatment provider shall develop the plan of outpatient treatment in cooperation with screening service staff, short-term care facility staff or the court, as applicable. When appropriate and available, and as permitted by law, the provider shall make reasonable efforts to gather information from the patient's family or significant others for the purposes of developing the plan of outpatient treatment. The bill defines "plan of outpatient treatment" as a plan for recovery from mental illness approved by a court that is to be carried out in an outpatient setting and is prepared by an outpatient treatment provider for a patient who has a history of responding to treatment. The plan may include medication as a component of the plan; however, medication shall not be involuntarily administered in an outpatient setting.

During the time a patient is assigned to the outpatient treatment provider for services pursuant to a commitment to outpatient treatment, the outpatient treatment provider must provide and coordinate the provision of care consistent with the plan of outpatient treatment.

If a patient fails to materially comply with the plan of outpatient treatment during the time the patient is assigned by a screening service to the outpatient treatment provider for services pursuant to a commitment to outpatient treatment or if the outpatient treatment provider determines that the plan is inadequate to meet the patient's mental health needs, the provider must notify the screening service of this material noncompliance or plan inadequacy. Similarly, if a patient fails to materially comply with the plan during the time the patient is assigned by a court to the provider or if the plan is inadequate, the provider must notify the court and screening service of this material noncompliance or plan inadequacy. In both cases, the patient would be referred to a screening service for an assessment to determine what services are available and where those services may be provided. The patient would be afforded the protections and procedures provided for

in the State's civil commitment laws. The bill also provides that if a provider determines that a plan of outpatient treatment is inadequate and needs to be modified, but referral to a screening service is not necessary, the provider shall seek court approval for such modification and shall notify the court, patient's attorney and the county adjuster of the request for court approval of the modification.

Similar to procedures for admission to inpatient treatment, the bill: (1) allows a screening service or outpatient treatment provider to initiate court proceedings for commitment to outpatient treatment, and also allows the same psychiatrist to execute the certificate after there has been a reasonable but unsuccessful attempt to have another psychiatrist conduct the evaluation and execute the certificate; and (2) provides that a patient who is involuntarily committed and assigned to an outpatient treatment provider would receive a court hearing with respect to the need for continued involuntary commitment within 20 days from initial commitment, unless administratively discharged by the outpatient treatment provider.

If the court finds by clear and convincing evidence that the patient needs continued involuntary commitment to treatment under N.J.S.A.30:4-27.15, it would issue an order authorizing the commitment as well as the placement of the patient in an outpatient or inpatient setting for treatment.

In determining the commitment placement, the court would consider the least restrictive environment for the patient to receive clinically appropriate treatment that would ameliorate the danger posed by the patient and provide the patient with appropriate treatment. If the court determines that the least restrictive environment for the patient to receive clinically appropriate treatment would be in an outpatient setting and that there is a likelihood of the patient responding to outpatient treatment, the court would obtain from a designated outpatient treatment provider a proposed plan of outpatient treatment for the patient, which the court shall review. The plan must be approved by the court.

Between the time period for periodic court review hearings pursuant to N.J.S.A.30:4-27.16, the chief executive officer of the psychiatric facility may recommend (to the court) changing the placement of a patient from an inpatient to outpatient setting, in order to ensure that the patient receives clinically appropriate treatment in the least restrictive environment. At the time the court sets the date for a hearing on the change in placement, notice would be provided to the patient, the patient's guardian, if any, the patient's next-of-kin, the patient's attorney and the county adjuster. The patient rights provided under N.J.S.A.30:4-27.14 would apply to the hearing.

The bill also requires the Commissioner of Human Services to monitor and evaluate the implementation of involuntary outpatient commitment and report to the Governor and the Legislature two and four years after the bill's effective date on the implementation of

involuntary outpatient commitment. The commissioner may contract with an individual or entity for the evaluation. The evaluation would include specific criteria enumerated in section 23 of the bill. The commissioner shall also include in his reports such recommendations for statutory changes as he deems necessary, including whether or not the provision for involuntary outpatient commitment established in this bill should be continued or revised.

The bill also amends:

-- N.J.S.A.30:4-27.6 to authorize State or local law enforcement officers to take custody of and take to a screening service a patient who needs to be referred to the service, upon certification by an outpatient treatment provider that the provider has reasonable cause to believe the patient is in need of evaluation for commitment to treatment;

-- N.J.S.A.2A:62A-16 and N.J.S.A.30:4-27.7 to add outpatient treatment providers to the list of professionals granted immunity under these sections of law;

-- N.J.S.A.30:4-27.11 to provide that patients assigned to an outpatient treatment provider have the same patient rights under this section of law as are provided to patients admitted to a short-term care or psychiatric facility or special psychiatric hospital;

-- N.J.S.A.30:4-27.16 concerning periodic court hearings to provide that if a patient has been assigned to an outpatient treatment provider, the court would conduct the first review hearing six months from the date of the first hearing, the next hearing nine months from the date of the first hearing and subsequent hearings 12 months from the date of the first hearing and annually thereafter;

-- N.J.S.A.30:4-27.17 to provide for an outpatient treatment provider to administratively discharge a patient; and

-- N.J.S.A.30:4-27.18 to provide for an outpatient treatment provider to participate in the formulation of a discharge plan.

The bill takes effect one year after enactment.

As reported by the committee, this bill is identical to Assembly Bill. No. 1618 Aca (McKeon/Fisher/Oliver) which the committee also reported on this date.

COMMITTEE AMENDMENTS

The committee adopted an amendment to section 5 of P.L.1987, c.116 (C.30:4-27.5) to clarify that upon completion of a screening certificate, screening service staff, in consultation with the psychiatrist or another physician, as appropriate, who completed the screening certificate, would determine the least restrictive environment for the appropriate treatment for the person.

STATEMENT TO

[First Reprint]
SENATE, No. 735

with Assembly Floor Amendments
(Proposed by Assemblyman MCKEON)

ADOPTED: JUNE 18, 2009

These amendments:

- direct the Commissioner of Human Services to phase in implementation of involuntary commitment to outpatient treatment (ICOT) over a three-year period. The commissioner shall select seven counties in the State to implement ICOT in the first year after the effective date, seven additional counties to implement ICOT in the second year after the effective date, and the remaining seven counties to fully implement ICOT Statewide in the third year after the effective date. The bill takes effect one year after enactment;
- direct the commissioner to monitor the implementation of ICOT and report annually to the Governor and the Legislature. The commissioner shall include in his reports such recommendations for administrative and statutory changes as he deems necessary. The annual reports shall address the following:

  -- the number of new patients who were involuntarily committed to outpatient treatment as compared to the number of patients committed to outpatient treatment who had previously been committed to inpatient treatment; and

  -- whether sufficient treatment services are available in the respective counties to serve persons who have been involuntarily committed to outpatient treatment and whether persons who have been involuntarily committed to outpatient treatment are receiving the mental health treatment services necessary for recovery;
- delay the original monitoring, evaluating, and reporting requirements from two and four years after the effective date of the bill (as the bill originally provided), to four and six years after the effective date, in order to reflect the phase-in of the provisions of the bill; and
- make technical corrections to use the term "involuntary commitment to outpatient treatment" consistently throughout the bill.

FISCAL NOTE

[Second Reprint]

SENATE, No. 735

STATE OF NEW JERSEY

213th LEGISLATURE

DATED: JULY 8, 2009

SUMMARY

Synopsis: Establishes involuntary commitment to outpatient treatment for persons in need of involuntary commitment to treatment.

Type of Impact: **Department of Human Services, Division of Mental Health Services.** Possible increase in State costs.

Judiciary. Possible increase in State costs.

Agencies Affected: Division of Mental Health Services in the Department of Human Services, and the Judiciary.

Executive and Judiciary Estimates

Fiscal Impact	Year 1	Year 2	Year 3
Office of Management and Budget	Unspecified increase in "outpatient treatment costs."	Same as Year 1.	Same as Year 1.
Division of Mental Health Services (DMHS)	$192,000	$10,196,000	$10,196,000
Judiciary	$56,700- $233,400	$58,900 - $237,800	$61,300 - $242,500

NOTE: The estimates above were submitted prior to the adoption of amendments to the bill that would phase-in the implementation of commitment to outpatient treatment over three years. As DMHS and the Judiciary did not submit revised estimates, the Office of Legislative Services assumes that the DMHS and Judiciary estimates would be prorated over three years as follows:

	Year 1	Year 2	Year 3
DMHS	$3,398,700	$6,797,300	$10,196,000
Judiciary	$18,700 - $70,000	$39,200 - $158,400	$61,300 – 242,500

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Office of Legislative Services Estimate

Fiscal impact	**Years 1 -3**
Division of Mental Health Services (DMHS). The proposed FY 2010 appropriations act includes sufficient funds to provide necessary services. However, if DMHS is unable to reallocate existing funds to meet any additional costs the legislation may entail, additional monies may be required.	
Judiciary. Minimal, as the Judiciary already incurs costs associated with the initial involuntary commitment hearings and follow-up hearings for those individuals who have been involuntarily committed.	

- The bill would phase-in implementation of involuntary commitment to outpatient treatment over three-years, beginning with seven counties selected by the Commissioner of Human Services in the first year, an additional seven counties in the second year, and all 21 counties in the third year.

- The proposed FY 2010 annual appropriations act includes sufficient funding to implement the provisions of the legislation. This includes monies recommended by the Governor's Task Force on Mental Health to expand the capabilities and services of mental health screening centers and to provide special case management to individuals who are resistant to mental health treatment services. Also, during FY 2009, DMHS awarded $7.0 million in contracts to develop Intensive Outpatient Treatment and Support Services Programs for individuals whose mental health service needs are similar to those of individuals in need of involuntary commitment to outpatient treatment.

- DMHS may have to reallocate funds among various mental health service components to provide services to individuals committed to outpatient treatment, and the criteria as to who can receive certain mental health services may have to be revised to accommodate the mental health service needs of such individuals. Contracted mental health provider agencies already prioritize services to individuals with serious mental illness or who are resistant to mental health treatment services; the mental health services needs of these individuals are similar to those of individuals who may be subject to outpatient commitment.

- The $10.1 million estimate provided by DMHS with respect to Grants-in-Aid expenditures does not reflect any federal Medicare or Medicaid reimbursement on behalf of patients subject to involuntary commitment to outpatient treatment. Such federal reimbursement would reduce overall costs.

- The availability of an involuntary commitment to outpatient treatment option may reduce the number of admissions to State and county psychiatric hospitals and other facilities. A reduction in the number of admissions to such facilities could reduce the operating costs of such facilities. The Administration may reallocate any institutional savings resulting from a reduction in admissions to support community programs.

- The number of initial involuntary commitment hearings varies from year to year, and the establishment of an involuntary commitment to outpatient treatment option should have little

impact on the total number of initial commitment hearings that are conducted. Similarly, compliance and treatment hearings conducted as part of the involuntary commitment to outpatient treatment option will not differ significantly from follow-up involuntary commitment hearings that are now conducted when an individual is committed to an institution.

- If an involuntary commitment to outpatient treatment option is established, the possibility exists that there may be an increase over time in the overall percentage of individuals subject to initial commitment hearings who are involuntarily committed, since this option provides for a less restrictive means of requiring that a person access mental health services. Even if there is an increase in the percentage of individuals who are involuntarily committed, as many of the individuals are already involved in the mental health system and may already receive services, there should not be a net increase in the number of persons accessing services.

BILL DESCRIPTION

Senate Bill No. 735 (2R) of 2008 amends the State's civil commitment laws to allow for the involuntary commitment to outpatient treatment of an individual. Under current law, involuntary commitment to treatment of an individual is permitted only to a State or county psychiatric hospital or to other designated inpatient facilities such as a Short Term Care Facility. Commitment to outpatient treatment would be subject to court review as is currently required under the inpatient commitment law.

The legislation also makes various technical changes with respect to definitions concerning involuntary commitment. Further, the legislation requires the Commissioner of Human Services to designate one or more mental health agencies in each county or multi-county region as the outpatient treatment provider for individuals assigned to involuntary commitment to outpatient treatment, subject to the agency's approval of the designation.

The legislation would phase-in implementation of involuntary commitment to outpatient treatment over a three-year period by having the commissioner select seven counties to participate in the program in the first year, seven additional counties in the second year, and all counties in the third year. The commissioner also would be required to prepare an annual report that addresses the legislation's implementation and related administrative, fiscal, and programmatic issues.

FISCAL ANALYSIS

EXECUTIVE BRANCH

The Office of Management and Budget (OMB) did not provide any specific fiscal information outside of noting that the legislation "is expected to result in increased outpatient treatment costs within DMHS."

Subsequent to the information provided by OMB, the Division of Mental Health Services provided the following fiscal information. No detail was provided regarding the type of mental health services to be provided or the number of persons expected to utilize such services.

	Year One	Year Two	Year Three
TOTAL	**$192,000**	**$10,196,000**	**$10,196,000**
Direct State Services	$42	$75,000	$75,000
Grants-in-Aid	$150,000	$10,121,000	$10,121,000

Note that the $10.2 million estimate was submitted prior to the adoption of amendments that would phase the legislation in over three years. As revised estimates were not submitted, the Office of Legislative Services assumed that the $10.2 million estimate would be prorated over three years as follows: First Year - $3.4 million; Second Year - $6.8 million; and Third Year - $10.2 million.

JUDICIARY

The Judiciary has provided the following range of estimates depending on the number of "involuntary commitment to outpatient treatment" hearings that may be held.

Number of Cases	Year One	Year Two	Year Three
400	$56,700	$58,900	$61,300
800	$68,700	$70,900	$73,300
1,600	$92,700	$94,900	$97,300
3,200	$185,400	$189,800	$194,500
4,800	$233,400	$237,800	$242,500

(Amounts have been rounded off to the nearest one hundred dollars.)

Note that these estimates were submitted prior to the adoption of amendments that would phase in the legislation over three years. As the Judiciary did not submit revised estimates, the Office of Legislative Services assumes that the Judiciary estimates would be prorated over three years as follows: First Year - $18,700 to $70,000; Second Year - $39,200 to $158,400; and Third Year - $61,300 to $242,500.

OFFICE OF LEGISLATIVE SERVICES

The Office of Legislative Services (OLS) anticipates minimal additional costs associated with the involuntary commitment to outpatient treatment legislation.

The fundamental difference with respect to the cost estimates is that both the Administration and the Judiciary anticipate that significant numbers of new clients will enter the mental health system, clients who were not previously known to or involved in the mental health system. The Office of Legislative Services is of the opinion that most persons subject to involuntary commitment to outpatient treatment are already known to and involved with the mental health system. These matters are discussed below.

DMHS. It is generally acknowledged that the overall community mental health system may not be adequately funded to meet the mental health needs of all State residents in need of services. Provider agencies have testified about their ongoing operational difficulties, particularly with respect to recruitment and retention of personnel. These funding limitations may result in individuals not being able to access mental health services on a timely basis and individuals not being able to receive all the mental health services they require or the intensity of services they require. The comments below regarding the legislation are not intended to address the overall funding issue affecting community mental health services.

(1) The proposed FY 2010 appropriations act provides $338.3 million to DMHS for community mental health services that will be provided by nearly 115 agencies. In addition to State appropriations, provider agencies obtain significant revenues from third parties such as Medicare and Medicaid, and receive fees, donations and other grants to supplement the State appropriation.

The proposed FY 2010 appropriations act also includes funds to support the recommendations of the Governor's Mental Health Task Force to enhance the capacity of screening services to provide services to individuals being assessed for involuntary commitment, and to provide case management services to individuals who are resistant to receiving mental health services. The proposed FY 2010 appropriations act also includes $7.0 million in funds awarded during FY 2009 to develop Intensive Outpatient Treatment and Support Services to individuals whose mental health services needs are similar to those who may need involuntary commitment to outpatient treatment.

The State appropriation, along with other monies available to the various mental health agencies, is used to provide various mental health services which range from services provided on a 24/7 basis such as Integrated Case Management services (ICMS), Program for Assertive Community Treatment (PACT) and Screening Services, to services of lesser intensity such as outpatient, partial care and residential care, to services that are self-directed or episodic such as job training, legal assistance and self-help centers.

The availability of mental health services varies, depending on the needs of an individual. Screening services are available to all individuals who may require involuntary commitment; ICMS and PACT are generally available to individuals who are discharged from an institutional setting and are not available to individuals who have not been hospitalized. Other mental health services are available to all individuals in need of such services, although priority may be given to individuals who have been institutionalized or to individuals who might otherwise be involuntarily committed to an institution.

Although OLS believes that sufficient funds are available to DMHS to implement the legislation, to the extent that DMHS is unable to reallocate existing monies to meet education and training costs associated with the new legislation and to provide services to individuals in need of outpatient commitment who are not currently receiving mental health services without adversely affecting services currently provided to individuals, additional funding may be required by DMHS. As it is not known how many individuals will meet the criteria until the legislation is implemented, costs cannot be determined.

(2) Since the standard for involuntary commitment is the same regardless of whether the individual is committed involuntarily to inpatient or outpatient treatment, the availability of an involuntary commitment to outpatient treatment option, as an alternative to involuntary inpatient commitment should have little impact on the total number of individuals being screened for possible involuntary commitment. Further, as service planning and the provision of services to individuals being screened are already required by regulation, the development of "an appropriate interim plan of treatment" and the provision of services to individuals involuntarily committed to outpatient treatment should not represent a significant workload increase.

(3) It is possible that individuals involuntarily committed to outpatient treatment may require ICMS or PACT services that are now usually available only to individuals discharged from an institutional setting. DMHS may have to broaden eligibility for such programs to include individuals in need of involuntary commitment to outpatient treatment. However, as such individuals would be eligible for ICMS or PACT upon discharge from an institution, the provision of ICMS or PACT is more a matter of when services are provided as opposed to providing a service that would otherwise not be available. In the case of other mental health services individuals committed to outpatient treatment may need, provider agencies may be required to give priority to these individuals over other persons with mental illness.

(4) The establishment of an involuntary commitment to outpatient treatment classification could result in a reduction in the number of persons admitted to State and county hospitals. Over time, a reduction in the number of admissions to State and county hospitals could result in a reduction in the operating costs of the facilities. The Administration would be able to reallocate such institutional savings to support community programs.

(5) The $10.1 million estimate provided by DMHS with respect to Grants-in-Aid expenditures or the prorated estimate provided by OLS does not reflect any federal Medicare or Medicaid reimbursement on behalf of patients subject to involuntary commitment to outpatient treatment. Such federal reimbursement would reduce overall costs.

(6) There is a possibility that there may be an overall increase in the percentage of individuals subject to initial commitment hearings who are involuntarily committed, if an involuntary commitment to outpatient services option is established.

At present, a judge may decide not to involuntarily commit an individual to an institution even though the individual may require intensive mental health services. The establishment of the less restrictive outpatient commitment option may result in judges selecting this option as a way to ensure that mental health services are provided to an individual. But until the legislation is implemented, it cannot be determined whether there will be an increase in the overall percentage of individuals involuntarily committed. Even if there is an increase in the percentage of commitments, many of the individuals subject to commitment are already involved in the mental health system and may already be receiving outpatient services.

The **Judiciary** already incurs costs associated with involuntary commitment hearings. The legislation should not result in an increase in the number of initial commitment hearings since the standard for commitment to outpatient treatment is the same as for commitment to inpatient treatment.

While there would be continued court involvement in instances where an individual is noncompliant with the terms and conditions of commitment to outpatient treatment, this requirement is not significantly different than the ongoing court involvement for individuals who are involuntarily committed to a State or county hospital or other inpatient facility. Thus, the availability of an involuntary commitment to outpatient treatment option for persons in need of involuntary commitment should have little impact on the Judiciary's overall costs related to involuntary commitment proceedings.

Section:	*Human Services*
Analyst:	*Jay Hershberg* *Principal Fiscal Analyst*
Approved:	*David J. Rosen* *Legislative Budget and Finance Officer*

This fiscal note has been prepared pursuant to P.L.1980, c.67 (C.52:13B-1 et seq.).

(3) the rate and geographic distribution of court orders for involuntary outpatient commitment to treatment;

(4) the responses of patients who have been committed to involuntary outpatient commitment to treatment to such treatment;

(5) the extent to which the use of involuntary outpatient commitment to treatment affects the rates of institutionalization and incarceration;

(6) whether sufficient treatment services are available to persons who have been involuntarily committed to outpatient treatment;

(7) whether persons who have been involuntarily committed to outpatient treatment are receiving the mental health treatment services necessary for recovery; and

(8) the effect of involuntary outpatient commitment to treatment on the availability of services to voluntary consumers with severe mental illness.

To carry out the purposes of this subsection, the commissioner may contract with an individual or entity with expertise in the field of evaluating mental health programs.

b. The commissioner shall include in his reports such recommendations for statutory changes as he deems necessary, including whether or not the provision for involuntary outpatient commitment as established pursuant to P.L. , c. (pending before the Legislature as this bill) shall be continued or revised.

24. a. The Commissioner of Human Services, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations necessary to effectuate the purposes of this act.

b. The Supreme Court of New Jersey may adopt court rules to effectuate the purposes of this act.

25. This act shall take effect one year after the date of enactment, but the Commissioner of Human Services may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act.

SPONSORS STATEMENT

This bill amends the State's civil commitment laws (N.J.S.A. 30:4-27.1 et seq.) to allow for involuntary commitment to outpatient treatment of persons who are "in need of involuntary commitment to treatment." The bill defines this term to mean that "an adult with mental illness, whose mental illness causes the person to be dangerous to self or dangerous to others or property and who is unwilling to accept appropriate treatment voluntarily after it has been offered, needs outpatient treatment or inpatient care at a

short-term care or psychiatric facility or special psychiatric hospital because other services are not appropriate or available to meet the person's mental health care needs."

Involuntary commitment to treatment of persons with mental illness is one of the most intrusive exercises of power by the State. New Jersey's involuntary commitment system currently only permits commitment to inpatient care for persons who are established to be dangerous within the reasonably foreseeable future to themselves, others or property. The bill defines "reasonably foreseeable future" to mean a time frame that may be beyond the immediate or imminent, but not longer than a time frame as to which reasonably certain judgments about a person's likely behavior can be reached. In most cases, the small minority of persons with mental illness who present a danger within the reasonably foreseeable future to themselves, others or property, do so because they do not voluntarily engage in treatment. In this regard, the bill recognizes the State's responsibility to make available appropriate voluntary services in the community and clarifies or modifies New Jersey's civil commitment law as described below.

As the treatment for people with mental illness has advanced, many successful treatments are entirely outpatient. For this reason and others, the bill shifts the sense of involuntary commitment from commitment to an inpatient facility to commitment to clinically appropriate treatment, which may be inpatient care, outpatient care, or a combination of inpatient and outpatient care. The finding that a person is in need of involuntary commitment to treatment, then, will result in an order of commitment to appropriate treatment, rather than commitment to a facility.

The treatment provided after the entry of an order of involuntary commitment to treatment will be governed by the principle of least restrictive environment. The commitment process, then, will have two steps: it will first be determined whether by clear and convincing evidence a person's condition meets the dangerousness standard; then the treatment to which the person is committed will be determined by considering the least restrictive treatment setting appropriate to ameliorate the danger presented and appropriate to provide services directed to the wellness and recovery of the person.

In addition, the bill amends N.J.S.A. 30:4-27.9 to clarify, but not change, the standard for civil commitment and therefore make terminology uniform throughout the law so that the statute provides that a person shall not be involuntarily committed to treatment unless the person is "in need of involuntary commitment to treatment," as that term is defined in N.J.S.A. 30:4-27.2.

The bill also amends the definition of "dangerous to self" to replace the term "serious physical debilitation" with the term "serious physical harm," and make the definition of "dangerous to

self" parallel to the definition of "dangerous to others or property" by including language from the latter, that the determination of dangerousness take into account a person's history, recent behavior and any recent acts or threat. The bill also adds to both definitions that the determination of dangerousness shall take into account a person's "serious psychiatric deterioration."

With respect to screening services, the bill amends N.J.S.A.30:4-27.5 to provide that when appropriate and available, and as permitted by law, screening staff shall make reasonable efforts to gather information from the person's family or significant others in preparing screening documents. Upon completion of a screening certificate, screening service staff would determine the least restrictive environment for the appropriate treatment for the person, taking into account the person's prior history and current mental health condition. "Least restrictive environment" is defined in the bill as "the available setting and form of treatment that appropriately addresses a person's need for care and the need to respond to dangers to the person, others or property and respects, to the greatest extent practicable, the person's interests in freedom of movement and self-direction."

The bill specifies that screening service staff shall designate inpatient treatment for the person if that person is immediately or imminently dangerous or when outpatient treatment is deemed inadequate to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future. Screening service staff shall designate outpatient treatment for the person when outpatient treatment is deemed sufficient to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future.

If the screening service staff determines that the person is in need of involuntary commitment to outpatient treatment, staff must consult with an outpatient treatment provider to arrange, if possible, for an appropriate interim plan of treatment. The Commissioner of Human Services is required to designate one or more mental health agencies in each county or multi-county region in the State as an outpatient treatment provider, and authorizes the provider to provide services to persons from a specified geographic area. The designation would only be made with the approval of the agency's governing body.

In the case of patients committed and assigned to outpatient treatment by screening service staff or order of the court, or both, the bill provides that an outpatient treatment provider shall develop the plan of outpatient treatment in cooperation with screening service staff, short-term care facility staff or the court, as applicable. When appropriate and available, and as permitted by law, the provider shall make reasonable efforts to gather information from the patient's family or significant others for the

purposes of developing the plan of outpatient treatment. The bill defines "plan of outpatient treatment" as a plan for recovery from mental illness approved by a court that is to be carried out in an outpatient setting and is prepared by an outpatient treatment provider for a patient who has a history of responding to treatment. The plan may include medication as a component of the plan; however, medication shall not be involuntarily administered in an outpatient setting.

During the time a patient is assigned to the outpatient treatment provider for services pursuant to a commitment to outpatient treatment, the outpatient treatment provider must provide and coordinate the provision of care consistent with the plan of outpatient treatment.

If a patient fails to materially comply with the plan of outpatient treatment during the time the patient is assigned by a screening service to the outpatient treatment provider for services pursuant to a commitment to outpatient treatment or if the outpatient treatment provider determines that the plan is inadequate to meet the patient's mental health needs, the provider must notify the screening service of this material noncompliance or plan inadequacy. Similarly, if a patient fails to materially comply with the plan during the time the patient is assigned by a court to the provider or if the plan is inadequate, the provider must notify the court and screening service of this material noncompliance or plan inadequacy. In both cases, the patient would be referred to a screening service for an assessment to determine what services are available and where those services may be provided. The patient would be afforded the protections and procedures provided for in the State's civil commitment laws. The bill also provides that if a provider determines that a plan of outpatient treatment is inadequate and needs to be modified, but referral to a screening service is not necessary, the provider shall seek court approval for such modification and shall notify the court, patient's attorney and the county adjuster of the request for court approval of the modification.

Similar to procedures for admission to inpatient treatment, the bill:

- allows a screening service or outpatient treatment provider to initiate court proceedings for commitment to outpatient treatment, and also allows the same psychiatrist to execute the certificate after there has been a reasonable but unsuccessful attempt to have another psychiatrist conduct the evaluation and execute the certificate; and
- provides that a patient who is involuntarily committed and assigned to an outpatient treatment provider would receive a court hearing with respect to the need for continued involuntary commitment within 20 days from initial

commitment, unless administratively discharged by the outpatient treatment provider.

If the court finds by clear and convincing evidence that the patient needs continued involuntary commitment to treatment under N.J.S.A. 30:4-27.15, it would issue an order authorizing the commitment as well as the placement of the patient in an outpatient or inpatient setting for treatment.

In determining the commitment placement, the court would consider the least restrictive environment for the patient to receive clinically appropriate treatment that would ameliorate the danger posed by the patient and provide the patient with appropriate treatment. If the court determines that the least restrictive environment for the patient to receive clinically appropriate treatment would be in an outpatient setting and that there is a likelihood of the patient responding to outpatient treatment, the court would obtain from a designated outpatient treatment provider a proposed plan of outpatient treatment for the patient, which the court shall review. The plan must be approved by the court.

Between the time period for periodic court review hearings pursuant to N.J.S.A. 30:4-27.16, the chief executive officer of the psychiatric facility may recommend (to the court) changing the placement of a patient from an inpatient to outpatient setting, in order to ensure that the patient receives clinically appropriate treatment in the least restrictive environment. At the time the court sets the date for a hearing on the change in placement, notice would be provided to the patient, the patient's guardian, if any, the patient's next of kin, the patient's attorney and the county adjuster. The patient rights provided under N.J.S.A. 30:4-27.14 would apply to the hearing.

The bill also requires the Commissioner of Human Services to monitor and evaluate the implementation of involuntary outpatient commitment and report to the Governor and the Legislature two and four years after the bill's effective date on the implementation of involuntary outpatient commitment. The commissioner may contract with an individual or entity for the evaluation. The evaluation would include specific criteria enumerated in the bill in section 23.

The commissioner shall also include in his reports such recommendations for statutory changes as he deems necessary, including whether or not the provision for involuntary outpatient commitment established in this bill should be continued or revised.

The bill also amends:

-- N.J.S.A.30:4-27.6 to authorize State or local law enforcement officers to take custody of and take to a screening service a patient who needs to be referred to the service, upon certification by an outpatient treatment provider that the provider has reasonable cause

to believe the patient is in need of evaluation for commitment to treatment;

-- N.J.S.A.2A:62A-16 and N.J.S.A.30:4-27.7 to add outpatient treatment providers to the list of professionals granted immunity under these sections of law;

-- N.J.S.A.30:4-27.11 to provide that patients assigned to an outpatient treatment provider have the same patient rights under this section of law as are provided to patients admitted to a short-term care or psychiatric facility or special psychiatric hospital;

-- N.J.S.A.30:4-27.16 concerning periodic court hearings to provide that if a patient has been assigned to an outpatient treatment provider, the court would conduct the first review hearing six months from the date of the first hearing, the next hearing nine months from the date of the first hearing and subsequent hearings 12 months from the date of the first hearing and annually thereafter;

-- N.J.S.A.30:4-27.17 to provide for an outpatient treatment provider to administratively discharge a patient; and

-- N.J.S.A. 30:4-27.18 to provide for an outpatient treatment provider to participate in the formulation of a discharge plan.

Lastly, the bill takes effect one year after enactment.

FISCAL NOTE
ASSEMBLY, No. 1618
STATE OF NEW JERSEY
213th LEGISLATURE

DATED: FEBRUARY 9, 2009

SUMMARY

Synopsis: Establishes involuntary outpatient commitment to treatment for persons in need of involuntary commitment to treatment.

Type of Impact: **Division of Mental Health Services** (DMHS). The DMHS appropriation already includes funds for mental health services that may be required by individuals in need of involuntary commitment to outpatient treatment. Additional costs related to education and training regarding the new law, and related to the provision of residential services may be incurred if DMHS is unable to reallocate existing funds to address these areas.

Judiciary. Although the Judiciary indicates that it may incur additional costs based on increased volume of involuntary commitment hearings, it is likely that the increase in the number of involuntary commitment hearings will be minimal.

Agencies Affected: Department of Human Services, DMHS. The Judiciary.

Executive and Judiciary Estimates

Fiscal Impact	Year 1	Year 2	Year 3
Office of Management and Budget	Unspecified increase in "outpatient treatment costs."	Same as Year 1.	Same as Year 1.
JUDICIARY	$56,700- $233,400	$58,900 - $237,800	$61,300 - $242,500

Office of Legislative Services Estimate

Fiscal impact **Years 1 -3**

DMHS. FY 2009 State appropriations provide sufficient funds to provide necessary services. **However, if DMHS is unable to reallocate existing funds to meet any additionl costs the legislation may entail, additional monies may be required.**

JUDICIARY. Minimal, as the Judiciary already incurs costs associated with the initial involuntary commitment hearings and follow-up hearings for those individuals who have been involuntarily committed.

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- The FY 2009 appropriations act provides additional funding recommended by the Governor's Task Force on Mental Health, including monies to expand the capabilities and services of mental health screening centers and to provide special case management to individuals who are resistant to mental health treatment services. DMHS is also in the process of awarding $7.0 million to develop Intensive Outpatient Treatment and Support Services Programs for individuals whose mental health services needs are similar to those of individuals in need of involuntary outpatient commitment.

- DMHS may have to reallocate funds among various mental health service components to provide services to individuals committed to outpatient treatment, and the criteria as to who can receive certain mental health services may have to be revised to accommodate the mental health service needs of such individuals. Contracted mental health provider agencies already prioritize services to individuals with serious mental illness or who are resistant to mental health treatment services; the mental health services needs of these individuals are similar to those of individuals who may be subject to outpatient commitment.

- The availability of an involuntary commitment to outpatient treatment option may reduce the number of admissions to State and county psychiatric hospitals and other facilities. A reduction in the number of admissions to such facilities could reduce the operating costs of such facilities.

- The number of initial involuntary commitment hearings varies from year to year, and the establishment of an involuntary commitment to outpatient treatment option should have little impact on the total number of initial commitment hearings that are conducted. Similarly, compliance and treatment hearings conducted as part of the involuntary commitment to outpatient treatment option are not significantly different than follow-up involuntary commitment hearings that are now conducted when an individual is committed to an institution.

- If an involuntary commitment to outpatient treatment option is established, the possibility exists that there may be an increase in the overall percentage of individuals subject to initial commitment hearings who are involuntarily committed, since this option provides for a less restrictive means of requiring that a person access mental health services. Even if there is an increase in the percentage of individuals who are involuntarily committed, however, since many of the individuals are already involved in the mental health system and may already be receiving services, there should not be a net increase in the number of persons accessing services.

BILL DESCRIPTION

Assembly Bill No. 1618 of 2008 amends the State's civil commitment laws to allow for the involuntary commitment to outpatient treatment of an individual. Under current law, involuntary commitment to treatment of an individual is permitted only to a State or county psychiatric hospital or to other designated inpatient facilities such as a Short Term Care Facility. Commitment to outpatient treatment would be subject to court review as is currently required under the inpatient commitment law.

The legislation makes various technical changes with respect to definitions concerning involuntary commitment. Further, the legislation requires the Commissioner of Human Services to designate one or more mental health agencies in each county or multi-county region as the outpatient treatment provider for individuals assigned to involuntary commitment to outpatient treatment, subject to the agency's approval of the designation.

FISCAL ANALYSIS

EXECUTIVE BRANCH

The Office of Management and Budget has not provided any specific fiscal information outside of noting that the legislation "is expected to result in increased outpatient treatment costs within DMHS."

JUDICIAL BRANCH

The Judiciary has provided a range of estimates depending on the number of "involuntary commitment to outpatient treatment" hearings that may be held, as follows:

Number of Cases	Year One	Year Two	Year Three
400	$56,700	$58,900	$61,300
800	$68,700	$70,900	$73,300
1,600	$92,700	$94,900	$97,300
3,200	$185,400	$189,800	$194,500
4,800	$233,400	$237,800	$242,500

(Amounts have been rounded off to the nearest one hundred dollars.)

OFFICE OF LEGISLATIVE SERVICES

There are minimal additional costs associated with the involuntary commitment to outpatient treatment legislation, as discussed below.

DMHS. It is generally acknowledged that the overall community mental health system may not be adequately funded to meet the mental health needs of all State residents in need of services. Provider agencies have testified about their ongoing operational difficulties, particularly with respect to recruitment and retention of personnel. These funding limitations may result in individuals not being able to receive all the mental health services they require or the intensity of services they require. The comments below regarding the legislation are not intended to address the overall funding issue affecting community mental health services.

The FY 2009 appropriations act includes $323.5 million to DMHS for community mental health services provided by nearly 130 agencies. In addition to State appropriations, provider agencies obtain significant revenues from third parties such as Medicare and Medicaid, and receive fees, donations and other grants to supplement the State appropriation.

Included within the $323.5 million State appropriation were new monies to implement recommendations of the Governor's Mental Health Task Force to enhance the capacity of screening services to provide services to individuals being assessed for involuntary commitment,

and to provide case management services to individuals who are resistant to receiving mental health services. Also, during FY 2009, DMHS issued a Request for Proposal and is in the process of awarding up to $7.0 million in funds to develop Intensive Outpatient Treatment and Support Services to individuals whose mental health services needs are similar to those who may need involuntary commitment to outpatient treatment.

The State appropriation, along with other monies available to the various mental health agencies, is used to provide various mental health services which range from services provided on a 24/7 basis such as Integrated Case Management services (ICMS), Program for Assertive Community Treatment (PACT) and Screening Services, to services of lesser intensity such as outpatient, partial care and residential care, to services that are self-directed or episodic such as job training, legal assistance and self-help centers.

The availability of mental health services varies, depending on the needs of an individual. Screening services are available to all individuals who may require involuntary commitment; ICMS and PACT are generally available to individuals being discharged from an institutional setting and are not available to individuals who have not been hospitalized; and other mental health services are available to all individuals in need of such services, although priority may be given to individuals who have been institutionalized or to individuals who might otherwise be involuntarily committed to an institution.

Although sufficient funds are available to DMHS to implement the legislation, to the extent that DMHS is unable to reallocate existing monies to meet education and training costs associated with the new legislation and to provide residential services to individuals in need of outpatient commitment without adversely affecting residential services currently being provided to individuals, additional funding may be required by DMHS. Such costs cannot be determined until the legislation is implemented.

The availability of an involuntary commitment to outpatient treatment option, as an alternative to involuntary commitment to a State or county hospital or other inpatient facility, should have little impact on the total number of individuals being screened for possible involuntary commitment, since the standard for involuntary commitment is the same regardless of whether the individual is committed to inpatient or outpatient treatment. Further, as service planning and the provision of services to individuals being screened are already required by regulation, the development of "an appropriate interim plan of treatment" and the provision of services to individuals involuntarily committed to outpatient treatment should not represent a significant workload increase.

It is possible that individuals involuntarily committed to outpatient treatment may require ICMS or PACT services that are now usually available only to individuals discharged from an institutional setting. Thus, DMHS may have to broaden eligibility for such programs to include individuals in need of involuntary commitment to outpatient treatment. However, as such individuals would be eligible for ICMS or PACT upon discharge from an institution, the provision of ICMS or PACT is more a matter of when services are provided as opposed to providing a service that would otherwise not be available. As the case of other mental health services individuals committed to outpatient treatment may need, provider agencies may be required to give priority to these individuals over other persons with mental illness.

The establishment of an involuntary outpatient commitment classification could result in a reduction in the number of persons admitted to State and county hospitals. Over time, a reduction in the number of admissions to State and county hospitals could result in a reduction in the operating costs of the facilities.

It is noted, however, that there is a possibility that there may be an overall increase in the percentage of individuals subject to initial commitment hearings who are involuntarily committed, if an "involuntary commitment to outpatient services" option is established. At

present, a judge may decide not to involuntarily commit an individual to an institution even though the individual may require intensive mental health services. The establishment of the less restrictive outpatient commitment option may result in judges selecting this option as a way to ensure that mental health services are provided to an individual. However, until the legislation is implemented, it cannot be determined whether there will be an increase in the overall percentage of individuals involuntarily committed. Even if there is an increase in the percentage of commitments, many of the individuals subject to commitment are already involved in the mental health system and may already be receiving outpatient services.

The **Judiciary** already incurs costs associated with involuntary commitment hearings. The legislation should not result in an increase in the number of initial commitment hearings since the standard for outpatient commitment to treatment is the same as for inpatient commitment to treatment.

While there would be continued court involvement in instances where an individual is noncompliant with the terms and conditions of outpatient commitment to treatment, this requirement is not significantly different than the ongoing court involvement for individuals who are involuntarily committed to a State or county hospital or other inpatient facility. Thus, the availability of an involuntary outpatient commitment option for persons in need of involuntary commitment should have little impact on the Judiciary's overall costs related to involuntary commitment proceedings.

Section:	*Human Services*
Analyst:	*Jay A. Hershberg* *Principal Fiscal Analyst*
Approved:	*David J. Rosen* *Legislative Budget and Finance Officer*

This fiscal note has been prepared pursuant to P.L.1980, c.67 (C. 52:13B-1 et seq.).

ASSEMBLY HUMAN SERVICES COMMITTEE

STATEMENT TO

ASSEMBLY, No. 1618

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 8, 2009

The Assembly Human Services Committee reports favorably and with committee amendments, Assembly Bill No. 1618.

As amended by the committee, this bill amends the State's civil commitment laws (N.J.S.A.30:4-27.1 et seq.) to allow for involuntary commitment to outpatient treatment of persons who are "in need of involuntary commitment to treatment." The bill defines this term to mean that "an adult with mental illness, whose mental illness causes the person to be dangerous to self or dangerous to others or property and who is unwilling to accept appropriate treatment voluntarily after it has been offered, needs outpatient treatment or inpatient care at a short-term care or psychiatric facility or special psychiatric hospital because other services are not appropriate or available to meet the person's mental health care needs."

Involuntary commitment to treatment of persons with mental illness is one of the most intrusive exercises of power by the State. New Jersey's involuntary commitment system currently only permits commitment to inpatient care for persons who are established to be dangerous within the reasonably foreseeable future to themselves, others or property. The bill defines "reasonably foreseeable future" to mean a time frame that may be beyond the immediate or imminent, but not longer than a time frame as to which reasonably certain judgments about a person's likely behavior can be reached. In most cases, the small minority of persons with mental illness who present a danger within the reasonably foreseeable future to themselves, others or property, do so because they do not voluntarily engage in treatment. In this regard, the bill recognizes the State's responsibility to make available appropriate voluntary services in the community and clarifies or modifies New Jersey's civil commitment law as described below.

As the treatment for people with mental illness has advanced, many successful treatments are entirely outpatient. For this reason and others, the bill shifts the sense of involuntary commitment from commitment to an inpatient facility to commitment to clinically appropriate treatment, which may be inpatient care, outpatient care, or a combination of inpatient and outpatient care. The finding that a person is in need of involuntary commitment to treatment, then, will

result in an order of commitment to appropriate treatment, rather than commitment to a facility.

The treatment provided after the entry of an order of involuntary commitment to treatment will be governed by the principle of least restrictive environment. The commitment process, then, will have two steps: it will first be determined whether by clear and convincing evidence a person's condition meets the dangerousness standard; then the treatment to which the person is committed will be determined by considering the least restrictive treatment setting appropriate to ameliorate the danger presented and appropriate to provide services directed to the wellness and recovery of the person.

In addition, the bill amends N.J.S.A. 30:4-27.9 to clarify, but not change, the standard for civil commitment and therefore make terminology uniform throughout the law so that the statute provides that a person shall not be involuntarily committed to treatment unless the person is "in need of involuntary commitment to treatment," as that term is defined in N.J.S.A. 30:4-27.2.

The bill also amends the definition of "dangerous to self" to replace the term "serious physical debilitation" with the term "serious physical harm," and make the definition of "dangerous to self" parallel to the definition of "dangerous to others or property" by including language from the latter, that the determination of dangerousness take into account a person's history, recent behavior and any recent acts or threat. The bill also adds to both definitions that the determination of dangerousness shall take into account a person's "serious psychiatric deterioration."

With respect to screening services, the bill amends N.J.S.A.30:4-27.5 to provide that when appropriate and available, and as permitted by law, screening staff shall make reasonable efforts to gather information from the person's family or significant others in preparing screening documents. Upon completion of a screening certificate, screening service staff, in consultation with the psychiatrist or another physician, as appropriate, who completed the certificate, would determine the least restrictive environment for the appropriate treatment for the person, taking into account the person's prior history and current mental health condition. "Least restrictive environment" is defined in the bill as "the available setting and form of treatment that appropriately addresses a person's need for care and the need to respond to dangers to the person, others or property and respects, to the greatest extent practicable, the person's interests in freedom of movement and self-direction."

The bill specifies that screening service staff shall designate inpatient treatment for the person if that person is immediately or imminently dangerous or when outpatient treatment is deemed inadequate to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future. Screening service staff shall designate outpatient treatment for the person when

outpatient treatment is deemed sufficient to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future.

If the screening service staff determines that the person is in need of involuntary commitment to outpatient treatment, staff must consult with an outpatient treatment provider to arrange, if possible, for an appropriate interim plan of treatment. The Commissioner of Human Services is required to designate one or more mental health agencies in each county or multi-county region in the State as an outpatient treatment provider, and authorizes the provider to provide services to persons from a specified geographic area. The designation would only be made with the approval of the agency's governing body.

In the case of patients committed and assigned to outpatient treatment by screening service staff or order of the court, or both, the bill provides that an outpatient treatment provider shall develop the plan of outpatient treatment in cooperation with screening service staff, short-term care facility staff or the court, as applicable. When appropriate and available, and as permitted by law, the provider shall make reasonable efforts to gather information from the patient's family or significant others for the purposes of developing the plan of outpatient treatment. The bill defines "plan of outpatient treatment" as a plan for recovery from mental illness approved by a court that is to be carried out in an outpatient setting and is prepared by an outpatient treatment provider for a patient who has a history of responding to treatment. The plan may include medication as a component of the plan; however, medication shall not be involuntarily administered in an outpatient setting.

During the time a patient is assigned to the outpatient treatment provider for services pursuant to a commitment to outpatient treatment, the outpatient treatment provider must provide and coordinate the provision of care consistent with the plan of outpatient treatment.

If a patient fails to materially comply with the plan of outpatient treatment during the time the patient is assigned by a screening service to the outpatient treatment provider for services pursuant to a commitment to outpatient treatment or if the outpatient treatment provider determines that the plan is inadequate to meet the patient's mental health needs, the provider must notify the screening service of this material noncompliance or plan inadequacy. Similarly, if a patient fails to materially comply with the plan during the time the patient is assigned by a court to the provider or if the plan is inadequate, the provider must notify the court and screening service of this material noncompliance or plan inadequacy. In both cases, the patient would be referred to a screening service for an assessment to determine what services are available and where those services may be provided. The patient would be afforded the protections and procedures provided for in the State's civil commitment laws. The bill also provides that if a

provider determines that a plan of outpatient treatment is inadequate and needs to be modified, but referral to a screening service is not necessary, the provider shall seek court approval for such modification and shall notify the court, patient's attorney and the county adjuster of the request for court approval of the modification.

Similar to procedures for admission to inpatient treatment, the bill:

(1) allows a screening service or outpatient treatment provider to initiate court proceedings for commitment to outpatient treatment, and also allows the same psychiatrist to execute the certificate after there has been a reasonable but unsuccessful attempt to have another psychiatrist conduct the evaluation and execute the certificate; and

(2) provides that a patient who is involuntarily committed and assigned to an outpatient treatment provider would receive a court hearing with respect to the need for continued involuntary commitment within 20 days from initial commitment, unless administratively discharged by the outpatient treatment provider.

If the court finds by clear and convincing evidence that the patient needs continued involuntary commitment to treatment under N.J.S.A.30:4-27.15, it would issue an order authorizing the commitment as well as the placement of the patient in an outpatient or inpatient setting for treatment.

In determining the commitment placement, the court would consider the least restrictive environment for the patient to receive clinically appropriate treatment that would ameliorate the danger posed by the patient and provide the patient with appropriate treatment. If the court determines that the least restrictive environment for the patient to receive clinically appropriate treatment would be in an outpatient setting and that there is a likelihood of the patient responding to outpatient treatment, the court would obtain from a designated outpatient treatment provider a proposed plan of outpatient treatment for the patient, which the court shall review. The plan must be approved by the court.

Between the time period for periodic court review hearings pursuant to N.J.S.A.30:4-27.16, the chief executive officer of the psychiatric facility may recommend (to the court) changing the placement of a patient from an inpatient to outpatient setting, in order to ensure that the patient receives clinically appropriate treatment in the least restrictive environment. At the time the court sets the date for a hearing on the change in placement, notice would be provided to the patient, the patient's guardian, if any, the patient's next-of-kin, the patient's attorney and the county adjuster. The patient rights provided under N.J.S.A.30:4-27.14 would apply to the hearing.

The bill also requires the Commissioner of Human Services to monitor and evaluate the implementation of involuntary outpatient commitment and report to the Governor and the Legislature two and four years after the bill's effective date on the implementation of

involuntary outpatient commitment. The commissioner may contract with an individual or entity for the evaluation. The evaluation would include specific criteria enumerated in section 23 of the bill. The commissioner shall also include in his reports such recommendations for statutory changes as he deems necessary, including whether or not the provision for involuntary outpatient commitment established in this bill should be continued or revised.

The bill also amends:

-- N.J.S.A.30:4-27.6 to authorize State or local law enforcement officers to take custody of and take to a screening service a patient who needs to be referred to the service, upon certification by an outpatient treatment provider that the provider has reasonable cause to believe the patient is in need of evaluation for commitment to treatment;

-- N.J.S.A.2A:62A-16 and N.J.S.A.30:4-27.7 to add outpatient treatment providers to the list of professionals granted immunity under these sections of law;

-- N.J.S.A.30:4-27.11 to provide that patients assigned to an outpatient treatment provider have the same patient rights under this section of law as are provided to patients admitted to a short-term care or psychiatric facility or special psychiatric hospital;

-- N.J.S.A.30:4-27.16 concerning periodic court hearings to provide that if a patient has been assigned to an outpatient treatment provider, the court would conduct the first review hearing six months from the date of the first hearing, the next hearing nine months from the date of the first hearing and subsequent hearings 12 months from the date of the first hearing and annually thereafter;

-- N.J.S.A.30:4-27.17 to provide for an outpatient treatment provider to administratively discharge a patient; and

-- N.J.S.A.30:4-27.18 to provide for an outpatient treatment provider to participate in the formulation of a discharge plan.

The bill takes effect one year after enactment.

As reported by the committee, this bill is identical to Senate Bill No. 735 Aca (Codey/Cardinale) which the committee also reported on this date.

This bill was pre-filed for introduction in the 2008-2009 session pending technical review. As reported, the bill includes the changes required by technical review, which has been performed.

COMMITTEE AMENDMENTS:

The committee adopted an amendment to section 5 of P.L.1987, c.116 (C.30:4-27.5) to clarify that upon completion of a screening certificate, screening service staff, in consultation with the psychiatrist or another physician, as appropriate, who completed the screening certificate, would determine the least restrictive environment for the appropriate treatment for the person.

The committee also adopted amendments that are technical in nature. The phrase "to treatment" is added in section 16 for consistency with other language provisions in the bill, and the statutory reference for reporting to the Legislature is added in section 23.

STATEMENT TO

[First Reprint]
ASSEMBLY, No. 1618

with Assembly Floor Amendments
(Proposed by Assemblyman MCKEON)

ADOPTED: JUNE 18, 2009

These amendments:

- direct the Commissioner of Human Services to phase in implementation of involuntary commitment to outpatient treatment (ICOT) over a three-year period. The commissioner shall select seven counties in the State to implement ICOT in the first year after the effective date, seven additional counties to implement ICOT in the second year after the effective date, and the remaining seven counties to fully implement ICOT Statewide in the third year after the effective date. The bill takes effect one year after enactment;
- direct the commissioner to monitor the implementation of ICOT and report annually to the Governor and the Legislature. The commissioner shall include in his reports such recommendations for administrative and statutory changes as he deems necessary. The annual reports shall address the following:

  -- the number of new patients who were involuntarily committed to outpatient treatment as compared to the number of patients committed to outpatient treatment who had previously been committed to inpatient treatment; and

  -- whether sufficient treatment services are available in the respective counties to serve persons who have been involuntarily committed to outpatient treatment and whether persons who have been involuntarily committed to outpatient treatment are receiving the mental health treatment services necessary for recovery;
- delay the original monitoring, evaluating, and reporting requirements from two and four years after the effective date of the bill (as the bill originally provided), to four and six years after the effective date, in order to reflect the phase-in of the provisions of the bill; and
- make technical corrections to use the term "involuntary commitment to outpatient treatment" consistently throughout the bill.

FISCAL NOTE

[Second Reprint]

ASSEMBLY, No. 1618

STATE OF NEW JERSEY
213th LEGISLATURE

DATED: JULY 8, 2009

SUMMARY

Synopsis: Establishes involuntary commitment to outpatient treatment for persons in need of involuntary commitment to treatment.

Type of Impact: **Department of Human Services, Division of Mental Health Services**. Possible increase in State costs.

Judiciary. Possible increase in State costs.

Agencies Affected: Division of Mental Health Services in the Department of Human Services, and the Judiciary.

Executive and Judiciary Estimates

Fiscal Impact	Year 1	Year 2	Year 3
Office of Management and Budget	Unspecified increase in "outpatient treatment costs."	Same as Year 1.	Same as Year 1.
Division of Mental Health Services (DMHS)	$192,000	$10,196,000	$10,196,000
Judiciary	$56,700- $233,400	$58,900 - $237,800	$61,300 - $242,500

NOTE: The estimates above were submitted prior to the adoption of amendments to the bill that would phase-in the implementation of commitment to outpatient treatment over three years. As DMHS and the Judiciary did not submit revised estimates, the Office of Legislative Services assumes that the DMHS and Judiciary estimates would be prorated over three years as follows:

	Year 1	Year 2	Year 3
DMHS	$3,398,700	$6,797,300	$10,196,000
Judiciary	$18,700 - $70,000	$39,200 - $158,400	$61,300 – 242,500

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Office of Legislative Services Estimate

Fiscal impact	**Years 1 -3**
Division of Mental Health Services (DMHS). The proposed FY 2010 appropriations act includes sufficient funds to provide necessary services. However, if DMHS is unable to reallocate existing funds to meet any additional costs the legislation may entail, additional monies may be required.	
Judiciary. Minimal, as the Judiciary already incurs costs associated with the initial involuntary commitment hearings and follow-up hearings for those individuals who have been involuntarily committed.	

- The bill would phase-in implementation of involuntary commitment to outpatient treatment over three-years, beginning with seven counties selected by the Commissioner of Human Services in the first year, an additional seven counties in the second year, and all 21 counties in the third year.

- The proposed FY 2010 annual appropriations act includes sufficient funding to implement the provisions of the legislation. This includes monies recommended by the Governor's Task Force on Mental Health to expand the capabilities and services of mental health screening centers and to provide special case management to individuals who are resistant to mental health treatment services. Also, during FY 2009, DMHS awarded $7.0 million in contracts to develop Intensive Outpatient Treatment and Support Services Programs for individuals whose mental health service needs are similar to those of individuals in need of involuntary commitment to outpatient treatment.

- The DMHS may have to reallocate funds among various mental health service components to provide services to individuals committed to outpatient treatment, and the criteria as to who can receive certain mental health services may have to be revised to accommodate the mental health service needs of such individuals. Contracted mental health provider agencies already prioritize services to individuals with serious mental illness or who are resistant to mental health treatment services; the mental health services needs of these individuals are similar to those of individuals who may be subject to outpatient commitment.

- The $10.1 million estimate provided by DMHS with respect to Grants-in-Aid expenditures does not reflect any federal Medicare or Medicaid reimbursement on behalf of patients subject to involuntary commitment to outpatient treatment. Such federal reimbursement would reduce overall costs.

- The availability of an involuntary commitment to outpatient treatment option may reduce the number of admissions to State and county psychiatric hospitals and other facilities. A reduction in the number of admissions to such facilities could reduce the operating costs of such facilities. The Administration may reallocate any institutional savings resulting from a reduction in admissions to support community programs.

- The number of initial involuntary commitment hearings varies from year to year, and the establishment of an involuntary commitment to outpatient treatment option should have little impact on the total number of initial commitment hearings that are conducted. Similarly, compliance and treatment hearings conducted as part of the involuntary commitment to outpatient treatment option will not differ significantly from follow-up involuntary commitment hearings that are now conducted when an individual is committed to an institution.

- If an involuntary commitment to outpatient treatment option is established, the possibility exists that there may be an increase over time in the overall percentage of individuals subject to initial commitment hearings who are involuntarily committed, since this option provides for a less restrictive means of requiring that a person access mental health services. Even if there is an increase in the percentage of individuals who are involuntarily committed, as many of the individuals are already involved in the mental health system and may already receive services, there should not be a net increase in the number of persons accessing services.

BILL DESCRIPTION

Assembly Bill No. 1618 (2R) of 2008 amends the State's civil commitment laws to allow for the involuntary commitment to outpatient treatment of an individual. Under current law, involuntary commitment to treatment of an individual is permitted only to a State or county psychiatric hospital or to other designated inpatient facilities such as a Short Term Care Facility. Commitment to outpatient treatment would be subject to court review as is currently required under the inpatient commitment law.

The legislation also makes various technical changes with respect to definitions concerning involuntary commitment. Further, the legislation requires the Commissioner of Human Services to designate one or more mental health agencies in each county or multi-county region as the outpatient treatment provider for individuals assigned to involuntary commitment to outpatient treatment, subject to the agency's approval of the designation.

The legislation would phase-in implementation of involuntary commitment to outpatient treatment over a three-year period by having the commissioner select seven counties to participate in the program in the first year, seven additional counties in the second year, and all counties in the third year. The commissioner also would be required to prepare an annual report that addresses the legislation's implementation and related administrative, fiscal, and programmatic issues.

FISCAL ANALYSIS

EXECUTIVE BRANCH

The Office of Management and Budget (OMB) did not provide any specific fiscal information outside of noting that the legislation "is expected to result in increased outpatient treatment costs within DMHS."

Subsequent to the information provided by OMB, the Division of Mental Health Services provided the following fiscal information. No detail was provided regarding the type of mental health services to be provided or the number of persons expected to utilize such services.

	Year One	Year Two	Year Three
TOTAL	**$192,000**	**$10,196,000**	**$10,196,000**
Direct State Services	$42,000	$75,000	$75,000
Grants-in-Aid	$150,000	$10,121,000	$10,121,000

Note that the $10.2 million estimate was submitted prior to the adoption of amendments that would phase the legislation in over three years. As revised estimates were not submitted, the Office of Legislative Services assumed that the $10.2 million estimate would be prorated over three years as follows: First Year - $3.4 million; Second Year - $6.8 million; and Third Year - $10.2 million.

JUDICIARY

The Judiciary has provided the following range of estimates depending on the number of "involuntary commitment to outpatient treatment" hearings that may be held.

Number of Cases	Year One	Year Two	Year Three
400	$56,700	$58,900	$61,300
800	$68,700	$70,900	$73,300
1,600	$92,700	$94,900	$97,300
3,200	$185,400	$189,800	$194,500
4,800	$233,400	$237,800	$242,500

(Amounts have been rounded off to the nearest one hundred dollars.)

Note that these estimates were submitted prior to the adoption of amendments that would phase in the legislation over three years. As the Judiciary did not submit revised estimates, the Office of Legislative Services assumes that the Judiciary estimates would be prorated over three years as follows: First Year - $18,700 to $70,000; Second Year - $39,200 to $158,400; and Third Year - $61,300 to $242,500.

OFFICE OF LEGISLATIVE SERVICES

The Office of Legislative Services (OLS) anticipates minimal additional costs associated with the involuntary commitment to outpatient treatment legislation.

The fundamental difference with respect to the cost estimates is that both the Administration and the Judiciary anticipate that significant numbers of new clients will enter the mental health system, clients who were not previously known to or involved in the mental health system. The Office of Legislative Services is of the opinion that most persons subject to involuntary commitment to outpatient treatment are already known to and involved with the mental health system. These matters are discussed below.

DMHS. It is generally acknowledged that the overall community mental health system may not be adequately funded to meet the mental health needs of all State residents in need of services. Provider agencies have testified about their ongoing operational difficulties, particularly with respect to recruitment and retention of personnel. These funding limitations may result in individuals not being able to access mental health services on a timely basis and individuals not being able to receive all the mental health services they require or the intensity of services they require. The comments below regarding the legislation are not intended to address the overall funding issue affecting community mental health services.

(1) The proposed FY 2010 appropriations act provides $338.3 million to DMHS for community mental health services that will be provided by nearly 115 agencies. In addition to State appropriations, provider agencies obtain significant revenues from third parties such as Medicare and Medicaid, and receive fees, donations and other grants to supplement the State appropriation.

The proposed FY 2010 appropriations act also includes funds to support the recommendations of the Governor's Mental Health Task Force to enhance the capacity of screening services to provide services to individuals being assessed for involuntary commitment, and to provide case management services to individuals who are resistant to receiving mental health services. The proposed FY 2010 appropriations act also includes $7.0 million in funds awarded during FY 2009 to develop Intensive Outpatient Treatment and Support Services to individuals whose mental health services needs are similar to those who may need involuntary commitment to outpatient treatment.

The State appropriation, along with other monies available to the various mental health agencies, is used to provide various mental health services which range from services provided on a 24/7 basis such as Integrated Case Management services (ICMS), Program for Assertive Community Treatment (PACT) and Screening Services, to services of lesser intensity such as outpatient, partial care and residential care, to services that are self-directed or episodic such as job training, legal assistance and self-help centers.

The availability of mental health services varies, depending on the needs of an individual. Screening services are available to all individuals who may require involuntary commitment; ICMS and PACT are generally available to individuals who are discharged from an institutional setting and are not available to individuals who have not been hospitalized. Other mental health services are available to all individuals in need of such services, although priority may be given to individuals who have been institutionalized or to individuals who might otherwise be involuntarily committed to an institution.

Although OLS believes that sufficient funds are available to DMHS to implement the legislation, to the extent that DMHS is unable to reallocate existing monies to meet education and training costs associated with the new legislation and to provide services to individuals in need of outpatient commitment who are not currently receiving mental health services without adversely affecting services currently provided to individuals, additional funding may be required by DMHS. As it is not known how many individuals will meet the criteria until the legislation is implemented, costs cannot be determined.

(2) Since the standard for involuntary commitment is the same regardless of whether the individual is committed involuntarily to inpatient or outpatient treatment, the availability of an involuntary commitment to outpatient treatment option, as an alternative to involuntary inpatient commitment should have little impact on the total number of individuals being screened for possible involuntary commitment. Further, as service planning and the provision of services to individuals being screened are already required by regulation, the development of "an appropriate interim plan of treatment" and the provision of services to individuals involuntarily committed to outpatient treatment should not represent a significant workload increase.

(3) It is possible that individuals involuntarily committed to outpatient treatment may require ICMS or PACT services that are now usually available only to individuals discharged from an institutional setting. DMHS may have to broaden eligibility for such programs to include individuals in need of involuntary commitment to outpatient treatment. However, as such individuals would be eligible for ICMS or PACT upon discharge from an institution, the provision of ICMS or PACT is more a matter of when services are provided as opposed to providing a service that would otherwise not be available. In the case of other mental health

services individuals committed to outpatient treatment may need, provider agencies may be required to give priority to these individuals over other persons with mental illness.

(4) The establishment of an involuntary commitment to outpatient treatment classification could result in a reduction in the number of persons admitted to State and county hospitals. Over time, a reduction in the number of admissions to State and county hospitals could result in a reduction in the operating costs of the facilities. The Administration would be able to reallocate such institutional savings to support community programs.

(5) The $10.1 million estimate provided by DMHS with respect to Grants-in-Aid expenditures or the prorated estimate provided by OLS does not reflect any federal Medicare or Medicaid reimbursement on behalf of patients subject to involuntary commitment to outpatient treatment. Such federal reimbursement would reduce overall costs.

(6) There is a possibility that there may be an overall increase in the percentage of individuals subject to initial commitment hearings who are involuntarily committed, if an involuntary commitment to outpatient services option is established.

At present, a judge may decide not to involuntarily commit an individual to an institution even though the individual may require intensive mental health services. The establishment of the less restrictive outpatient commitment option may result in judges selecting this option as a way to ensure that mental health services are provided to an individual. But until the legislation is implemented, it cannot be determined whether there will be an increase in the overall percentage of individuals involuntarily committed. Even if there is an increase in the percentage of commitments, many of the individuals subject to commitment are already involved in the mental health system and may already be receiving outpatient services.

The **Judiciary** already incurs costs associated with involuntary commitment hearings. The legislation should not result in an increase in the number of initial commitment hearings since the standard for commitment to outpatient treatment is the same as for commitment to inpatient treatment.

While there would be continued court involvement in instances where an individual is noncompliant with the terms and conditions of commitment to outpatient treatment, this requirement is not significantly different than the ongoing court involvement for individuals who are involuntarily committed to a State or county hospital or other inpatient facility. Thus, the availability of an involuntary commitment to outpatient treatment option for persons in need of involuntary commitment should have little impact on the Judiciary's overall costs related to involuntary commitment proceedings.

Section:	*Human Services*
Analyst:	*Jay Hershberg* *Principal Fiscal Analyst*
Approved:	*David J. Rosen* *Legislative Budget and Finance Officer*

This fiscal note has been prepared pursuant to P.L. 1980, c.67 (C. 52:13B-1 et seq.).

JON S. CORZINE
Governor

For Immediate Release:
Date: August 11, 2009

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Governor Corzine Signs Measure to Improve Mental Health Treatment Options

CEDAR GROVE - Governor Jon S. Corzine today signed legislation revising the State's civil commitment laws to allow for the involuntary commitment to outpatient treatment for individuals as an alternative to an inpatient commitment.

"Mental health issues continue to be the most challenging and at times, the most perplexing for medical professionals and for families who must often make difficult decisions regarding an affected loved one," Governor Corzine said. "Today, we are enacting legislation that will give these families options that will help protect the rights and safety of those that need help, and will ultimately prevent undue suffering."

The bill, S-735/A-1618, provides for clinically appropriate treatment in the least restrictive environment for individuals in need of mental health services who may not meet the threshold of in-patient care. Presently, New Jersey law provides only for commitment to treatment in an inpatient facility for individuals in need of commitment who are established to be dangerous to themselves, others, or property.

This legislation balances the preservation of personal freedoms with the State's concerns for individual and public safety.

"The goal of this bill is to minimize time in the hospital and keep patients in the least restrictive environment that will help foster their recovery. With our mental health infrastructure ranking fourth in the nation, it makes far more sense to try and get patients the treatment they need in an outpatient setting," said Senate President Richard J. Codey (D-Essex).

Studies have shown that involuntary outpatient commitment has been highly successful in helping patients comply with their medication needs, reducing their hospital stays and helping patients along on the path to recovery and productivity. Currently, more than 40 states have laws for assisted outpatient treatment.

"This law will provide the authorities with the necessary tools to safeguard individuals who are incapable of taking care of themselves due to a mental illness," Senator Gerald Cardinale (D-Bergen) stated. "We have built in redundant safeguards the rights of the patients are protected from potential abuses. Also, the bill is an opportunity for many individuals to live normal and productive lives by taking readily available medication."

Effective one year after the date of enactment, the bill requires a phase-in period of three years to implement involuntary commitment to outpatient treatment statewide. The Department of Human Services will identify the particular community-based treatment services needed to safely and adequately carry out the bill's provisions and will work together with Administration and the Legislature to support the services identified to protect the severely mentally ill.

"As the treatment for people with mental illness has advanced, many successful treatments are entirely outpatient, but New Jersey was one of only eight states without an outpatient commitment law," said Assemblyman John F. McKeon (D-Essex). "Outpatient commitment is an important tool for family members caring for the severely mentally ill, and this new law provides the necessary tools to ensure the safety of the individual and the public in the rare cases when involuntary commitment is required."

"This law will make certain people who represent a danger to themselves are compliant with a treatment plan and a regiment of medication," Assemblywoman Sheila Y. Oliver (D-Essex, Passaic) said. "This step forward will be tremendous help to families and those trying to overcome mental illness. It will also save lives. It is the right thing to do."

Primary sponsors of the legislation include Senators Richard J. Codey (D-Essex) and Gerald Cardinale (D-Bergen) as well as Assemblymen John F. McKeon (D-Essex) and Douglas H. Fisher (D-Salem, Cumberland, Gloucester) and Assemblywoman Sheila Y. Oliver (D-Essex, Passaic).

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