



Members of the Assembly Human Services Committee:

Thank you for the opportunity to provide testimony today. I came to express **opposition to A.1618 - the Involuntary Outpatient Commitment Bill**. I am testifying on behalf of the New Jersey Psychiatric Rehabilitation Association. NJPRA is an association of professionals who provide recovery oriented supports and services to people who have severe mental illnesses. I myself am a Licensed Clinical Social Worker who has worked with this population for more than 25 years. I am well aware of the complex issues raised by the proposed legislation and I implore you to carefully consider these issues as you make your decision about the fate of this bill.

NJPRA strongly opposes involuntary outpatient commitment for many reasons. It provides **a false sense of security** to families, consumers, and the general public, introducing an ill-defined, arbitrary standard for coerced treatment. The bill also **fails to address the significant, expected fiscal impact that IOC would have on New Jersey's mental health system**. In addition, the **research done so far fails to show that forced treatment produces the desired outcomes**. Finally, a study released by New York City and New York State last summer provides strong evidence that **involuntary outpatient commitment does not prevent the type of violent incidents that prompt legislators to introduce involuntary outpatient commitment bills**. What does have the best chance of preventing these tragedies is a strong, well coordinated mental health system. For individuals who are at high risk for becoming acutely ill and who have a history of threatening or dangerous behavior, this means **immediate access to intensive outreach done by service providers who are trained to engage and monitor individuals who lack insight**. Details and references that support these arguments follow.

**1. Passage of A.1618 could very well endanger the public rather than protect them.** The bill applies the current criteria for inpatient commitment to outpatient commitment. Thus, it provides criteria that might allow persons who are dangerous to themselves and others to remain in the community, rather than being hospitalized and receiving the supervised care they need. It should be noted that other states have involuntary outpatient commitment laws that are distinct from their involuntary inpatient commitment laws. For example, Kendra's Law in New York makes a clear distinction between a person who is currently a danger to themselves or others and a person who has a history of dangerous or threatening behavior. The former is only eligible for inpatient care.

**2. This bill's fiscal note provides no appropriation and greatly underestimates the large amount of resources that are typically required to implement outpatient commitment.** According to the National Center for State Courts, "Involuntary outpatient commitment should be used cautiously, and it requires much more of the mental health system than traditional [inpatient] commitment does. Likewise, involuntary commitments require more time from mental health staff and judges, more resources, more knowledge of these resources, supervision of patients, monitoring of commitment conditions, and a system of revoking this commitment." Administrative costs for Kendra's law in New York top \$10 million annually; costs of additional services have been estimated between \$50-200 million dollars per year. Pro-rated for New Jersey's population that would be between 25-80 million dollars annually.

This omission of an appropriation in the fiscal note is particularly grievous during the current fiscal crisis. How will providers, who are currently struggling to provide their contracted services during a period with rising costs and no COLA, be paid for providing this intensive service? The answer is that without additional monies or a major shift in resources there will be no one to provide these promised services. It is my understanding the Department of Human Services issued a fiscal note of \$10 million dollars to serve 400 persons. However, with 50,000 admissions to screening centers annually, and 12,000 hospitalizations, it is likely that many more than 400 will receive outpatient commitment.

**3. Research studies on the efficacy of IOC are at best inconclusive.** The most scholarly analyses of scientific evidence in this area, the Cochrane Collaborative (2005), has concluded: "Only two relevant (controlled) trials were found and these provided little evidence of efficacy on any outcome such as health service use, social functioning, mental state, quality of life or satisfaction with care." Indeed, the evidence is that enhanced services, not coerced treatment is accounting for any observed effect (O'Reilly, 2001). For example, a three-year study at Bellevue Hospital compared the impact of providing an enhanced, better-coordinated package of services with and without the use of a coercive mandate found no difference in rates of improved outcomes, yielding the conclusion that people do better when they are offered better services, not because they are forced to accept them (NYAPSRs, 2005).

**4. An IOC bill is unlikely to prevent the frightening violent incidents that typically motivate legislators and advocates to pass a bill that forces individuals to accept services.** Last year "a panel of New York State and New York City mental health and criminal justice officials released a joint report aimed at recommending actions to improve services and promote the safety of all New Yorkers. The report was issued in the wake of several highly publicized violent incidents involving city residents with psychiatric disabilities. Two incidents involved fatal shootings by police of two troubled individuals. Two other incidents involved violent behavior of two men with long treatment histories. All four of the individuals involved in these acts of violence were receiving mental health care that failed them due to poor coordination, fragmented oversight and lack of accountability, and inconsistencies in the quality of care. The report also cited obstacles to appropriate data sharing and "insufficient training, supports and tools to identify and engage justice-involved individuals with mental

illnesses". (Rosenthal, 2008, p 5; Hogan, et al., 2008 ). The lesson here is that tragedies will still occur even when a State has IOC in place. We don't need more laws; we need well coordinated early intervention services that help prevent relapses – particularly for individuals who have a history of dangerousness.

NJPRA has drafted a position paper describing an early intervention pilot program that is designed to engage and monitor people at risk for psychiatric decompensation. This can be implemented at a relatively low cost by adding staff resources to our PACT teams (Program for Assertive Community Treatment). It is one way to address the problems that we are here to talk about today without legislating coercive treatment. It is also a solution that is more consistent with the wellness and recovery orientation that the NJ Division of Mental Health Services (DMHS) has adopted.

From a civil rights perspective there are a number of additional problems with A.1618. The proposed legislation permits an individual to be ordered to involuntary outpatient commitment for as many as twenty days before having an opportunity to appear in person before a judge. No order requiring an individual to comply with involuntary outpatient commitment should be entered before the individual has an opportunity for an in-person hearing before a judge. The proposed law is also inconsistent with and does not consider the recently passed Advance Directive for Mental Health Act. It also does not take into consideration existing statutes and case law that have found that competent individuals are permitted to make personal medical decisions.

In conclusion, the 2005 ***Governor's Mental Health Task Force*** report included the caution that "no move to involuntary outpatient commitment should take place in New Jersey unless and until adequate, appropriate services are available in the community for those who voluntarily seek them," and "that the development of an adequate system of community care is an absolute precondition for the adoption of involuntary outpatient commitment." DMHS is in the process of implementing its three year Wellness and Recovery Transformation Action Plan, which provides a blue print for a mental health system that we can all be proud of. Recently implemented enhancements to the system include a new Family Psycho-education Program initiative and additional Residential Intensive Support Teams (RIST). These are exactly the type of services that we need to assist families in crisis and high risk individuals who need frequent outreach visits. So we are making progress - but we still have a long way to go to resolve many problems such as long waiting lists for outpatient services and short term care facilities. The members of NJPRA do not believe that IOC will help solve our problems. In fact passage of this particular bill during an economic crisis will do more harm than good.

Thank you for your consideration of NJPRA's viewpoint.

Sincerely,

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Chairperson, NJPRA Public Policy Committee

### References

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