State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH SERVICES
CAPITAL CENTER, 50 E. STATE STREET
PO BOX 727
TRENTON, NJ 08625-0727

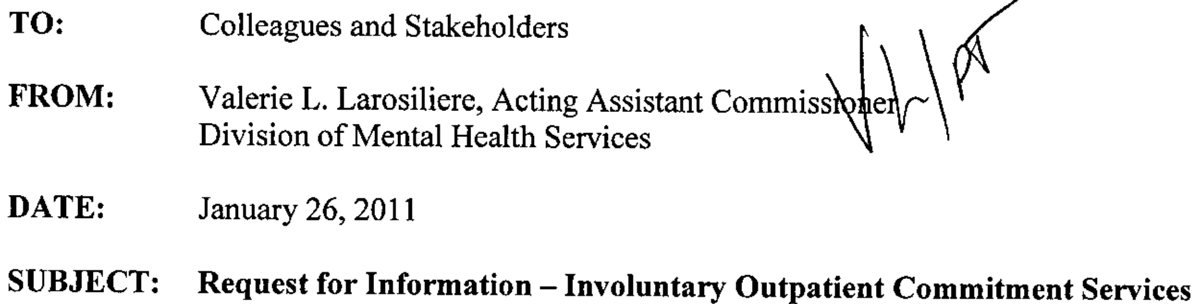
CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
Commissioner

VALERIE L. LAROSILIERE
Acting Assistant Commissioner

MEMORANDUM



TO: Colleagues and Stakeholders

FROM: Valerie L. Larosiliere, Acting Assistant Commissioner
Division of Mental Health Services

DATE: January 26, 2011

SUBJECT: **Request for Information – Involuntary Outpatient Commitment Services**

In August 2009, Governor Corzine signed P.L. 2009, Ch. 112, commonly known as the Involuntary Outpatient Commitment to Treatment (IOC) Law. The intent of the law is to provide a new option for consumers: supervision in the community for a class of consumers that the Legislature agreed was not well-served without this law. This population comprises those who are not willing to receive treatment voluntarily and will become, in the foreseeable future, dangerous enough because of a mental illness to require supervision, but who are not so imminently dangerous that they need to be committed to an inpatient program.

The law required that mental health providers in seven counties be designated by the Commissioner of the Department of Human Services (DHS) to provide IOC treatment beginning on August 11, 2010. Seven more counties were to be added a year later, and the final seven counties should be brought online in 2012. Due to budgetary constraints, implementation of the law was delayed. However, DHS continues to work toward implementing IOC. The Division of Mental Health Services is solicitating information from multiple stakeholders through the Request for Information (RFI) to inform the development of a future, competitive Request for Proposals. Respondents should answer questions to the extent possible. All responses can be sent to paula.hayes@dhs.state.nj.us. We look forward to your response.

Thank you.

VLL:pjt
Attachment

New Jersey Department of Human Services
Division of Mental Health Services
Involuntary Outpatient Commitment Request for Information
Due to DMHS February 15, 2011

This Request for Information (RFI) is intended for providers and other stakeholders that may have a role in the implementation of Involuntary Outpatient Commitment in New Jersey, per P.L. 2009, ch. 112 signed into law by Governor Corzine in 2009. This RFI is not a competitive solicitation to implement the program. Rather, this information will be used to ensure the development of RFP's that will meet the needs of the program. In an effort to increase access to treatment and support services for those ordered committed to treatment in the community, the DMHS needs to determine what services, infrastructure and linkages need to be developed in each county, what their costs will be and to identify any appropriate and available outpatient service capacity that can be accessed by consumers referred by State and County Hospitals, Short Term Care Facilities, Designated Screening Services, or other programs through the courts.

Respondents should answer the questions below to the extent possible. Responses should consider the services and infrastructure that would need to be developed to implement IOC in your county, including an estimate of the costs related to the services and infrastructure.

POPULATION TO BE SERVED

IOC is legally required to be considered for any adult who has been found to meet the standard for commitment to involuntary treatment within a county that has an IOC program. Individuals eligible for IOC must:

- Meet the legal standard for involuntary commitment (ie, currently have a mental illness that will make them dangerous to self, others, or property, are not appropriate for any less restrictive available alternatives to court-ordered treatment, and are unwilling to consent to treatment)
- Be likely to be dangerous in the reasonably foreseeable future, but not imminently
- Be 18 years of age or older.
- Have the capacity to participate in their treatment and development of their individual Wellness/Recovery Action Plan, even if unwilling to do so.
- Not be at imminent risk of a medical crisis.

We are requesting that, by answering the questions below, you describe the current capacity of appropriate outpatient services in your county, both available capacity and capacity already being utilized by consumers, and how you would access that service for consumers who are committed to IOC; and that you describe the individuals you would anticipate serving if you were the selected county provider for this program. We also request that you describe your relationship (current or anticipated) with each point of entry for IOC customers. (ie, Designated Screening Service (DSS), STCF, state hospital, or private hospital, developmental disability programs, substance abuse programs, jails, private psychiatrists.)

1. Approximately what percentage of those screened in your county (not considering whether appropriate services are available now) would meet the standard above? What percentage of those people would now be hospitalized? What percentage could be placed on IOC and linked to community services? What factors would make the difference in disposition? (e.g., capacity in intensive supervision programs, medication adherence, housing, family support, etc)

2. When IOC is implemented in your county, do you anticipate an increase in screening center referrals? If so, by how much? Can you accommodate the increased demand? What additional capacity will you need to meet the demand?

3. Are there agencies, individuals, or facilities in your county that you anticipate will refer consumers to IOC via alternate route commitments? Can you estimate how many candidates there might be? Is there a viable mechanism in your county for judicial training?

4. Do you anticipate IOC commitments among parolees from the county jail or state prisons? About how many parolees are currently referred to/required to participate in community mental health services in your county as a condition of parole?

5. How many probationers are required to participate in mental health programs as a condition of probation each year in your county? What percentage, if any, do you anticipate might be committed to IOC?

6. Are there facilities for the developmentally disabled, substance abuse programs, etc. in your county that might make referrals for IOC? Please identify those programs and estimate the number of referrals, either to screening or through alternate route, that might occur.

7. What population do you anticipate would be best served by this program? Is there any problem or gap in services that you think could be solved or filled if this program is adequately and appropriately implemented?

8. How do you envision the payment obligation for an individual receiving outpatient treatment to be collected? Will existing billing and calculation methods through the county adjusters be adequate?

   Can you identify any issues around payment arrangements for consumers engaged in treatment at other provider agencies but referred to the IOC provider for services or monitoring? Will affiliation agreements be necessary?

SERVICES NEEDED

DMHS also needs information regarding how your agency would provide a comprehensive outpatient coordination and referral system. We want to know what your approach would be to:

- treatment planning and development
- treatment plan adherence support
- assessment of dangerousness and clinical progress
- arrangements for transportation to court hearings, evaluations, and programs, and
- direct linkage to ongoing clinical and support services as identified in the Wellness Recovery Action Plan (WRAP) and any psychiatric advance directive.
- linkage to Superior Court, County Adjuster's Office and the consumer's counsel.
- costs related to above.

Agencies selected as providers in an RFP will need to develop new services, identify appropriate existing services and describe case management and coordination services that will provide adequate monitoring to assure the safety of the consumers and the public. Agencies will need to identify whether capacity currently exists or project costs related to new services and/or co-ordination.

1. Do you anticipate applying to become the designated IOC provider in your county? If not, what would your agency need in order to become the designated service provider?

2. What should an IOC program look like in your county?

3. Do you have programs appropriate to provide community based ambulatory treatment alternatives for adults who meet the outpatient commitment standard? Please indicate what programs currently serve this population and how frequently they have vacancies. Estimate how many total consumers of this kind could be served with present funding (may include persons who are served currently, and those who are enrolled but not consistently engaged in treatment).

4. If there is not sufficient capacity, are there programs that could expand current capacity and/or expand their services, or would wholly new programs have to be created?

5. If you have a waiting list for services, how would your agency handle an IOC referral?

6. Are there Division policies or requirements that are barriers to the creation or retention of such programs?

7. Are there Division standards or policies that could be promulgated that would assist in the creation or maintenance of such programs?

8. What additional workload will county government incur? What additional expenses would county government incur? Can you quantify this in aggregate or on a per person basis? What do you envision would be the most effective approach to establish linkages, policies, and protocols with the Municipal or Superior Courts, County Adjuster's Office, County Counsel, and the consumer's attorneys for the purpose of effectuating the commitments through initiating, monitoring and managing the necessary hearings?

9. Who should monitor the program's effectiveness?

10. Is public transportation or taxi service readily available/affordable in your county to take consumers to hearings and treatments (i.e. service providers, Board of Social Services, county courthouse, and residential areas, etc.)? If not, how do you recommend transportation be provided/coordinated?

11. How should services be coordinated among providers? If you choose not to be the designated service provider in your county, would you provide services to someone who is on involuntary Outpatient Commitment? What Affiliation Agreements need to be developed in your county?

12. Some advocates have suggested the IOC will save the counties money through reductions in hospitalizations. If savings are generated, how in your opinion can these anticipated savings be redirected to prevention and community services?

13. Do you anticipate increased costs as a result of IOC? If so, who will experience those costs and how should they be funded? Based on your experience, how much per person, on average, would IOC cost to implement in your county? Please provide an explanation.

14. What, if any, additional staff or training would be necessary in order to implement IOC?