Gregory's Law in limbo at state level - Evesham parents upset

Tuesday, September 28, 2010
by Dubravka Kolumbic

Evesham—The New Jersey State Assembly Human Services Committee met earlier this month to hear testimony regarding Gov. Chris Christie's decision to indefinitely delay implementing New Jersey's Involuntary Outpatient Commitment (IOC) Law, or what's come to be known as "Gregory's Law." The law would have allowed involuntary commitment to outpatient treatment for certain individuals with mental illnesses.

Gregory's Law was named after Gregory Katnelson, an 11-year-old Marlton boy who was killed in a random act of violence in 2002 by a Ronald Pitch, a Medford man who suffered from paranoid schizophrenia and had not been taking his medication. Pitch had killed his mother just before he encountered Katnelson who was riding his bike home on a path through the woods in the Kings Grant neighborhood. Since then, Gregory's parents, Mark and Cathy Katnelson, have been working to pass a law that would require outpatient treatment for mentally ill patients meeting certain criteria.

The move to allow for involuntary outpatient commitment (IOC) treatment was signed into law last year by then Gov. Jon Corzine and was set to go into effect on Aug. 11. But the day before it was to begin a three-year implementation process, the law was tabled due to budget constraints and an already strained state health system, according to a statement by state Department of Human Services Commissioner Jennifer Velez.

Human Services Committee Chairwoman Valarie Vainieri Huttle (D-Bergen) led the hearing on Sept. 16 where a number of professionals and family members of mental ill patients spoke on behalf of or against Gregory's Law.

"The point of the hearing today is to discuss the administration's decision to disregard the Involuntary outpatient commitment law, what this means for New Jersey and where we go from here," Vainieri-Huttle said at the beginning of the hearing.

"I think all of us here are quite sensitive to the financial situation that New Jersey faces," Vainieri-Huttle said, adding that, "I don't know if that is a good enough reason to disregard a law that was already signed into law. But I think it's an obligation of this administration to find ways to address funding situations like this as fast as possible and not to ignore the issues until a more convenient time." Vainieri-Huttle questioned why, if it was known that there was not enough funding or resources to enforce the law, that issue was not brought up prior to the day before the law's scheduled implementation.

"If we had been notified of the administration's intentions in a more appropriate time, not one day before the law was scheduled for implementation, maybe we could have been (able) to work through some of these financial issues."

Most of the mental health professionals who spoke at the hearing supported the administration's decision to delay implementing the law. Key among the reasons were the lack of resources available for residents currently receiving
mental health care in the state. The majority felt that adding another required level of service would force staff, resources and money away from those currently receiving care.

Kevin Martone, Deputy Commissioner of the Department of Human Services, the group assigned responsibility for implementing the law, spoke first and defended his department's decision to delay the law.

"In no way are we suggesting that we are not going to implement the law," Martone stated. "But we felt the need to delay it for circumstances that I am going to go into."

Martone then went on to explain that implementing IOC is broad and complex and that some states have implemented it with "mixed results." He emphasized that an administration must be adequately prepared to enforce IOC or it will not work the way it is designed to work. He also emphasized that all the state's agencies have had reductions and that "IOC costs money" and without "additional resources the department would be forced to cut vital services to existing consumers in order to fund IOC."

According to Martone, implementing the IOC program would cost about $10 million total, or about $25,000 per person, based on an estimated 400 people being placed on IOC.

Martone also stressed the impact on the court system as family members move to place relatives on IOC.

"The department is fully aware of its responsibilities for implementing IOC in New Jersey and we will continue to work toward implementation as resources are made available," he said.

Martone explained that the Division of Mental Health Services and the Department of Human Services had looked for ways to reallocate resources up until August of this year when they realized that it couldn't happen without negatively impacting existing services.

He stated that about 5 to 7 percent of adults experience a serious mental illness. In New Jersey, that's about 450,000 people, yet only 175,000 are provided health services funding by the state.

"We can't meet the demand," he stated. He did, however, concede that "Absent an IOC option, some people could then be placed on an inpatient basis," which could end up costing the state even more money.

The law was scheduled to be implemented over a three-year period, phasing in seven counties a year. New Jersey is one of only eight states that does not have an IOC law.

The Katsnelsons spoke of all the time and effort put into crafting the law over the last six years, only to have it end so abruptly.

"It means our son's life and death is not important to Gov. Christie — at least not important enough to follow through and do something about it, something to prevent it from happening to anyone else," said Cathy Katsnelson.

"How many more tragedies need to take place?" she asked. "How many more lives and families will be destroyed in New Jersey because of untreated mental illness?"

"By providing treatment to patients who are too overcome by their disease to realize they even need help, we are giving them the opportunity for a better quality of life and a chance to contribute to our community and society rather than burdening our citizens with costly hospitalizations or incarcerations and senseless tragedies."

Most of the speakers at the hearing were public health professionals who echoed Martone's stance that the system is
not prepared to effectively implement IOC and certainly not without negative impact to existing mental health services. The few supporters of the law that spoke were the Kaelnelsons, two other families whose adult sons have been diagnosed as schizophrenic and are refusing treatment, and Brian Stettin, policy director and counsel for the Treatment Advocacy Center in Washington, D.C. Stettin proposed that those who need IOC are the most in need of mental health help.

"Nobody wants to see services denied to people who are in need of them and relying on them. And nobody is going to defend the indefensible."

"That's the reality," Stettin said. "We should make decisions on merit, not on who's receiving the services now."

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Evesham mother of slain 11-year-old gratified by funding for 'Gregory's Law'

Star-Ledger Wire Services By Star-Ledger Wire Services
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on July 26, 2011 at 4:13 PM, updated July 26, 2011 at 4:52 PM

BY JEREMY ROSEN
The Courier-Post

Evesham — An Evesham bike path entrance haunts Cathy Katsnelson.

She passes it every day on her way to and from her Kings Grant home. But Katsnelson gathered the courage to walk that path in 103-degree heat last Thursday.

She has only gone a few times to the spot where her son, Gregory, was murdered in October 2002 by a schizophrenic man who had just killed his mother over a pack of cigarettes.

"Sometimes I think, 'At least I know what happened,' " she said softly while standing where her 11-year-old son was found face-down in a pond.

"At least I have closure."

But Katsnelson received closure of another kind Monday. Her nine-year battle for an Involuntary Outpatient Care (IOC) law in her son's memory ended when New Jersey Department of Human Services (DHS) officials confirmed that $2 million in the recently signed budget will be used to begin implementing what is unofficially known as "Gregory's Law."

The legislation permits court-ordered, involuntary outpatient care for severely mentally ill people and creates new outpatient options. It was signed Aug. 11, 2009, by then-Gov. Jon S. Corzine.

Katsnelson attended Corzine's bill signing in Trenton and had spoken during prior legislative hearings. After one session, she recalled, the father of her son's convicted murderer, Ronald Pituch, approached her and apologized.
Pituch is serving a sentence of nearly 50 years.

Once Gregory's Law was signed, it was expected to be fully implemented over three years, seven counties per year, starting in August 2010. But Gov. Chris Christie stalled implementation indefinitely last year, crushing Katsnelson's hopes of preventing similar tragedies for people in the state and sparking outrage from residents, public health advocates and lawmakers.

"Had (Christie) been personally affected, implementation would've been a priority," Katsnelson said. "How do you pick and choose which laws to enforce?"

None of the other 44 states with IOC laws delayed implementation, according to Doris A. Fuller, communications director of the Virginia-based Treatment Advocacy Center, a champion of Gregory's Law.

State Department of Corrections data show 3,065 mentally ill inmates in New Jersey prisons. The Treatment Advocacy Center estimates people with untreated schizophrenia and bipolar disorder commit about 1,000 of the 20,000 homicides per year nationwide.

In January, Jared Lee Loughner was charged with the Arizona murders of six people in a shooting rampage that injured a dozen people — including Rep. Gabrielle Giffords — and shook the country. Mental health experts have determined Loughner suffers from schizophrenia, according to the Associated Press.

In New Jersey, meanwhile, "Gregory's Law" seemed all but forgotten, and Katsnelson shifted her focus to the well-being of her husband, Mark, and her oldest son, Aaron, 24.

Until Monday.

"Oh, my gosh," she said emphatically when told the law would finally see the light of day. "This is really good news."

DHS Spokeswoman Nicole Brossole said an advisory committee of judicial, legal, government, mental health advocates and stakeholders is determining how to spend the $2 million for implementation and what seven counties will be a part of the Phase One rollout. Camden, Monmouth and Essex counties have representatives on the committee.

Brossole said a timeline for Phase One depends on a request for proposal expected to be issued this fall or winter. A request will enable procurement of additional outpatient services.

It's unclear how much if any of the $8 million estimated to fully fund Gregory's Law will be available to support Phase Two.
The DHS would not comment on why Katsnelson or the Treatment Advocacy Center — with whom Katsnelson has worked closely over the years — weren’t contacted. But Katsnelson said she’s happy to provide input.

Dr. Paul Appelbaum, professor of psychiatry at Columbia University in New York, advises Katsnelson and other Gregory’s Law advocates to fight for greater funding.

Along those lines, the New Jersey Association of County Human Service Directors wrote a letter of concern to the DHS last year, calling an unfunded and underplanned Gregory’s Law “doomed to failure.”

“If more funding is needed, I’ll do whatever it takes,” Katsnelson said.

Unlike New York, assessments for New Jersey’s IOC law are in the hands of the state and county governments, as well as courts and community agencies.

New York’s IOC statute, Kendra’s Law, came with an infusion of funds and is subject to renewal every five years. Since implementation of the legislation as a pilot program in 1999, New York has spent $200 million on Kendra’s Law, named for Kendra Webdale, a 32-year-old woman who was pushed in front of an oncoming subway train in 1999 by an untreated schizophrenic.

“Many states adopted statutes that aren’t funded when adopted, and later evaluation shows they’re not as effective and haven’t been used much,” Appelbaum said.

Studies of Kendra’s Law were completed in 2005 by the New York state Office of Mental Health and in 2009 by a state contracted independent research team. They found those involved in Kendra’s Law outpatient programming experienced drastically lower rates of homelessness, hospitalization, arrest, incarceration, suicide and drug abuse.

When IOC laws are used to their fullest capacity, as in New York, they can drastically decrease costs and increase vacancies in prisons, mental health care centers and hospitals, according to experts. In New York, many IOC patients were previously going through a revolving door of arrest or hospitalization.

Appelbaum said by far, most New York IOC petitions come from hospitals and mental health services providers, but also correctional facilities and a tiny number of family members.

A rigorous cost-savings analysis of Kendra’s Law is under way and expected to be completed this year. It will be a benchmark for IOC programs in New Jersey and other states.

Meanwhile, Katsnelson will continue her roller coaster of coping with Gregory’s death, ironically by staying involved with Gregory’s Law.
She and her husband are considering moving out of the house where they lived with Gregory, who his mother said would likely be studying pre-med somewhere, chasing his dream of becoming a doctor.

"I get calls from nieces and nephews around Gregory's age talking about their driver's licenses and graduations," she said through tears. "And I'm happy for them. But I never saw him drive. I never saw him graduate.

"We're still struggling with learning how to be a family again."

This story first appeared in the Courier-Post.

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I. IDENTIFYING INFORMATION

Consumer Name: ___________________________

Last  First  MI

Consumer also known as: ___________________________

D.O.B. ___________________________

Consumer Address: ___________________________

City, Township  Zip Code

E-mail address: ___________________________

Phone No.: ___________________________

Name of Referring Psychiatrist: ___________________________

Phone #: ___________________________

Referring Facility/Provider Name: ___________________________

II. CLINICAL INFORMATION

Please refer to the attached Screening/Commitment documents dated 12/7/12 for information in this regard.

III. HOUSING ARRANGEMENTS

A. Please list below current and/or pending housing for consumer. Check all that apply.

<table>
<thead>
<tr>
<th>HOUSING ARRANGEMENT</th>
<th>CONTACT PERSON/AGENCY NAME, ADDRESS, PHONE NUMBER (if applicable)</th>
<th>Current ✓</th>
<th>Pending ✓</th>
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<tbody>
<tr>
<td>Own home/apartment</td>
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<td>Living with family member(s)</td>
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<td>Supportive Housing</td>
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<td>Group Home/Supervised Apt.</td>
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<td>RHCF ( ) Boarding Home ( ) Check one</td>
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<td>Shelter</td>
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<td>Halfway House</td>
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<tr>
<td>Residential Substance Abuse Rehab (Indicate length of stay)</td>
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<td>Other (List):</td>
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IV. EMPLOYMENT/EDUCATION/VOCATIONAL

Please indicate if consumer is currently:

Working: ( ) Full Time ( ) Part-Time (X) N/A

List Details: ___________________________

Revised 7/26/12
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
INVolUNTARY OUTPATIENT TREATMENT PLAN

Enrolled in School:  ( ) Full Time  ( ) Part-Time (X) N/A
List Details:

Other training (DVR, One Stop, etc. please specify):

V. PARTICIPATION IN IOC INITIAL TREATMENT PLAN
A. In preparing a treatment plan, the consumer of the petition must be given an opportunity to participate actively in developing the plan. Was the consumer given an opportunity to participate in the treatment plan?
YES (X) NO ( ) (If NO, explain):

B. Upon the request of the consumer, an individual significant to the consumer (i.e. a relative or close friend) may participate in developing the plan. Did the consumer request that any other person(s) participate in developing the treatment plan?
YES (X) NO ( )
1. If YES, was such person(s) given an opportunity to participate? YES (X) NO ( ) (If NO, explain):

2. If others participated in the treatment plan, list their names and their relationship to the consumer:
   a. Name __________________________ Relationship __________________________
   b. Name __________________________ Relationship __________________________

VI. SERVICE RECOMMENDATIONS
A. Medication Recommendations
Please list all recommended medication, dosage and frequency to provide maximum benefit to the consumer. (NOTE: medication as identified herein may be modified if deemed appropriate by service provider and with the approval of the IOC team for said county)

<table>
<thead>
<tr>
<th>MEDICATION NAME</th>
<th>DOSAGE</th>
<th>FREQUENCY</th>
</tr>
</thead>
</table>

Check here if medications are not applicable:

B. OTHER SERVICES:
Please list below all categories of service recommended, other than medication. Check all that apply. Add additional sheets of paper if necessary. (NOTE: treatment as identified herein may be modified if deemed appropriate by service provider and with the approval of the IOC team for said county)

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<thead>
<tr>
<th>V</th>
<th>CATEGORY OF SERVICE</th>
<th>ORGANIZATION NAME, CONTACT PERSON &amp; PHONE #</th>
<th>CONTINGENCY (frequency and duration)</th>
<th>Active</th>
<th>Pending</th>
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<td>Medication Management</td>
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<td>Other Case Management Services</td>
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<td>Acute Partial Hospitalization</td>
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<td>Partial Hospitalization</td>
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<tr>
<td>Partial Care Program</td>
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<tr>
<td>Intensive Outpatient Treatment and Support Services (IOTSS)</td>
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<td>Intensive Outpatient Treatment Program (IOP)</td>
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<td>Substance Abuse</td>
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<td>Co-occurring Substance Abuse Counseling</td>
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<td>Individual/Group Therapy</td>
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<td>CATEGORY OF SERVICE (Continued)</td>
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<td>Laboratory Testing (ie: Lithium bloodwork)</td>
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<td>Toxicology Testing</td>
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<td>Urine Drug Screen</td>
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<tr>
<td>Consumer Self Help/Consumer Support Services</td>
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<tr>
<td>Other Contingencies (List):</td>
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<tr>
<th>PHYSICIAN'S SIGNATURE</th>
<th>DATE</th>
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<th>CONSUMER'S SIGNATURE</th>
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Revised 7/26/12
Mental illness law may finally be getting push from the state

June 22, 2012

The Courier-Post (http://www.courierpostonline.com/article/20120622/NEWS/306229771/Mental-illness-law-may-finally-getting-push-from-some-checks) By Courier-Post staff

A state law designed to require treatment for the dangerously mentally ill may be getting more leverage, with a panel expected to review the legislation this month and propose changes.

All of this comes more than a year after the death of Cathy Kozelkoski.

The Marlton woman was thrust into a decade-long fight for the law after a schizophrenic man stabbed her 21-year-old son Gregory to death in the woods behind their Kings Grant home.

Gregory's killer, Ronald J. Atch, had already been in prison for death that October day in 2002, after he reportedly refused to buy his cigarettes. He was sentenced to more than 40 years in prison.

"We really need to put our attention and put our efforts into treating this as a disease," the 45-year-old Kozelkoski said of mental illness. "I think over the next few years, we will start seeing the benefits of what we've done."

In one of his final acts in office, Gov. Jon S. Corzine signed the legislation in 2009. "Gregory's Law," as it is unofficially known, requires people to undergo treatment if they are deemed a danger to themselves or others, measures that are court enforced.

But the state has been slow to implement involuntary outpatient commitment, blaming funding shortfalls. By now every county in the state is supposed to have an active IOP program, according to the bill. Instead, just six of the state's 21 counties — including Burlington — have met that goal.

As the time frame nears, few people take advantage of the programs, according to the New Jersey Department of Human Services. Spokesperson Ellen Lovejoy said 57 people across the state were being treated as of April 30, with 114 people total treated since the law took effect.

The program gets $2 million in funding, Lovejoy said, with $2 million expected for the next fiscal year. Typically, the Louis A. Dreyfus Behavioral Health Center in Toms River provides IOP as part of a $787,500 state contract that is up for renewal at the end of the month, Lovejoy said.

But DHR Commissioner Jennifer Valeris said an Assembly Budget Committee hearing in April the program is "not working out the way it's intended." Officials believed the program would divert people from hospitalization, according to Valeris. Instead, it is used as a tool in nursing home patients discharged from psychiatric hospitals.

YOU MAY ALSO BE INTERESTED IN:

- Offenders with Mental Illness Have Aliens in SAMH (http://csjournals.org/mental-healthmedia/1812-offenders-with-mental-illness-have-aliens-in-samh)
- Prisoner runs down to centralize inmates with severe mental illness (http://csjournals.org/mental-healthmedia/1812-prisoner-runs-down-to-centralize-inmates-with-severe-mental-illness)
- Mental Health Issues Present "Evolving Door" in Massachusetts (http://csjournals.org/mental-healthmedia/1812-mental-health-issues-present-evolving-door-in-massachusetts)
- NH PD Officer Reassigned for Mental Health Education (http://csjournals.org/mental-healthmedia/1812-nh-pd-officer-reassigned-for-mental-health-education)

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- NJ Senate Passes Suicide Prevention Bill (http://csjournals.org/mental-healthmedia/1812-nj-senate-passes-suicide-prevention-bill)

***
Part of the problem, she added, is the unexpected court costs associated with judges making the determination that a person needed mandatory treatment. Bar Assemblyman John Burzichelli, D-Gloucester, blamed a lack of funding.

“If we are sincere about helping these individuals and addressing mental health issues, we must implement this law as it was intended, not as half-heartedly as we are doing now,” he said in a statement.

But that may change soon. Following December’s mass murder of 20 children and six adults at Sandy Hook Elementary School in Newtown, Conn., Gov. Chris Christie convened the NJ SAFE taskforce to evaluate gun control and mental health issues.

Christie proposed the task force’s recommendations in April. They include simplifying the screening and treatment process for courts and mental health professionals, as well as clarifying the involuntary treatment standards.

Christie also proposed amending the current law to add new standards for mandatory treatment. They would cover a person who has committed or threatened violence within the previous four years or has a history of not complying with treatment.

As the program progresses, Christie also proposed greater flexibility to treatments and insurance of a patient’s ability to move to outpatient services.

In early June, lawmakers introduced a bill that would allow some judges in any county to require a person with a diagnosis to undergo treatment at the time of release. The bill, now in committee, would also emphasize injectable drugs.

Phyllis Lubit, associate director of the mental health advocacy group NAMI New Jersey, said the DCC program needs adequate state funding to survive. Health care providers, she said, are wary of taking on patients if they believe funds may dry up.

Lubit also supports clarifying the criteria used to distinguish between in- and outpatient treatments, and said the mental health system needed to be able to intervene more quickly. That could set a person on faster and avoid unnecessary hospitalizations, she said.

Mental health officials are expected to take part in an statewide DCC conference on June 24, DHS Lovejoy said. The goal is to provide information regarding the DCC program and address successes and challenges to date.

It has been nearly 11 years since the tragedy that reshaped her life. Yet Kastenschmidt recently told a reporter, “Gregory will be 23 in August.”

She’s frustrated that officials did not prioritize the program until the Sandy Hook shootings, but hopeful sure midterms will begin to see the law’s benefits.

Ultimately, Kastenschmidt wants to protect other parents from her nightmare.

“I think that what we in general fail to realize is, until we start looking at mental illness, and putting our money in prevention and treatment, these tragedies will continue.”
Involuntary Outpatient Commitment

FAQ - INVOLUNTARY OUTPATIENT COMMITMENT

1. What is Involuntary outpatient commitment?
   Involuntary commitment refers to mental health laws which exist in 42 states and now in New Jersey which allows for the compulsory, community-based treatment of individuals with mental illness who as a result of a mental illness meet a legal standard for commitment. When a person is assessed by a mental health screener and psychologist and involuntary commitment to treatment seems necessary, screening service staff shall determine the treatment that is appropriate to the person's condition and is the least restrictive environment. Outpatient treatment may include, but is not limited to, day treatment services, case management, residential services, outpatient counseling and psychotherapy, and medication treatment.

2. Who will it benefit?
   The Governor's Task Force on Mental Health estimated that approximately 400 individuals will be affected by this law, P.L. 2009, CHAPTER 112, at any given time once it is fully implemented. These are individuals who are experiencing serious psychological distress but are unable to access mental health services on a voluntary basis. The use of the least restrictive alternative of outpatient commitment has led to significant reductions in hospitalizations, incarceration and homelessness in other states, notably New York.

3. When will it be implemented?
   This act shall take effect on August 11, 2010 one year after the date of enactment. The law will be phased in over a three year period with seven counties to be selected by the Commissioner of Human Services in each of the three years.

4. Who will oversee it?
   During the time the 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. If a patient fails to materially comply with the plan of outpatient treatment during the time the patient is assigned 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 services 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.

   The Commissioner of Human Services is to monitor and evaluate the implementation of involuntary commitment to outpatient treatment and report to the Governor and to the Legislature.

5. Comments?
   Over the coming months the Division of Mental Health Services will be developing regulations that will be the framework for the implementation of outpatient commitment. It is time for advocates who have been on both sides of the issue to come together to assure that involuntary commitment is employed only after an array of voluntary services have been offered and rejected and that the services provided under the plan of outpatient treatment are clinically appropriate and based on proven or promising treatments directed to wellness and recovery.

6. Current Standard
   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 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.

* This determination shall take into account a person’s history, recent behavior and any recent act, threat or serious psychiatric deterioration.

* “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.
January 31, 2013

2013-R-0105

UPDATED REPORT: INVOLUNTARY OUTPATIENT MENTAL HEALTH TREATMENT LAWS

By: Michael Caccio, Legislative Fellow

You asked for an update of OLR Report 2011-R-0438, which described involuntary outpatient mental health treatment laws in other states. You want to know how often the states with such laws have invoked them. Finally, you requested information on recent legislative changes to New York’s outpatient commitment law.

SUMMARY

Involuntary outpatient treatment, also called “assisted outpatient treatment” (AOT), is court-ordered, community-based treatment for people with untreated severe mental illness, such as bipolar disorder or schizophrenia, who meet strict legal criteria. Generally, these individuals are too ill to recognize they need medical care and have a history of medication and treatment noncompliance. The goal of AOT is to provide treatment to these individuals before they require psychiatric hospitalization. Proponents of AOT laws believe they reduce psychiatric hospital admissions, homelessness, and violence and improve treatment compliance. Those opposed feel such laws remove an individual’s civil right to choose whether and how to receive treatment.

According to the Treatment Advocacy Center, 44 states and the District of Columbia allow courts to order involuntary outpatient treatment for people with severe untreated mental illness. Connecticut is one of six states (also Maryland, Massachusetts, New Mexico, Nevada, and Tennessee) that do not have such a law. New Jersey’s AOT law took effect in August of 2010, but its implementation was delayed by Governor Christie due to inadequate funding for treatment. In 2013, the New Jersey legislature appropriated approximately $2 million to begin its implementation.

States vary somewhat in terms of eligibility requirements, processes, and who can apply to the court to admit an individual to AOT. For example, some states such as Florida, California, and New York limit AOT to adults, whereas other states such as Georgia, Maine, and North Carolina also allow minors to receive such treatment. Some states require an individual to be involuntarily hospitalized at the time of the court application for AOT, while others allow an application to be initiated when an individual still lives in the community.

We have summarized the states’ AOT laws. Maine, New Hampshire, New Jersey, and New York, including the most recent changes to New York law in response to the Newtown, Connecticut school shootings and an evaluation of the state’s program. Additionally, we have provided statistical information, where available, on how frequently these four states actually invoke their AOT laws. A web link to a chart with all 50 states’ involuntary outpatient hospitalization and outpatient treatment laws is provided for your additional information.

New York amended its AOT law earlier this month. Some of the changes include: (1) doubling the period of court-ordered outpatient treatment for an initial court commitment and (2) ensuring continuity of care for those patients who move from one part of the state to another.

MAINE

LAW

Maine law authorizes court-ordered outpatient treatment through a “progressive treatment program” (PTP). The supervising or chief administrative officer of a psychiatric hospital, the commissioner of the Department of Health and Human Services (DHHS), or the director of an “Assisted Community Treatment” (ACT) team may apply to the District Court to commit an individual to the PTP. (An ACT team director may apply only if the team existed as of April 14, 2010 and complies with nationally recognized standards DHHS identifies.)

To be eligible for involuntary outpatient treatment in Maine, an individual must:

1. have a severe and persistent mental illness;
2. pose a likelihood of serious harm;
3. have an individualized treatment plan and community resources available to support the plan; and
4. be unable to voluntarily follow the treatment plan.

In addition, the court must find that court-ordered compliance will (1) help protect the individual from interruptions in treatment, relapses, or mental health deterioration and (2) enable him or her to survive more safely in a community setting without posing a likelihood of serious harm.
FTP services are provided based on an individualized treatment plan. The court commits the individual to the care and supervision of an ACT team or other outpatient facility. An ACT team is on duty 24 hours per day, seven days per week and includes at least a psychiatrist, registered nurse, rehabilitation counselor, or employment specialist, peer recovery specialist, and substance abuse counselors.

The court commits an individual to the FTP for an initial period of up to 12 months and may grant an unlimited number of 12 month extensions. If an individual fails to comply with the FTP, the court may order an emergency authorization to hospitalize the patient for evaluation and treatment (340 MBRA § 3670-A et seq.).

Implementation

Maine has two state hospitals that accept FTP referrals: Riverview Psychiatric Center and Dorothea Dix Psychiatric Center, both of which began accepting FTP referrals in 2007. According to DHEC, from January 2007 through December 2011, the following enrollment statistics for the FTP program were reported at Riverview:

- 21 commitments involving 15 individuals (one individual was admitted three times and two were admitted twice)
- Of the 21 commitments, nine fully completed the FTP.
- As of December 2011, there were four clients enrolled in the program.

At Dorothea Dix, the following FTP enrollment statistics were reported for the same period:

- 45 commitments involving 42 individuals (three clients had two commitments)
- Of the 45 commitments, 27 fully completed FTP.
- As of December 2011, there were five clients enrolled in FTP.

The most recent statistics provided by Riverview's superintendent show that Riverview has had 25 and Dorothea Dix 48 total FTP commitments ranging in duration from six to 12 months since 2007. The ACT team at Riverview is employed by the state, while the state contracts for the ACT team at Dorothea Dix.

NEW HAMPSHIRE

Law

New Hampshire law allows any "responsible person" (the law does not define this term) to petition the court to commit an individual to involuntary outpatient treatment. An individual is eligible for such treatment if he or she has a mental illness that creates a potentially serious likelihood of danger to him, or herself, or others as evidenced by either:

1. Self-infection of serious bodily injury, attempted suicide, or serious self-injury in the last 40 days which is likely to recur without treatment;
2. Threatened self-infection of serious bodily injury in the last 40 days and likely to attempt to inflict serious self-injury without treatment;
3. Lack of capacity to care for his or her own welfare and a likelihood of death, serious bodily injury, or serious debilitation.

In addition, an individual must have:

1. Severe mental disability for at least one year and an involuntary hospital admission within the last two years;
2. Refused necessary treatment and a psychiatrist has determined there is a substantial probability that this refusal will lead to death, serious bodily injury, or serious debilitation;
3. Threatened, attempted, or committed violent acts in the last 40 days, and
4. No guardian.

If an individual meets these criteria, he or she is involuntarily admitted to the state's psychiatric hospital, New Hampshire Hospital (formerly the Division of Emergency Admissions (DEA). Within 30 days of admission, a district court judge must hold a probable cause hearing and can commit the individual to outpatient treatment at a local community mental health center (CMHC) as part of a conditional discharge. The court sets the length of the commitment and treatment conditions as developed by the CMHC and the patient. The patient is then immediately discharged from the hospital and begins outpatient treatment.

If the individual complies with the treatment plan, he or she is released at the end of the outpatient commitment term. If the individual is noncompliant, the CMHC must schedule a probable cause hearing to review the case and request the individual's rehospitalization. (New Hampshire Revised Statutes Annotated §§ 135-C:17 et seq.)

Implementation

An official at New Hampshire Hospital reported that the hospital discharged about 1,400 patients each year, and that approximately 30% of these are conditional discharges, i.e., the patient must undergo outpatient treatment. The average length of the court-ordered treatment is between one-and-a-half and two years.

NEW JERSEY

Law

New Jersey's involuntary outpatient commitment (IOC) law took effect in August 2010 (P.L. 2009, Chapter 112). It allows a short- or long-term care psychiatric facility, psychiatric hospital, screening service, or outpatient treatment provider to apply to the court to commit an individual to involuntary outpatient treatment.

Individuals are eligible for outpatient commitment if they (1) have a mental illness that causes them to be a danger to self, others, or property and (2) are noncompliant with needed treatment. The law defines someone as being a danger to self if he or she is unable to satisfy the need for nourishment, essential medical care, or shelter without assistance and that substantial bodily injury, physical harm, or death is
The law directed the commissioner of the Department of Human Services (DHS) to phase in its implementation over a three-year period by selecting seven counties per year to implement it. For each county selected, the department must contract with a community service provider as the designated “outpatient treatment provider” for that county. (New Jersey Statutes Annotated §§ 30:4-27.4).

Implementation

Because the legislature did not appropriate additional funds to DHS for FY 11, Governor Christie delayed its implementation. For FY 2012, the legislature appropriated approximately $2 million, and DHS announced that it was launching the IOC in May 2012. Roger Burichowski from the New Jersey Office of Prevention, Early Intervention and Community Services, Division of Mental Health and Addiction Services, reported that this funding allowed the department to implement only six IOC programs.

IOC is modeled after the existing statute for screening inpatient commitment services. New Jersey contracted with new vendors to provide IOC screening when a candidate arrives at the emergency room. Patients are assigned to IOC in the same way that an inpatient is in New Jersey, through the probable court. The judge may order a person who is (1) found not to be an imminent danger to him- or herself or others and (2) whose best prognosis is that of a person with the potential for danger in the foreseeable future to participate in an IOC. Patients may also be released from inpatient into outpatient programs.

Burichowski noted that since the program’s implementation, most outpatient commitments have been outpatient conversion orders, in which the patient is already detailed and the court, upon the recommendation of the appropriate healthcare expert, releases the person in custody to outpatient treatment. A clinician determines where the person is held while the court is making its decision. Technically, someone who comes in after being admitted can be released back to the community until his or her case is heard and a determination made.

A judge can order a class of medication (e.g., antipsychotics) for a specific person undergoing inpatient or outpatient commitment, but may not order a specific prescription. When a patient does not comply with his or her treatment order, the IOC program notifies the judge, who decides if there is a breach. The judge also orders a screening center to assess the person, if the patient is an imminent danger, he or she is committed as an inpatient. If not, the patient’s treatment order is adjusted appropriately to reflect his or her needs.

The New Jersey IOC statute requires a program evaluation. New Jersey has contracted with Rutgers University to track data concerning how many people use IOC and for how long. Because IOC was recently implemented, data is not yet available.

NEW YORK

Kendra’s Law

In 1999, the legislature enacted a law allowing courts to order involuntary outpatient treatment for certain individuals with mental illness who, when considering their treatment history and current circumstances, are unlikely to safely survive in the community without supervision. The law is commonly referred to as “Kendra’s Law,” after Kendra Weidale, a young woman who died in 1999 after being pushed in front of a New York City subway train by a person with untreated schizophrenia.

An individual can only be placed in AOT by an order of the supreme or county court where that individual lives. People who may apply to the court for such an order include:

1. the individual’s adult roommate, parent, spouse, adult child, or adult sibling;
2. the director of a psychiatric hospital where the individual is hospitalized;
3. the director of a nonprofit or public agency or home that provides mental health services to the individual;
4. a treating or supervising licensed psychiatrist, psychologist, or social worker;
5. the director of community or social services in the town or city where the person lives; or
6. a supervising parole or probation officer.

The law prohibits an individual from being placed in an AOT unless the court finds by clear and convincing evidence that the individual:

1. is at least 18 years old;
2. has a mental illness;
3. based on a clinical determination, is unlikely to safely survive in the community without supervision;
4. has a history of treatment noncompliance that has (a) at least twice in the last three years been a significant factor in his or her being hospitalized or receiving services in a correctional facility or (b) resulted in one or more acts of serious violence or threats or attempts of such acts in the last four years;
5. is unlikely to voluntarily participate in the outpatient treatment because of his or her mental illness;
6. is in need of AOT to prevent a relapse or deterioration that would likely result in serious harm to him- or herself or others; and
7. is likely to benefit from AOT.

A court cannot issue an AOT order unless it finds that AOT is the least restrictive alternative available to that person.

If the court determines an individual meets the criteria for AOT, it issues an order to the person who oversees the county or local mental health program. The order is based on a written treatment plan the examining physician submits. The order may involuntarily compel medication, therapy, rehabilitative services and blood and urine testing. An initial order is effective for up to one year and can be extended for periods of up to one year. The law also establishes a procedure for hospital evaluation in cases where the individual fails to comply with the ordered treatment and may pose a risk of harm.
The law requires the Office of Mental Health to designate “program coordinators” responsible for monitoring and overseeing AOT programs. County directors of community services must operate AOT programs, either individually or jointly with other counties. The mental health commissioner must approve all AOT programs.

An individual who is noncompliant with the AOT order may be held for up to 72 hours in a psychiatric hospital, during which he or she is evaluated to determine whether involuntary hospitalization is required (New York Mental Hygiene Law 8.9 [d]).

2013 Changes

Earlier this month, the New York legislature passed a law concerning firearms regulation and mental health in response to the Newtown, Connecticut school shootings. The new law made several AOT-related changes to “Kendra’s Law”:

- The initial period of court-ordered outpatient treatment was extended from six months to one year.
- Before an AOT order expires, county directors of community services must evaluate the need for ongoing AOT. If a director determines that the outpatient continues to meet the criteria for AOT, he or she may petition the court to order continued AOT.
- When a director has reason to believe that an outpatient has or will change his or her county of residence while an AOT order is in effect, he or she must notify the community services director in the outpatient’s new county of residence. The director in the outpatient’s new county of residence must provide outpatient care services.
- The Kendra’s Law sunset date was extended from June 30, 2015 until June 30, 2017.

Implementation

According to OMIH, 10,923 AOT petitions were filed between November 1999 and January 2013, of which 10,618 were granted. The median length of time individuals spent in AOT was 12-18 months. And over 18,000 individuals have been screened for AOT. A total of 6,492 court orders have been renewed (63%). Currently, 1,816 people are active under an AOT court order, with a total of 2,874 people active during the past 13 months.

Evaluation

A 2009 AOT program evaluation noted that AOT recipients represent a small percentage of the total number of adults who receive OMIH services. For example, in 2005, of the 150,602 OMIH adult service recipients with severe mental illness, only 2,620 (1.7%) received AOT treatment. Despite the relatively small number, the evaluation found that AOT recipients received disproportionate attention because of their serious needs, high care costs, and the public's concern about the target population for Kendra's Law.

The researchers also noted that some counties have an AOT program and never use it, and some have no AOT program at all; these are often smaller counties or those that use a different program to coordinate services for high-needs patients. All counties receive AOT program funding from the state; those that do not use an AOT program may use that funding to serve high-risk patients in other ways.

Sources


# New Jersey Division of Mental Health and Addiction Services
## Involuntary Outpatient Commitment Programs

<table>
<thead>
<tr>
<th>County</th>
<th>Agency Name</th>
<th>CEO/Administrator</th>
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<tbody>
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<td>Kathy Howie Ph. (908) 994-7543 <a href="mailto:khowie@trinitas.org">khowie@trinitas.org</a></td>
<td>654 East Jersey Street Elizabeth, NJ 07206</td>
<td>Ph 908-994-7543 Fax 908-994-7046</td>
<td>908-994-7634</td>
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<tr>
<td>Warren</td>
<td>Family Guidance Center of Warren County</td>
<td>Richard McDonnell,</td>
<td>Laura Guancione Ph. (908) 454-4470 x320 <a href="mailto:lguancione@fagwc.org">lguancione@fagwc.org</a></td>
<td>492 Rt. 57W, Washington, NJ 07782</td>
<td>Ph 908-454-5141 Fax 908-454-7067</td>
<td>908 689-1000</td>
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