INVOLUNTARY CIVIL COMMITMENTS

RESOURCE BINDER

Revised June 2024

FOREWORD

This document was prepared by:

Division of Mental Health and Addiction Services
Department of Human Services

Division of Mental Health Advocacy
Office of the Public Defender

Civil Practice Division
Administrative Office of the Courts

It is designed to be used as a research starting point regarding the law and practice of involuntary civil commitments in the State of New Jersey. Reliance upon this document should be limited accordingly. The document has not been reviewed or approved by the Supreme Court nor is it an official publication of any of the offices listed above.

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IOC Directory

Children's Crisis Intervention Services (CCIS)

I. OVERVIEW OF MENTAL HEALTH SYSTEM

A. DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES

Central Office: Division of Mental Health and Addiction Services
5 Commerce Way
Hamilton, New Jersey 08691
Phone: (609) 438-4352

The Division of Mental Health and Addiction Services (DMHAS), within the Department of Human Services, is responsible for the following:

1. Contracts with community mental health providers for direct services to clients, including treatment, rehabilitative and support services. Additionally, DMHAS contracts for some consultation and training services that assist providers to better meet consumers' needs and funds consumer-operated recovery (self-help) centers.

2. Monitors contracted community mental health providers in accordance with Department and national standards and reviews the financial and management plans of the county psychiatric hospitals according to N.J.S.A. 30: 4-78.1.

3. Designates screening services in accordance with N.J.S.A. 30:4:27.1 *et seq*.

4. Designates short-term care facility beds in accordance with N.J.A.C. 10:37G *et seq*.

5. Establishes policy regarding the delivery of mental health services; where such policy affects the health care delivery system it will be developed in consultation with the Department of Health and the Statewide Health Coordinating Council (SHCC).

6. Conducts needs assessments for mental health services within specific geographic areas and allocates available funds and technical assistance to community providers of such services.

7. Recommends regulations for promulgation by the Department of Human Services within Title 10 of the New Jersey Administrative Code.

8. Provides technical assistance and recommendations to the Department of Health and the SHCC regarding Certificate of Need and licensure standards.

9. Reviews programs for Medicaid certification and makes recommendations to the Division of Medical Assistance and Health Services.

B. STATE HOSPITALS

The Division of Behavioral Health Services, within the Department of Health, is responsible for the operation of three regional adult psychiatric hospitals (Ancora, Greystone and Trenton) and one specialized facility providing maximum security (Ann Klein Forensic Center). The State bills the 21 counties for 15% of the cost for county residents who are receiving care in these facilities. See N.J.S.A. 30:1-7; N.J.S.A. 30:4-160; and N.J.S.A. 30:4-27.2(u).

Central Office for
Department of Health: Department of Health
P.O. Box 360
Trenton, New Jersey 08625-0360
Phone: (609) 292-7837
Toll Free: 1-800-367-6543

Regional Hospitals. The three regional adult psychiatric hospitals (Ancora, Greystone, and Trenton) are part of a comprehensive inpatient mental health service delivery system, which is organized geographically by county. These hospitals service the following counties:

Ancora: (609) 561-1700

Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Ocean, and Salem

Greystone: (973) 538-1800

Bergen, Essex, Hunterdon, Hudson, Morris, Passaic, Somerset, Sussex, Union, and Warren

Trenton: (609) 633-1500

Mercer, Middlesex, and Monmouth

Specialty Hospital.

Ann Klein Forensic Center: (609) 633-0900

The Ann Klein Forensic Center (AKFC) provides a highly structured, secure and supervised evaluative and treatment environment. It is a psychiatric facility as defined by *N.J.S.A*. 30:4-27.2(u) and, therefore, may treat involuntarily committed individuals.

C. COUNTY HOSPITALS

In addition to the four State-operated hospitals above, New Jersey has four county-operated hospitals providing psychiatric inpatient services. These hospitals are operated by the county on a voluntary basis but while monitored by the State (*N.J.S.A*. 30:1-14), do not fall under the direct authority of the DMHAS. These four hospitals are:

- Bergen New Bridge Medical Center, Bergen County;
- Cornerstone Hospital, Union County;
- Essex County Hospital Center, Essex County; and
- Meadowview Hospital, Hudson County.

These hospital units are psychiatric facilities as defined by *N.J.S.A*. 30:4-27.2(u) and, therefore, may treat involuntarily committed individuals. The State contributes to the operational funding of these hospitals by paying 85% of the costs of care for patients who are county residents.

D. PRIVATE PSYCHIATRIC HOSPITALS

Psychiatric patients in New Jersey may also be committed to private psychiatric hospitals in the State. Some examples of private psychiatric hospitals are Hampton Behavioral Health Center, Hackensack Meridian Health at Carrier Clinic, Summit Oaks Hospital, RWJBarnabas Health Behavioral Health Center, and Ramapo Ridge Psychiatric Hospital.

E. PSYCHIATRIC UNITS LOCATED IN GENERAL MEDICAL HOSPITALS

General medical hospitals in the community may also provide for inpatient services for persons with psychiatric illness through either:

1. short term care facility
2. voluntary psychiatric unit
3. involuntary psychiatric beds

F. ENACTMENT OF SCREENING/COMMITMENT LEGISLATION

On May 7, 1987, New Jersey Governor Thomas H. Kean signed into law a major revision of the statutes concerning involuntary civil commitment to psychiatric facilities, *N.J.S.A*. 30:4-27.1 *et seq*. This "Mental Health Screening/Commitment" legislation became effective on June 7, 1989.

Among the Legislative findings and declarations in this act was the following statement:

> It is the policy of this State to encourage each county or designated mental health service area to develop a screening service 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. Similarly, the State encourages the development of short-term care facilities to enable a mentally ill person to receive acute, inpatient care in a facility near the person's community. Development and use of screening services 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. *N.J.S.A*. 30:4-27.1(d).

G. DESIGNATED SCREENING SERVICES

N.J.S.A. 30:4-27.4 provides that the Commissioner of Human Services shall designate one or more mental health agencies or facilities in each county or multi-county region in the State as a screening service. This screening service is a public or private ambulatory care service providing assessment, emergency and referral services to mentally ill persons in a specified geographic area.

Screening service evaluation is the preferred process for entry into short-term care facilities or psychiatric facilities so that appropriate consideration is given to less restrictive treatment alternatives. *N.J.S.A*. 30:4-27.4. 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 commitment to a short-term care, 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. *N.J.S.A*. 30:4-27.5(a). Not all emergency service providers are designated screening services.

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 and the person is unwilling or unable to come to the screening service for an assessment. *N.J.S.A*. 30:4-27.5(d). Police officers can be contacted by screeners to assist in taking custody of a patient; however, they can only take custody after a screener has made a screening outreach visit.

H. SHORT-TERM CARE FACILITIES (STCF)

N.J.S.A. 30:4-27.8 provides that the Commissioner of Human Services, in consultation with the Commissioner of Health, 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. These are inpatient, community based facilities providing acute care and assessment services to a mentally ill person whose mental illness causes the person to be dangerous to self or dangerous to others or property. *N.J.S.A*. 30:4-27.2(bb).

Individuals shall be admitted involuntarily to short-term care facilities only by referral from a screening service or temporary court order. *N.J.S.A*. 30:4-27.9(b). STCF's are authorized to provide assessment, treatment and rehabilitation services and shall provide discharge planning services as required pursuant to *N.J.S.A*. 30:4-27.18.

I. COMMUNITY PROGRAMS

The DMHAS coordinates the provision of community-based mental health services through a network of private, nonprofit organizations.

There are private, not-for-profit, and for-profit community mental health providers, supported in part through State and federal funds. Specific program elements include: mental health Early Intervention Support Services (EISS), Integrated Case Management Services (ICMS), Designated Screening Service, outpatient services, partial care, systems advocacy, residential care, community support services, PACT (Programs of Assertive Community Treatment), PATH (Programs for Assistance in Transition from Homelessness), justice involved services, supported employment, supported education, self-help centers and other programs which relate directly to services to the

DMHAS's target populations and exclusive of the elements previously listed.

Among these agencies in New Jersey, there is a wide variety of community mental health programs. Many provide a complete array of community mental health services while others provide only one or two specific program elements, which are complemented by services provided by other agencies within a specified geographic area.

II. OWNERSHIP OF THE CIVIL COMMITMENT PROCESS BY THE CIVIL DIVISION

Civil Commitment hearings are scheduled by the County Adjuster and the confidential case files are opened and maintained in their offices and docketed on their computer system. As the cases are heard by judges of the Superior and Municipal Courts, the Civil Division plays an important role in fostering communication, managing, and reviewing the calendar, staffing, supplying resources, and troubleshooting. Accordingly, each vicinage should take ownership of the process and establish protocols consistent with the following principles:

A. IDENTIFYING STAKEHOLDERS AND ESTABLISHING OPEN COMMUNICATIONS

N.J.S.A. 30:4-27.1 *et seq.* along with *R*. 4:74-7 provide the framework for the civil commitment process as provided for in detail in this resource binder. The various entities and individuals responsible for the effective and efficient processing, scheduling, and handling of civil commitment hearings are all considered partners or stakeholders. It is important to not only recognize who these stakeholders are, but also to understand the essential role each stakeholder has in the process to ensure a fair and just hearing.

Stakeholders include:

- NJ Superior Court
  - Administrative Office of the Courts
  - Vicinage and Municipal Court Judges and Staff
  - Trial Court Administrators, Division Managers (i.e., civil, municipal, finance, IT, general operations, human resources);

court staff in various divisions (i.e. interpreting unit, fleet management unit; accounts payable unit, etc.)

- County
  - Adjuster/officer personnel and couriers;
  - County counsel;
  - County processing/scheduling staff from the adjuster's office;
  - Sheriff and sheriff's officers and office personnel
- NJ Office of the Public Defender Division of Mental Health Advocacy
  - Assistant Public Defenders and staff
- NJ Office of the Attorney General
- Department of Human Services, Division of Mental Health and Addiction Services and office personnel;
- Department of Health, Division of Behavioral Health Services;
- Hospital facilities (county, state or private), including hospital administrators, coordinators, nurse managers, physicians and other personnel; and
- Designated screening services, including administrators.

It is important to recognize that the stakeholders vary between vicinages depending upon the process for handling civil commitment orders and hearings. Therefore, it is important for vicinage leadership to properly identify all stakeholders and establish strong working relationships that support and enhance the civil commitment program in their county. This responsibility rests with the Assignment Judge or the Assignment Judge's designee.

One way to establish strong partnerships with the stakeholders is to conduct regularly scheduled meetings, at least annually. Regular meetings facilitate communications and improve coordination between all participants. An annual meeting also affords the opportunity for vicinage leadership to assess and review the civil commitment process and address areas in need of improvement or areas where conflict exist. Minutes of the meeting memorialize discussions and action items can be followed up on as necessary.

B. CASE MANAGEMENT

The Administrative Code (*N.J.A.C.* 10:7 *et seq.*) and *N.J.S.A*. 30:4-27.1 *et seq.* sets forth the responsibilities of the county adjuster regarding the case

management and case processing of civil commitment hearings. The vicinage staff has no direct access to the adjuster's scheduling system and case management system (known as CCATs) or case files, however, judges may access the electronic civil commitment case jacket. Vicinage leadership also maintains a vital role in support of the county adjuster and the civil commitment program.

1. Calendar Management

Pursuant to the April 27, 1994 memo of Chief Justice Wilentz[1], Vicinage leadership was asked to implement several recommendations geared towards improved civil commitment procedures. One of those recommendations included that CEPP hearings be broken out and scheduled *separately* from initial and review hearings. This recommendation appears to be most applicable for larger state facilities and hospitals (i.e. Greystone, Ancora, Ann Klein, Trenton State), where it might be more challenging to calendar a larger number of cases within required statutory time frames. In some instances, it may be necessary to consider one or more additional hearing days to accommodate large numbers of cases. In other instances, it may be necessary to schedule a morning calendar dedicated only to initial and review hearings. A separate afternoon calendar can then be scheduled and dedicated only to CEPP hearings. This type of calendaring system may prove effective for smaller, local facilities and hospitals.

Another recommendation made as part of the 1994 review was that those judges handling the hearings be sensitive to the overall number of cases on each calendar. While stopping short of recommending a numerical maximum of matters that could be scheduled on a particular calendar, a need to be sensitive to the number of cases on each calendar was acknowledged. For example, a decision to calendar CEPP hearings separately from initial and review hearings may not, in and of itself, reduce calendars to more manageable sizes. The hearing Judge must be alert to the number of cases on any particular calendar. The number of cases scheduled should not be so great as to negatively impact patient's rights or the requirements of due process.

Prior to any enactment of these recommendations, the court and county adjuster will make every effort to consult with affected stakeholders (e.g.

1 A copy of the April 27, 1994 memo is attached in the appendix.

hospital administrators, state agency staff, county counsel, OPD) to discuss the feasibility and implementation of calendar changes at the particular facility or hospital.

Annual Calendar - Developing a calendar for the court year to achieve the goals set forth above requires collaboration between the stakeholders identified earlier. The calendar impacts stakeholders in a variety of ways but it is the County Adjuster who schedules events, and it is the Court who must, in the interests of judicial economy, control many elements of the calendar.

- Hospitals: Coordinate availability of physicians and patients. There may also be issues with the availability of the hearing room on specific days.
- Public Defender's Office: Coordinate availability of defense attorneys if they cover the vicinage.
- County Counsel: Coordinate availability of counsel for the county.
- County Adjuster's Office: Schedules the hearings, coordinates between the Court, attorneys and hospitals.
- The Court: Supplies the judge and court clerk for hearings. Balances judge and court clerk availability and overtime issues when reviewing calendar.
- County Sheriff: Supplies a Sheriff's Officer for each schedule civil commitment day (may vary by vicinage). Overtime affects this department as well.

Thus, the Court should relay any calendar concerns to the Adjuster's Office as soon as possible. Discussions with individual hospitals regarding over-scheduling or issues with the hearing date or time, should be addressed by the Assignment Judge, or the Assignment Judge's designees, the County Adjuster and the hospital.

The annual calendar should be drafted by the County Adjuster and forwarded to the Assignment Judge and Trial Court Administrator for approval no less than three months before the beginning of the year.

This process affords the court an opportunity to verify the dates and times of the projected calendar and address any known conflicts (i.e. court holidays, judicial recess, vacations, etc.). Once the projected calendar is approved by

the court, the county adjuster can populate the calendar with cases as needed. It is recommended that this calendar approval process be conducted at least twice within a court year (i.e., at six-month intervals) for all civil commitment calendars at all hospitals and facilities.

Also, periodic review (i.e., at least once every two years) of the county rotation system for state facilities should be conducted by the Civil Practice Division. In support of this review, yearly data should be maintained by the adjuster's office on calendar management through CCATs. An analysis on this empirical data should be performed to determine if the current county rotation system continues to be both effective and efficient. Input from all stakeholders should be solicited and included in the review. Results of the analysis by Civil Practice should be provided to the vicinage Assignment Judges to allow the opportunity to further recommend any needed adjustments to the daily hearing schedule based upon the approved rotation schedule.

Scheduling At Commitment Hearings - Some county adjusters' offices provide support staff at civil commitment hearings to assist with calendar management. For example, when a judge determines to re-list a particular case, the adjuster's staff is able to provide the judge with viable future calendar dates. This has proven to be a valuable aid to the judge and an enhancement to calendar management.

Another advantage to having staff from the adjuster's office attend civil commitment hearings is that they are better able to coordinate calendars with staff from the facilities and hospitals. For example, future calendar projections can take into account the type of facility (short term care or long-term care); type of patients (adult or juvenile); the type of proceeding required (review or CEPP), along with all statutory calendaring requirements.

Coordination of calendars with staff from the facilities and hospitals is an important component of civil commitment hearings. Patients who are the subject of civil commitment hearings should be ready and available for the hearings through the cooperation of the facilities and hospitals. The county adjuster and legal representation for the patients should be in contact with hospital administration and/or coordinators to address any issues or concerns regarding the readiness of the patients for their scheduled hearing date/times.

The civil presiding judge, or the civil presiding judge's designee, should be available to discuss and address issues that cannot otherwise be resolved.

1. Orders

Due to the time constraints for the issuance of orders of temporary commitment, it is imperative that the court, the adjuster, and the hospital maintain communication regarding the need for efficient processing of screening certificates and orders.

In addition, due to the time constraints, it is possible that emergent duty judges may need to be contacted. Facilities must reserve these requests for exceptional circumstances (such as holiday weekends). Vicinages shall work closely with the adjuster's office and adjusters shall work closely with the facilities so that orders are issued during normal working hours.

2. Support Services

a. Facilities and Security

Another recommendation made as part of the 1994 review addressed the physical location of the hearings conducted at facilities and hospitals. It was determined at that time that, while not in the direct purview of the courts, hearing rooms should nonetheless reflect the nature and quality of the proceedings taking place therein. The court should work in concert with all other stakeholders to help ensure that hearing rooms foster the formality and solemnity appropriate to a judicial proceeding as well as the safety of the participants. This standard is also applicable to those vicinages that utilize courthouse facilities for outpatient hearings as well.

Pursuant to Division of Mental Health and Addiction Services Administrative Bulletin 3:40, effective October 5, 2015 (attached in the appendix), state psychiatric hospitals must have in place a civil commitment courtroom safety plan which addresses access control, circulation control, courtroom security, and emergency procedures, and which delineates the roles and responsibilities of hospital staff and others involved in court proceedings. Courtrooms must contain an emergency alert system, be in a secured location, and be in an area where interaction between visitors, Judiciary staff, court participants and groups of patients are kept to a minimum. Risk assessments of the facility and

patients shall be done prior to holding court. Hospitals must establish procedures for entrance of Judiciary Staff and others into the location containing the courtroom that minimizes security risks to all involved. Architecture and equipment outside the courtroom must include locations where family and patients can wait for court which does not impede access by the Judiciary staff and a location where attorneys can conference privately with their clients.

Civil commitment hearing rooms should have a separate means of ingress and egress for the judge, adequate space and weighty and well-constructed furnishings for participants, including but not limited to the judge, attorneys, clerk, security, patient, witnesses and family members.

The hospital will establish procedures for managing patients who will be attending court, including transportation to and from court, in the waiting area and during court proceedings. The hospital will establish procedure for the registration of visitors entering the courtroom. The hospital will execute protocols for disturbances and emergency situations.

Additionally, all civil commitment hearings must be conducted in the presence of a uniformed/armed county sheriff's officer including civil commitment hearings off-site as well as in a courthouse location, where applicable. See: (1) Memorandum - Judiciary Security Protocol – Civil Commitment Hearings dated July 29, 2015, and (2) Notice to Bar (Civil Commitment Proceedings – Requirement of Uniformed/Armed Sheriff's Officer - Supreme Court Administrative Determination) dated March 4, 2020, attached in appendix.

3. Recording Device

Portable recording devices (i.e., Marantz digital recorders) or CourtSmart is currently utilized at hospitals and facilities to record civil commitment hearings. CourtSmart is utilized at courthouses (i.e., outpatient hearings). The set up and maintenance of recording systems is the responsibility of the state and falls under the General Operations Division of the vicinage. In some instances, the portable recording devices are stored in a secured area at the hospitals and facilities. Where a portable recording device is used, the court clerk is responsible to set up/disassemble the recording device at the start/end of civil commitment hearings. Where the court clerk is off site and CourtSmart is being used, the court clerk must monitor CourtSmart to ensure

the proceeding is being recorded. The court clerk must immediately report any issues or problems to the judge and division manager.

4. Court Clerk

The court clerk (Judiciary Clerk 2, 3 or 4) is assigned by the vicinage to attend or record from a remote location civil commitment hearings. Responsibilities of the court clerk might include recording the hearings on site or from a remote location using CourtSmart and/or Morantz machine; maintaining the recording log sheet; marking evidence; administering oaths/affirmations of witnesses; facilitating the handling of signed orders; and basic court room administration/direction of the calendared cases. It is not unusual for a court clerk to work in unison with staff from the adjuster's office and/or hospital/facility coordinators in order to ensure efficient time management of court proceedings.

It is the responsibility of the civil division manager and civil presiding judge, or civil presiding judge's designee, to ensure that any court clerk attending civil commitment hearings are fully trained. This training should include information specific to the nature and requirements of civil commitment hearings. For example, court clerks must understand that civil commitment hearings are confidential and closed proceedings; proceedings are often held at hospitals or other facilities; the sensitivity of the cases; testimony is typically offered by a treating psychiatrist; patients might become upset or even agitated by or during court proceedings, etc.

A court clerk's job performance at civil commitment hearings should be periodically assessed by the civil division manager or the civil division manager's designee. Assessments can include, for example, a review of both the audio and court recording log. (See attached assessment form). Further assessment can include direct feedback from the judge, the hospital/facility coordinator, or the adjuster's office.

Court clerks are unionized employees of the Judiciary. Judges handling civil commitment hearings should be generally aware of contractual obligations afforded to unionized employees (i.e., over time, travel pay, breaks, lunch, etc.). Vicinage managers should ensure court clerks are appropriately compensated pursuant to the terms of the union contract.

5. Transportation Issues

The county adjuster's office maintains all case files relating to civil commitment hearings pursuant to the statute. As such, the responsibility lies with the county adjuster to coordinate the transport of case files to and from civil commitment hearings. In fact, the predominate statewide practice is that the county adjuster transports civil commitment files to civil commitment hearings.

However, other stakeholders may assist in the transportation of files as directed by the Assignment Judge or the Assignment Judge's designee. Practices may vary depending upon the vicinage and/or the location of the hospital or facility. For example, some vicinages arrange for the Sheriff Department to provide transportation to/from the civil commitment hearings for a Judge and/or court clerk. In that instance, the files are transported by the Officer along with the Judge and/or court clerk.

6. Interpreting Services and Osmosis

Interpreting services for civil commitment hearings must be requested through the county adjuster's office. Once the county adjuster receives a request for interpreting services, the adjuster's office forwards the request to the vicinage (i.e. either directly to the VCIS in General Operations or to designated staff in the Civil Division) so that the request can be recorded and processed in OSMOSIS. Cancellation of interpreting services are handled in the same manner.

7. Unexpected Closings

The Assignment Judge, or the Assignment Judge's designee, is responsible to designate the plan to be followed in the event of an unexpected court closing. Stakeholders should be made aware of this plan and the plan should be incorporated into the vicinage COOP. Copies of the plan, along with all pertinent contact information, should be distributed to all stakeholders at the annual meeting referred to in Section A. Stakeholders can also refer to the Judiciary website for up to date closing information.

III. ORDER OF TEMPORARY COMMITMENT

A. OVERVIEW

When it is alleged that an individual is in need of involuntary commitment to treatment, it is necessary to obtain an order of temporary commitment to detain (1) a person involuntarily confined to a short term care facility, psychiatric facility or special psychiatric hospital following an assessment at a screening service or (2) a person not presently hospitalized or confined for treatment of mental illness, such as an independent (non-screening) alternate referral application. An order for temporary commitment is also required to recommit a patient who is under an order of conditional extension pending placement (CEPP) and to detain a voluntary patient requesting discharge or an inmate scheduled for release upon completion of a maximum term of incarceration.

B. COMMENCEMENT OF AN ACTION

An action for involuntary commitment to treatment shall be commenced by one of the following:

1. A Screening Service Referral – Most applications for an order of temporary commitment to treatment are brought by a short-term care or psychiatric facility or special psychiatric hospital to which an individual has been involuntarily admitted from a screening service referral. Such a person will have recently (within the past 72 hours) undergone an assessment at a screening service. The person may have voluntarily entered the screening service or may have been taken there involuntarily by a family member or law enforcement officer. The law enforcement officer may have acted upon personal observation (*N.J.S.A*. 30:4-27.6(a)), the certification of a mental health screener who performed a screening outreach visit (*N.J.S.A*. 30:4-27.6(b)), or a court order (*N.J.S.A*. 30:4-27.6(c)). At the screening service, a mental health screener would have first assessed the person and completed a screening document. *N.J.S.A*. 30:4-27.5(b). The screening service may detain the person for only up to 24 hours for the purposes of providing the treatment and conducting the assessment. *N.J.S.A.* 30:4-27.5(a). The person would have been next assessed by a

psychiatrist (or other physician[2]) who will have completed a screening certificate, concluding that involuntary commitment was necessary.

Upon completion of the screening certificate, the person would have been involuntarily admitted to a short-term care facility, psychiatric facility or special psychiatric hospital, determined to be appropriate by the screening service. A clinical certificate will be completed by a psychiatrist or physician at that facility. If involuntary commitment is deemed necessary by the patient's treatment team, the facility or hospital shall initiate court proceedings. A person cannot be detained at a facility or hospital for more than 72 hours from the time the screening certificate is completed.[3] During this period of time, the facility shall initiate court proceedings for the involuntary commitment of the person pursuant to *N.J.S.A.* 30:4-27.10. Accordingly, the facility must obtain an order of temporary commitment within 72 hours or the individual must be discharged. *R.* 4:74-7(b)(1).

2. Alternate Application – If a screening service procedure is not used, proceedings for involuntary commitment to treatment may be initiated by filing an application supported by two clinical certificates, at least one of which is prepared by a psychiatrist, stating that the individual is in need of involuntary commitment. The originals must be filed with the court with copies sent to the office of the county adjuster. If proceedings are instituted by alternate application, there shall be no involuntary commitment prior to the entry of an order of temporary commitment by the court. *R.* 4:74-7(b)(2).

a. Voluntary Patients Requesting Discharge — If a voluntary patient at a short-term care facility, a psychiatric facility, or a special psychiatric hospital requests to be discharged and the patient's treatment team is of the opinion that involuntary

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[2] *N.J.S.A* 30:4:27.5(b) provides that a physician other than a psychiatrist may execute a screening certificate if the contract between the DMHAS and the screening service so allows. The judge should be satisfied that the relevant contract includes this provision before signing a temporary order of commitment based in part upon a screening certificate executed by a physician other than a psychiatrist.

3 On August 16, 2023, Governor Murphy signed into law N.J.S.A. 30:4-27.9a, which permits a general hospital to file an emergent application for a temporary court order extending a patient's hold for an additional 72 hours beyond the initial 72-hour period typically allowed in civil commitment matters. The law took effect immediately, and as of the date of enactment, is scheduled to sunset on August 31, 2025. See Directive #01-24 dated February 26, 2024. A Supplement to Directive #01-24, dated April 24, 2024, updates the template "Order for Continued Hold of Patient."

commitment is necessary, a court order for temporary involuntary commitment must be obtained. This situation may occur at the hearing for voluntary patients, *i.e.*, the patient states the patient wants to leave or the judge ascertains that the patient is either not truly at the hospital on a voluntary basis or lacks the competency to understand what "voluntary" means. (For a greater explanation of voluntary hearings, see Section X).

Without a temporary or final court order, the patient must be discharged within 48 hours of the discharge request or at the end of the next working day following the request, whichever is longer. *N.J.S.A*. 30:4-27.20.

In support of a petition for an order of temporary commitment, the hospital or facility must submit an application for commitment and two clinical certificates prepared and executed by physicians, at least one of whom must be a psychiatrist. In the event the patient's treatment team includes a psychiatrist, that psychiatrist should prepare and execute one of the certificates. If the order for temporary commitment is signed by a judge, a final hearing must be scheduled within 20 days.

b. Patients Under an Order of Conditional Extension Pending Placement (CEPP) — If it is determined that a patient under a CEPP order (See Section VII.D., *infra)* needs to be involuntarily committed, it is necessary to obtain an order for temporary commitment. All the procedures of *N.J.S.A*. 30:4-27.1 *et seq*. and *R*. 4:74-7 must be followed just as if it were an initial commitment.

c. Commitment of Inmates Scheduled for Release — If it is determined that an inmate scheduled for release upon the expiration of a maximum term of incarceration is in need of involuntary commitment, the Attorney General or county prosecutor may initiate the commitment process by the submission to the court of an application for an order of temporary commitment supported by two clinical certificates, at least one of which must be prepared by a psychiatrist. *N.J.S.A*. 30:4-27.10(c). If the court finds that there is probable cause to believe that the inmate is in need of involuntary commitment, 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 to the AKFC or other facility designated for the criminally insane pending the final hearing and prior to the expiration of the inmate's term. *N.J.S.A*. 30:4-27.10(h).

3. The Attorney General – The Attorney General, in the exercise of the State's authority as *parens patriae*, may initiate a court proceeding for the involuntary commitment of any person. *N.J.S.A*. 30:4-27.10(d). When the Attorney General determines that the public safety requires initiation of a court proceeding, the Attorney General may apply to the court for an order compelling the psychiatric evaluation of the person. The court shall grant the application if it determines that there is probable cause to believe that the person may be in need of involuntary commitment. The Attorney General may delegate authority under *N.J.S.A.* 30:4-27.10(d), on a case-by-case basis, to the county prosecutor.

C. CONTENTS OF THE CERTIFICATES

In support of a petition for an order of temporary involuntary commitment, the facility or hospital must submit:

a. a screening certificate executed by a psychiatrist[4] affiliated with a screening service; and

b. a clinical certificate completed by a psychiatrist who is a member of the patient's treatment team at the short-term care facility[5]

The two certificates required for commencement of an action must state with particularity the facts upon which the psychiatrist, physician or mental health screener relies in concluding that (1) the patient is mentally ill, (2) the mental illness causes the patient to be dangerous to self or others or property as defined by *N.J.S.A*. 30:4-27.2(h) and -27.2(i), and (3) the patient is unwilling to accept appropriate treatment voluntarily after it has been offered, (4) the patient needs outpatient or

[4] *See infra*, form of screening/clinical certificate approved by the Administrative Office of the Courts.

[5] *See supra,* note 2 and accompanying text.

inpatient care at a short term care or psychiatric facility or special psychiatric hospital and (5) other less restrictive alternative services are not appropriate or available to meet the person's mental health care needs. *R*. 4:74-7(b) (3)(A). It is strongly encouraged that the facility or hospital also submit a screening document prescribed by the DMHAS executed by the screener providing information on the patient's history and available alternative facilities and services deemed inappropriate for the judge's consideration.

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 and at least one of them must be prepared by a psychiatrist. *N.J.S.A*. 30:4-27.10(b).

D. PERSONS DISQUALIFIED

No certificate may be executed by a person who is a relative by blood or marriage of the person being examined. If a screening service referral is used, the same psychiatrist may not sign both the screening certificate and the clinical certificate unless that psychiatrist has made a reasonable but unsuccessful attempt to have another psychiatrist conduct the evaluation and execute the certificate. *R*. 4:74-7(b)(3)(B).

E. STANDARD OF REVIEW

N.J.S.A. 30:4-27.10(f) requires immediate court (Superior Court judge or Municipal Court judge) review of the papers presented and a determination of whether there exists the statutory basis for issuance of a temporary order of commitment.[6] Before signing an order of temporary commitment, the judge must find "probable cause to believe that the person is in need of involuntary commitment." *N.J.S.A*. 30:4-27.10(g); *R*. 4:74-7(c).

"In need of involuntary commitment" or "in need of involuntary commitment to treatment" is defined by the statute as:[7]

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[6] In non-emergent situations, the court may consider giving the person alleged to be in need of commitment or that individual's counsel an opportunity to respond to the commitment allegations. *In re Commitment of MG*., 331 *N.J. Super*. 365 (App. Div. 2000). *See also Brehm v. Pine Acres Nursing Home, Inc*. 190 *N.J. Super* 10, 3 (App. Div. 1983).

[7] *See also*, *N.J.S.A*. 30:4-27.2(h) for definition of "Dangerous to Self;" *N.J.S.A*. 30:4-27.2(i) for definition of "Dangerous to Others or Property;" and *N.J.S.A*. 30:4-27.2(r) for definition of "Mental Illness."

> 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. *N.J.S.A.* 30:4-27.2(m)

See Section VI.C. "Standard of Commitment.

F. REQUIRED ELEMENTS OF CERTIFICATES

1. Clinical Certificate: *N.J.S.A*. 30:4-27.2(b).

   - must be in prescribed form;[8]
   - must be prepared and executed by a psychiatrist or physician having conducted an examination of the person within three days of presenting the person for admission to a facility (other than the screening service);
   - must include the psychiatrist's/physician's conclusion that involuntary commitment is needed;
   - must include specific facts upon which conclusion is based;
   - must not be completed/executed by a relative (by blood or marriage) of the person subject to commitment;[9] and
   - must be certified in accordance with *R*. 1:4-4(b).

[8] *See*, *infra*, screening/clinical certificate.

[9] *See also N.J.S.A*. 30:4-27.10(e).

2. Screening Certificate*: N.J.S.A*. 30:4-27.2(y).

- must comply with all required elements of clinical certificate, set forth above; and

- the psychiatrist/physician[10] must be affiliated with a screening service.

G. CONTENTS OF ORDER OF TEMPORARY COMMITMENT

R. 4:74-7(c) requires that a temporary order of commitment include:

1. A place and date certain for the initial commitment hearing, which shall be within 20 days from the initial commitment to treatment;

2. Assignment of counsel to present the case for involuntary commitment;

3. Assignment of counsel to an unrepresented patient;

4. The persons to be notified by the county adjuster of the admitting county of the time and place of the hearing, *N.J.S.A*. 30:4-27.13(a);

5. The mode of service of the hearing notice;

6. The date by which the hearing notice must be served, at least 10 days prior to the court hearing, *N.J.S.A*. 30:4-27.13(a); and

7. The directive that copies of the clinical and screening certificates, as well as any other supporting documents, the temporary court order and a statement of patient's rights at the court hearing be served upon the patient and the patient's attorney, *N.J.S.A*. 30:4-27.13(a).

H. REVIEW OF REQUIREMENTS FOR ENTRY OF ORDER OF TEMPORARY COMMITMENT

[10] *See, supra,* note 1.

Referral from a Screening Service:

- Has the individual been detained in a facility for more than 72 hours from the time the screening certificate was completed? If yes, the order of temporary commitment cannot be entered.

- Has a screening certificate been completed by a psychiatrist or physician affiliated with the screening service?

- Has a clinical certificate been completed by a psychiatrist or physician on the patient's treatment team?

- Was at least one of the two submitted certificates completed by a psychiatrist? If not, the application is not complete and the order should not be entered.

- Were the screening certificate and the clinical certificate completed by the same psychiatrist? If yes, has the psychiatrist made a reasonable but unsuccessful attempt to have another psychiatrist conduct an evaluation and execute the certificate.

- Is any person completing a screening certificate or clinical certificate related by blood or marriage to the person being examined? If yes, the document may not be accepted.

- Were copies of the two documents filed with the office of the county adjuster?

Contents of the Screening and Clinical Certificates:

- Are the certificates in the prescribed form?
- Do the certificates state the conclusion that involuntary commitment is needed, *i.e.*, that the person is mentally ill, that the mental illness causes the person to be a danger to self, others or property, that the individual is unwilling to be admitted voluntarily for care, and that there are no other appropriate facilities or services available?
- Are there specific facts supporting the conclusion that commitment is needed? Are all sections completed?
- Are they properly certified in accordance with *R*. 1:4-4(b)?

Standard of Review

- Is there probable cause to believe that the person is in need of involuntary commitment, *i.e.*, is there probable cause to believe that the person is mentally ill, that the mental illness causes the person to be a danger to self, others or property, and that there are no other appropriate facilities or services available? If yes, the judge may enter an order of temporary commitment authorizing the admission to or retention of custody by a facility pending a final hearing.

Contents of Order of Temporary Commitment

- Is there a place and date certain for the initial commitment hearing?
- Is the hearing scheduled within 20 days of the initial commitment to treatment?
- Is there an assignment of counsel to present the case for involuntary commitment?
- Is there assignment of counsel for an unrepresented patient?
- Does the order contain a list of persons to be notified by the county adjuster of the time and place of the hearing?
- Is the mode of service of the hearing notice specified?
- Does the order contain the date by which the hearing notice must be served, at least 10 days prior to the court hearing?
- Does the order specify that copies of the clinical and screening certificates, as well as any other supporting documents, the order for temporary commitment, and statements of patient's rights at the court hearing be served on the patient and the patient's attorney?

Alternate Referral (not from screening service)

- Are there two clinical certificates completed by physicians, one of whom must be a psychiatrist? There will be no screening certificate.
- Are the certificates prepared and executed by a psychiatrist or physician who has conducted an examination of the person within three days of presenting the person for admission to a facility. If no, the application must be rejected. The required

contents of the certificates and order are the same as for a screening service referral.

- If the application is made for a voluntary patient who is seeking to be discharged, but whose treatment team believes is in need of involuntary commitment, has the patient been detained for more than 48 hours after the request or until the end of the next working day, whichever is later? If yes, the order of temporary civil commitment cannot be entered.
- If the application is made for an inmate scheduled for release upon expiration of the maximum term of incarceration and the court finds that there is probably cause to believe the individual is in need of involuntary commitment, is the final hearing date scheduled and has the Commissioner of the Department of Corrections been authorized to arrange for temporary commitment to the AKFC or other facility designed for the criminally insane pending the final hearing and prior to the expiration of the prison term? Does the order specifically provide for the transfer of custody to the AKFC or other facility designed for the criminally insane if the maximum term will expire prior to the hearing?
- If the application is made for an individual on CEPP status, have all the procedural requirements of *R*. 4:74-7 been met?

IV. PRE-HEARING EVENTS

A. DISCOVERY

Patient's attorney or guardian *ad litem* has the right to inspect and copy all records relating to the patient's mental condition, including the patient's clinical chart, notwithstanding any rule, regulation or policy of confidentiality. *R*. 4:74-7(d); *N.J.S.A*. 30:4-27.11(c). The court may also order testing or examination of the patient by an independent psychiatrist, psychologist, or other expert. *R*. 4:74-7(d). Any expert witness who is to testify shall prepare a written report and shall make it available to the court and all counsel no later than one business day prior to the hearing. *R*. 4:74-7(e). The report shall be in a form prescribed by the Department of Human Services and approved by the Administrative Director of the Courts.

B. ADJOURNMENTS

1. Initial hearings must be held within 20 days from initial commitment to treatment. *N.J.S.A*. 30:4-27.12. Although the initial hearing can be adjourned for up to 14 days beyond the originally prescribed 20 days, *R*. 4:74-7(c)(1), this should be done only in "exceptional circumstances and for good cause shown in open court."[11] For example, an emergency closure of the courthouse or unavoidable and unexpected absence of a treating psychiatrist scheduled to testify could qualify as exceptional. *See In the Matter of the Commitment of M.M.*, 384 N.J. Super. 313, 331 (App. Div. 2006).

   Efforts to avoid the necessity for an adjournment could include, for example, the court asking the hospital to designate an alternate psychiatrist to examine the patient and review the

[11] *See In re Matter of Z. O.,* 197 *N.J. Super.* 330, 339 (App. Div. 1984), holding that although an untimely hearing would not result in the dismissal of the commitment case, "statutory time limits on restricting the liberty of person should not be casually disregarded." *See also In the Matter of the Commitment of M.M.,* 384 *N.J. Super.* 313 (App. Div. 2006), holding that, in the absence of a request by the patient, the circumstances authorizing the extension of the statutory deadline must be atypical rather than routine and reasonably unforeseen or unavoidable, rather than within the reasonable control of the state or the court; holding further that "good cause" exists when the state's interest in extending the time for a hearing due to exceptional circumstances substantially outweighs the patient's interest in terminating a confinement that is not supported by clear and convincing evidence of the existence of grounds for commitment.

patient's records, in order to testify where the treating psychiatrist is unavailable due to vacation or illness.

2. Where an adjournment is sought because of the recent transfer of the individual from a short-term care facility or special psychiatric hospital to a state or county psychiatric hospital, the court should consider as background the provisions of *N.J.S.A.* 30:4-27.10(i).

   That section provides that such transfer is prohibited within five days prior to the hearing unless an unexpected change in the patient's clinical conditions occurs, necessitating the transfer. Moreover, the patient, patient's family and attorney must be given 24 hours advance notice of the pending transfer and the transfer is to be accomplished in a manner which will give the receiving facility adequate time to examine the patient, become familiar with the patient and prepare for the hearing.

V. INITIAL COMMITMENT HEARING — PROCEDURAL

A. TIMING AND LOCATION OF HEARING

1. Initial hearing must be held within 20 days from initial commitment to treatment. *N.J.S.A*. 30:4-27.12. Initial hearings for involuntary inpatient civil commitment will generally proceed in person but may proceed virtually with the consent of all parties; consent of a party will not be required if that party is absent and unreachable. *See* October 27, 2022 Order on the Future of Court Operations (attached in Appendix). Pursuant to *R*. 4:74-7A(b)(2), commitment hearings for minors are to be scheduled within 14 days after the initial inpatient admission. *See* Section XIV for more information about the commitment of minors.

2. The hearing, if possible, takes place at the hospital.

B. CONDUCTING THE HEARING

1. Because involuntary commitment to a mental hospital deprives the committee of important liberty interests, the procedural and substantive safeguards established by statute and Court Rules "...must be scrupulously followed," even when 76 hearings are scheduled for one day.[12] *In the Matter of Commitment of Raymond S.,* 263 *N.J. Super.* 428, 432 (App. Div. 1993).

2. The vicinage responsible for conducting the commitment hearing must assign a Sheriff's Officer to provide security at the hearing.

3. All witnesses must be sworn.

4. The entire proceeding is on the record. The testimony must be either stenographically recorded or tape-recorded. (If tape-

[12] The Appellate Division indicated that while a trial judge presented with long hearing calendars is placed under considerable time constraints, "...those in charge of calendaring must be sensitive to the rights of patients and the requirements of due process." *In the Matter of Commitment of Raymond S., supra.,* 263 *N.J. Super.* at 432.

recorded, guidelines contained in AOC Manual on Sound Recording should be followed.)

5. The patient "has the right to a hearing *in camera*." *N.J.S.A*. 30:4-27.14(e).[13] Records and transcripts of civil commitment proceedings are excluded from public access. *R*. 1:38-3(f)(2).

6. Although the hearing is *in camera*, the patient's family may attend and testify at the court hearing "if the court so determines." *N.J.S.A*. 30:4-27.13(c).

7. The case for involuntary commitment must be presented by county counsel or county adjuster. *N.J.S.A.* 30:4-27.12(b). It is inappropriate for the judge to advance the case for commitment "...because it places the judge in the role of an adversary rather than that of a neutral decision maker." *Matter of the Commitment of Raymond S., supra,* 263 *N.J. Super.* at 432.

8. The Attorney General may assume responsibility for presenting any case for involuntary commitment or may participate with county counsel in presenting any such case. *N.J.S.A.* 30:4-27.12(c)(1). The Attorney General may apply to the court for an order compelling the psychiatric evaluation of a person where public safety requires initiation of commitment proceeding. *N.J.S.A*. 30:4-27.10(d). The county prosecutor may assume responsibility for or participate in presenting a case for involuntary commitment at the request of the Attorney General or in any case initiated by the prosecutor and may initiate an application by involuntary commitment of an inmate who is scheduled for release upon expiration of a maximum term of incarceration. *N.J.S.A.* 30:4-27.12(c)(1) and (2). *In re Civil Commitment of J.G.*, 322 *N.J. Super*. 309 (App. Div. 1999).

9. The case for involuntary commitment must be supported by the oral testimony of a psychiatrist on the patient's treatment team. *R*. 4:74-7 (e). At an initial hearing, testimony of a non-psychiatrist physician is not a permissible substitute. *See Matter*

[13] The hearings are *in camera* except for *Krol* hearings, *Matter of Edward S.*, 118 *N.J.* 118 (1990); *Matter of the Commitment of Calu*, 301 *N.J. Super*. 20 (App. Div. 1997) (holding that there is a presumption that the hearing for a person civilly committed after acquitted of murder by reason of insanity who is seeking release from a mental hospital should be held in open court. *R*. 3:19-2.)

of Commitment of P.D., 381 *N.J. Super.* 389, 394 (App. Div. 2005); *Matter of Commitment of Raymond S., supra,* 263 *N.J. Super.* at 432.

a. Testimony must be based on personal examination, not review of written medical records alone. *N.J.S.A.* 30:4-27.13(b).

b. The personal examination which forms the basis of the testimony must be no more than five days prior to the court hearing. *R.* 4:74-7(e); *Matter of Commitment of P.D.*, *supra,* 381 *N.J. Super.* at 394.

10. Other members of the treatment team may also testify. *N.J.S.A.* 30:4-27.13(b); *R.* 4:74-7(e). Other witnesses with relevant information may be offered by the patient or the attorney presenting the case for civil commitment. *N.J.S.A.* 30:4-27.13(b). They may be permitted to provide testimony in the form of opinion only if the requirement of *N.J. Evid. R.* 701 are met.[14] The patient's next-of-kin may also testify, if the court permits. *R.* 4:74-7(e).

11. The patient may not appear at the hearing *pro se*. *N.J.S.A.* 30:4-27.12(d); *R.* 4:74-7(e). Counsel is always necessary. Caution should be exercised where family retains counsel for the patient, in order to ensure that counsel's loyalty is solely to the patient.

12. The patient has the right, through counsel, to present evidence and cross-examine witnesses. *N.J.S.A.* 30:4-27.14; *R.* 4:74-7(e). *See Matter of Commitment of Raymond S., supra,* 263 *N.J. Super.* at 432; *Matter of the Commitment of D.M.,* 313 *N.J. Super.* 449, 453 (App. Div. 1998); *Matter of Commitment of P.D., supra.*

13. Rules of evidence apply to medical and business records. "Court needs sufficient information to consider the trustworthiness of

[14] *N.J. Evid. Rule* 701 provides:

Opinion Testimony of Lay Witness
If a witness is not testifying as an expert, the witness' testimony in the form of opinions or inferences may be admitted if it (a) is rationally based on the perception of the witness and (b) will assist in understanding the witness' testimony or in determining a fact in issue.

the sources of information or the method, purpose or circumstances of preparation." *Matter of Commitment of J.B.,* 295 *N.J. Super*. 75, 78-79 (App. Div. 1996) (citing *N.J.R.E*. 803(c)(6) "[a] statement contained in a writing or other records of acts, events, conditions, and, subject to Rule 808, opinions or diagnoses, made at or near the time of observation by a person with actual knowledge or from information supplied by such a person, if the writing or other record was made in the regular course of business and it was the regular practice of that business to make it, unless the sources of information or the method, purpose or circumstances of preparation indicate that it is not trustworthy.").

14. The patient has the right to be present at the hearing. A court can suspend this right where "the court determines that because of the person's conduct at the hearing the proceeding cannot reasonably continue while the person is present." *N.J.S.A*. 30:4-27.14(b).[15] *R*. 4:74-7(e). *See In the Matter of the Commitment of K.F.,* 244 *N.J. Super.* 550 (App. Div. 1990), which held that an involuntary patient has a right to be present at the patient's review hearing even though listening to the treating doctor's testimony may adversely affect future treatment.

15. The patient has the right to testify at the hearing. *R*. 4:74-7(e).

16. Patient's counsel is entitled to seek an order requiring the person or public body charged with the patient's legal settlement to pay for the cost of an independent examination by a psychiatrist, psychologist or other expert. *R*. 4:74-7(d).

17. Court must make findings of fact and conclusions of law to support commitment. *R.* 1:7-4; *Matter of Commitment of D.M., supra,* 313 *N.J. Super*. at 454.

18. An order should be signed at the conclusion of each case before proceeding to the hearing of the next matter.

19. The period for the next scheduled review hearing should be specified (three months, six months, etc.).

[15] Compare prior practice: *R*. 4:74-7(e) had previously allowed the Court to exclude the patient from the courtroom during all or part of the testimony for "good cause."

C. REVIEW OF PROCEDURAL ASPECTS OF HEARING

Discovery

- Have all records, including the patient's clinical chart, been provided to patient's counsel or guardian *ad litem*?
- Has written report of expert witness been provided to court and counsel at least one day prior to the hearing? Is the report in the form prescribed by the Department of Human Services and approved by the Administrative Office of the Courts?

Notice

- Did the appropriate individuals (Patient, patient's guardian if any, patient's next-of-kin, patient's attorney, patient's custodian, county adjuster, etc.) receive notice of the hearing at least ten days prior to the court date?
- Did the notice specify the date, time and location of the hearing?
- Did the patient and the patient's attorney 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?

Timing and Location of Hearing

- Is hearing scheduled within 20 days from initial commitment to treatment?
- If an adjournment has been sought, has it been based on exceptional circumstances and for good cause shown?
- Is the hearing scheduled to take place at the hospital where the patient is admitted?

Conducting the Hearing

- Has the vicinage responsible for holding the hearing arranged for security at the hearing?
- Have all witnesses been sworn in?
- Is the proceeding being recorded either stenographically or on tape?
- If the patient has requested an in camera hearing, has that request been honored?

- Has the patient's family been permitted to attend the hearing? If a family member wishes to testify, has the court made a ruling?
- Is the case for involuntary commitment being presented by either county counsel, county adjuster, county prosecutor or attorney general?
- Has the psychiatrist on the patient's treatment team examined the patient personally within five days of the court date prior to giving testimony?
- Is the patient represented by counsel? If not, the hearing cannot go forward.
- Is the patient present at the hearing? If not, has the judge made a determination regarding the patient's conduct?
- If the patient requests to testify, has the judge permitted the testimony?
- Has the court provided findings of fact and conclusions of law to support the decision on voluntary commitment?
- If involuntary commitment is ordered, does the court order contain the time frame for the review hearing?
- Is the order signed by the judge?

VI. INITIAL COMMITMENT HEARING – SUBSTANTIVE LAW

A. BURDEN OF PROOF

Burden of proof rests with the State. *In re S.L.,* 94 *N.J.* 128, 137 (1983).

B. STANDARD OF PROOF

1. The State must demonstrate by clear and convincing evidence that the patient needs continued involuntary commitment. *N.J.S.A.* 30:4-27.15(a); *Addington v. Texas,* 441 *U.S.* 418 (1979); *In re S.L., supra.* Note, however, that the continued involuntary commitment of a defendant found not guilty by reason of insanity is established by a preponderance of the evidence, during the maximum period of imprisonment that could have been imposed. *N.J.S.A*. 2C:4-8b(3); *I/M/O Commitment of M.M.*, 377 *N.J. Super.* 71 (App. Div. 2005), *aff'd* 186 *N.J.* 430 (2006) (holding that a trial court is not to consider statutory aggravating and mitigating factors in determining the length of the civil commitment for a defendant found not guilty by reason of insanity).

2. Evidence is "clear and convincing" when it produce(s) in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, evidence so clear, direct and weighty and convincing as to enable (the fact finder) to come to a clear conviction, without hesitancy, of the truth of the precise facts in issue." *Matter of Commitment of Robert S.,* 263 *N.J. Super*. 307, 312 (App. Div. 1992), citing *In re Jobes*, 108 *N.J*. 394 (1987).

C. STANDARD OF COMMITMENT

Pursuant to *N.J.S.A.* 30:4-27.2(m), "in need of involuntary commitment" or "in need of involuntary commitment to treatment" means an adult:

- who is mentally ill;

- whose mental illness causes the person to be dangerous to self or dangerous to others or property;

- who is unwilling to 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.

1. "Who is mentally ill...?"

   a. Finding of mental illness is a prerequisite for involuntary commitment. *Matter of Commitment of N.N.* 146 *N.J.* 112, 124 (1996); *Matter of Commitment of P.D., supra.*

   b. It must be established that a person to be committed suffers from a current, substantial disturbance of thought, mood, perception or orientation which significantly impairs judgment, capacity to control behavior or capacity to recognize reality. 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 above. *N.J.S.A.* 30:4-27.2(r).

   c. Medical terminology cannot substitute for statutory standard, *i.e*. substantial disturbance of thought, mood, perception or orientation. *Matter of Commitment of D.M. supra,* 313 *N.J. Super*. at 450

   d. Mental illness alone cannot serve as the basis for involuntary commitment. *In re S.L., supra,* 94 *N.J.* at 137-138*, Boesch v. Kirk***,** 97 *N.J.L* 92, 95 (1922).

   e. Mental illness 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 in paragraph (b) above. *N.J.S.A.* 30:4-27.2(r).

2. "...whose mental illness causes the person to be dangerous to self or dangerous to others or property..."

a. "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 (see paragraphs (i), (ii) and (iii) below), 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. *N.J.S.A.* 30:4-27.2(h).

(i) Persons able to satisfy needs for nourishment, essential medical care or shelter with the assistance and supervision of others who are willing and available are not to be deemed unable to satisfy their needs. *See, In re S.L., supra,* 94 *N.J.* at 138, citing *O'Connor v. Donaldson*, 422 *U.S*. 583 (1975). *See also, Matter of Commitment of Raymond S.*, *supra,* 263 *N.J. Super*. at 433-34 (failure to take medication prior to commitment, refusal to talk to psychiatrist do not constitute clear and convincing evidence of dangerousness).

(ii) Court must find that it is probable that substantial bodily injury, serious physical debilitation or death will result in the reasonably foreseeable future from patient's inability to satisfy patient's needs. *In re Matter of Newsome*, 176 *N.J. Super*. 511 (App. Div. 1980) (concern about the potential ill effects of a failure to take medication is insufficient to support a commitment).

(iii) Court declined to expand judicial standards of commitment to include "an individual who by

reason of mental illness is unable to care for himself without some level of aid or supervision." *In re S.L.*, *supra,* 94 *N.J.* at 139. *See also*, *In re Matter of S.D.*, 212 *N.J. Super*. 211 (App. Div. 1986) (discussing implications of *In re S.L.*).

b. "Dangerous to others and 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. The determination shall take into account a person's history, recent behavior and any recent act, threat, or serious psychiatric deterioration. *N.J.S.A*. 30:4-27.2(i). *See State v. Krol*, *supra,* 68 *N.J*. at 259-262 and in *State v. Fields*, 77 *N.J*. 282 (1978)[16] noting the following:

- Dangerous conduct is not identical with criminal conduct.
- Dangerous conduct involves not merely violation of social norms but significant injury to person or substantial destruction of property.
- Persons are not to be confined because they present a risk of future conduct that is merely socially undesirable, even if conduct is odd, disagreeable or offensive or a public nuisance.
- Evaluation of the magnitude of the risk involves consideration both of the likelihood of dangerous conduct and the seriousness of the harm which may ensue if such conduct takes place.

[16] *See also*, *In the Matter of R.B.*, 158 *N.J. Super*. 542 (App. Div. 1978); *In re Matter of J.L.J.*, 196 *N.J. Super*. 34 (App. Div. 1984), *certif. denied* 101 *N.J*. 210 (1985); *In re Matter of B.S.*, 213 *N.J. Super*. 243 (App. Div. 1986); *Matter of Commitment of Raymond S.*, *supra.*

- It is not sufficient that the state establish a possibility that a person might commit some dangerous acts at some time in the indefinite future. The risk of danger must be substantial and within the reasonably foreseeable future. *State v. Krol*, *supra*; *Matter of Robert S.*, *supra.*

- Certainty of prediction of conduct is not required and cannot reasonably be expected.

- A person may be dangerous in only certain types of situations or in connection with relationships with certain individuals. An evaluation of dangerousness in such cases must take into account the likelihood that the person will be exposed to such situations or come into contact with such individuals.

- Past conduct is important evidence and may be given substantial weight in evaluation of patient's present mental condition and predicting future conduct.

- The determination of dangerousness involves a delicate balancing of society's interest in protection from harmful conduct against the individual's interest in personal liberty and autonomy.

- Determination of dangerousness is one to be made by the judge and not medical experts.

c. Psychological harm (*e.g*. abusive speech, hollering, and erratic behavior) to family not considered serious bodily harm upon another person absent testimony by a psychiatrist, psychologist, or other qualified professional. *Matter of Commitment of A.A.*, 252 *N.J. Super*. 170, 179 (1991).

3. <u>"...who is unwilling to be accept appropriate treatment voluntarily after it has been offered…"</u>

Even if the State is able to meet the requisite proofs of mental illness and dangerousness required for involuntary civil commitment, and the patient does not refuse the prescribed care on a voluntary basis, the patient should be admitted as a voluntary patient. *In re M.D.*, 251 *N.J. Super*. 19 (Ch. Div. 1991); *N.J.S.A*. 30:4-27.2(m); *See also, In the Matter of the Commitment of A.A.*, *supra,* 252 *N.J. Super*. at 177-178.

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

   a. Statute requires consideration of whether the person's mental health care needs and danger presented can be alleviated by some means short of involuntary commitment. *Matter of Commitment of D.M., supra,* 313 *N.J. Super.* at 456.

   b. State must present evidence concerning alternative disposition. *Matter of Commitment of J.B., supra, 295 N.J. Super*. at 80, citing *R*. 4:74-7(f); *N.J.S.A*. 30:4-27.15(a); and *N.J.S.A*. 30:4-27.9(d).

   c. Screening document must include information concerning consideration of available alternative facilities which were considered and deemed inappropriate at the time of initial admission. *N.J.S.A.* 30:4-27.5(b).

   d. Under the New Jersey Patients Bill of Rights, each patient has a right to treatment in the least restrictive conditions necessary to achieve the purpose of treatment. *N.J.S.A.* 30:4-24.2(e)(2).

D. LEGAL REFERENCES

Statute:
N.J.S.A. 30:4-27.1 *et seq*. (*See* appendix)

Court Rule:
Rule 4:74-7 (*See* appendix)

Relevant Case Law:

Addington v. Texas, 441 *U.S*. 418 (1979)

Boesch v. Kirk, 97 *N.J.L*. 92 (1922)

I.M.O. Commitment of C.M., 458 *N.J. Super.* 563 (App. Div. 2019)

Brehm v. Pine Acres Nursing Home Inc., 190 *N.J. Super*. 103 (App. Div. 1983)

I/M/O Commitment of M.M., 377 *N.J. Super*. 71 (App. Div. 2005), *aff'd* 186 *N.J.* 430 (2006)

In the Matter of the Commitment of K.F., 244 *N.J. Super*. 550 (App. Div. 1990)

In the Matter of the Commitment of M.M., 384 *N.J. Super* 313 (App. Div. 2006)

In the Matter of Commitment of Raymond S., 263 *N.J. Super*. 428 (App. Div. 1993)

In the Matter of the Commitment of T.J., 401 *N.J. Super.* 111(App. Div. 2008)

In re Civil Commitment of J.G., 322 *N.J. Super*. 309 (App. Div. 1999)

In re Commitment of M.G., 331 *N.J. Super.* 365 (App. Div. 2000)

In re Matter of B.S., 213 *N.J. Super*. 243 (App. Div. 1986)

In re Matter of J.L.J., 196 *N.J. Super.* 34 (App. Div. 1984), *certif. denied* 101 *N.J*. 210 (1985)

In re Matter of Newsome, 176 *N.J. Super*. 511 (App. Div. 1980)

In the Matter of R.B., 158 *N.J. Super*. 542 (App. Div. 1978)

In re Matter of S.D., 212 *N.J. Super.* 211 (App. Div. 1986)

In re Matter of Z. O., 197 *N.J. Super*. 330 (App. Div. 1984)

In re M.D., 251 *N.J. Super*. 19 (Ch. Div. 1991)

Matter of Commitment of A.A., 252 *N.J. Super*. 170 (1991)

Matter of the Commitment of Calu, 301 *N.J. Super*. 20 (App. Div. 1997)

Matter of the Commitment of D.M., 313 *N.J. Supe*r. 449 (App. Div. 1998), *certif. denied* 144 *N.J*. 377(1996)

Matter of Commitment of J.B., 295 *N.J. Super*. 75 (App. Div. 1996)

Matter of Commitment of N.N., 146 *N.J*. 112 (1996)

Matter of Commitment of P.D., 381 *N.J. Super*. 389(App. Div. 2005)

Matter of Commitment of Robert S., 263 *N.J. Super*. 307(App. Div. 1992)

Matter of Edward S., 118 *N.J*. 118 (1990)

State v. Fields, 77 *N.J*. 282 (1978)

State v. Krol, 68 *N.J*. 236 (1975)

VII. DECISION BY THE COURT

Upon the conclusion of an initial hearing for an involuntarily committed patient, the court shall issue an order[17] from among the following four options:

1. Continuing involuntary commitment. *N.J.S.A*. 30:4-27.15.a

2. Finding the patient does not need continued involuntary commitment and entering an order of discharge. *N.J.S.A*. 30:4-27.15.b

[17] *See* form of Order, *infra*.

3. Discharging the patient subject to conditions recommended by the facility and mental health agency staff and developed with the participation of the patient (usually regarding medication or continued treatment). *N.J.S.A.* 30:4-27.15.c

4. Authorizing the Conditional Extension Pending Placement (CEPP) of the patient's hospitalization when a patient, otherwise entitled to discharge, cannot be immediately discharged due to the unavailability of an appropriate placement. *R*. 4:74-7(g)(2); *In re S.L.*, *supra*

A. INVOLUNTARY COMMITMENT

The court shall determine whether a patient who has been found to need continued involuntary commitment to treatment pursuant to *N.J.S.A.* 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, in accordance with *N.J.S.A.* 30:4-27.15a. 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. DISCHARGE

If the court concludes that the evidence does not warrant continued commitment, an order of discharge shall be entered.

The facility shall discharge the patient as soon as practicable but no later than 48 hours after the court's verbal order or by the end of the next working day, whichever is later. *N.J.S.A*. 30:4:27.15(b); *R*. 4:74-7(h)(1).

C. CONDITIONAL DISCHARGE

1. An Order of Conditional Discharge discharges the patient subject to conditions recommended by the facility and mental health

agency staff and developed with the participation of the patient.[18] *N.J.S.A*. 30:4-27.15(c); *R*. 4:74-7(h)(1); *Cf*. *State v. Carter*, 64 *N.J*. 382 (1974).

2. Conditions may only be imposed by the court if it finds pursuant to *N.J.S.A.* 30:4-27.15(c)(1) that:

   a. the patient's history indicates a high risk of rehospitalization because of the patient's failure to comply with discharge plans, or

   b. there is a substantial likelihood that due to mental illness, the patient will be dangerous to self, others, or property if the patient does not receive the services that render involuntary commitment unnecessary.

3. Conditions must be specific and may not exceed 90 days. Conditions may be imposed for a longer period of time in a case in which the Attorney General or county prosecutor participated. If the court imposes conditions for a period exceeding six months, the court shall provide for a review hearing not later than six months from entry of the order. *N.J.S.A.* 30:4-27.15(c)(2); *R*. 4:74-7(h)(1).

4. An order of conditional discharge may only be revoked and the patient recommitted only if the standard for initial commitment is satisfied. *Matter of Commitment of B.L. & M.W.*, 346 *N.J. Super.* 285, 309 (App. Div. 2002).

   a. *N.J.S.A.* 30:4-27.15(c)(3) provides: 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[19] and, if so, the patient shall be returned to the facility. The court shall hold a hearing within 20 days

[18] Accordingly, conditional discharge is only appropriate for individuals who are civilly committed.

[19] *See* appendix – Assignment Jude Memorandum dated August 20, 2003 – Procedures for Rehospitalization of Patients on Conditional Release

of the day the patient was returned to the facility to determine if the order of conditional discharge should be vacated.

D. CONDITIONAL EXTENSION PENDING PLACEMENT (CEPP) PURSUANT TO RULE 4:74-7(h)(2)

1. The Court may enter an order of CEPP when a patient no longer satisfies the standard for involuntary commitment, but cannot be discharged to live on the patient's own or with family and there is no appropriate placement immediately available.[20] The intent of this order is to discharge the patient as soon as an appropriate placement is found. When a CEPP Order is entered, the patient is no longer committed.

2. CEPP is not appropriate for patients who have a place to live but for whom the hospital has not yet made arrangements for follow-up care in the community. *Matter of Commitment of G.G.,* 272 *N.J. Super.* 597 (App. Div. 1994); *see also Matter of Commitment of B.L., supra,* 346 *N.J. Super.*at 308; *In re Commitment of M.C.,* 385 *N.J. Super.*151, 162 (App. Div. 2006). The Court should not order CEPP where there is no evidence presented of "the unavailability of an appropriate placement." *Matter of Commitment of G.G., supra,* 272 *N.J. Super*. at 605. The term "appropriate placement" as used in *R*. 4:74-7(h)(2) refers to a facility that will provide continuing support and assistance through the day to people who are incapable of survival on their own *e.g.*., elderly patients who have lost their personal capacity to survive due to the effects of prolonged hospitalization. *In re S.L.*, *supra*, 94 *N.J.* at 139-140. The phrase "appropriate placement" must be based on the justification for the CEPP exception to the general rule requiring release of those who are not dangerous within the meaning of *N.J.S.A*. 30:4-27.2(h), (i). Justification is based on the patient's incapacity to survive. *In re S.L.*, *supra*, 94 *N.J.* at 140; *In re Commitment of M.C., supra*, 385 *N.J. Super.* at 163. CEPP is not a fallback option when the state cannot implement a discharge plan within

[20] CEPP was formerly known as DPP (Discharged Pending Placement). The DPP status originated by administrative order of Chief Justice Hughes, dated July 28, 1978, and its concept was not incorporated into a court rule until January 1, 1988. The court rule was adopted after the Supreme Court's opinion *In re S.L.*, *supra*, directed the Supreme Court's Task Force on Mental Commitments to recommend a rule.

48 hours. Nor is it a means through which the judge may delay a conditional release. *In re Commitment of M.C., supra*. Fear of potential relapse and recidivism is not legally sufficient to maintain an individual on CEPP status. *I/M/O Commitment of T.J.,* 401 *N.J. Super.* 111 (App. Div. 2008).

3. Once an order of CEPP has been entered, the individual can be recommitted only if the procedures of *N.J.S.A*. 30:4-27.1 *et seq*. and *R*. 4:74-7 are met. A CEPP Order cannot be summarily revoked. *In re S.L*.

4. When a judgment of CEPP is entered, the court "shall inquire into the needs of the individual for custodial and supportive care, the desires of the individual regarding placement, the type of facility that would provide the needed level of care in the least restrictive manner, the availability of such placement, the efforts of the state to locate such placement and any other matters it deems pertinent. *In re S.L.*

5. If DDD is involved the court should inquire into whether eligibility has been established for DDD, and what efforts are being made by the hospital to facilitate placement. *See In re Matter of B.R.,* 202 *N.J. Super.* 182 (App. Div. 1985). In most cases, the commitment court cannot require DDD to provide services for a patient before DDD has made a determination of eligibility.

6. As long as the patient remains physically in the hospital under a CEPP Order, the patient's case must receive periodic review. Such a review is known as a "CEPP review hearing" or "placement review hearing" to differentiate it from periodic review of a patient still under an order of involuntary commitment.

7. The first such placement review hearing is held within 60 days from the entry of the CEPP judgment. Prior to the review hearing, the hospital employee who has primary responsibility for placing the patient shall prepare a written report and shall make it available to the court and all counsel no later than one business day prior to the hearing. *R.* 4:74-7(h)(2). At the placement review hearing, the Court:

a. reviews the needs and desires of the patient regarding placement and the recommendations of the hospital regarding placement.

b. reviews the efforts made by the hospital to locate a suitable placement. The court "must determine whether the State has undertaken all good faith efforts necessary to place the individual in an appropriate setting outside the mental institution." *In re S.L.*, *supra*. 94 *N.J.* at 141. If the court is advised that an appropriate placement is available, it shall order such placement. *R*. 4:74-7(h)(2).

c. determines whether in the interim the hospital has placed the individual in the least restrictive setting in the institution.

d. determines whether "all reasonable efforts within available resources (are being) made to improve the individual's ability to function in a placement outside the hospital." *In re S.L.*, *supra,* 94 *N.J.* at 141.

e. reviews the written report prepared by the employee who has primary responsibility for placing the patient. This report shall be made available to the court and to counsel at least one business day prior to the hearing. *R*. 4:74-7(h)(2).

8. If placement has not been accomplished by the time of the first placement review hearing, the court should set the matter down for a second placement review hearing no later than six months after the initial CEPP hearing. Subsequent placement review hearings shall occur at least every six months until the individual is physically discharged. The court shall inquire into the same factors as in the initial placement review hearing. *R*. 4:74-7(h)(2).

9. The patient has the right to counsel in all placement review hearings. *R*. 4:74-7(h)(2).

10. Notice of the date, time and place of all such hearings shall be given to the patient and the patient’s counsel no later than ten days prior to the hearing. At the placement review hearing,

counsel has the right to introduce evidence and cross-examine. Counsel is also entitled to inspect and copy all records relating to the patient's condition (including clinical chart and records relating to placement) in advance of the hearing. *R*. 4:74-7(h)(2).

11. If an appropriate placement becomes available in the interval between hearings, the patient must be administratively discharged to such placement. *R*. 4:74-7(h)(2).

12. Court has discretion to require that a report be submitted by the parties within a six-month period following placement as to the overall adequacy of the placement. *In re S.L., supra*, 94 *N.J.* at 141-42.

13. At any time thereafter, any party or the court on its own motion may reinstitute proceedings concerning the individual's placement. *In re S.L.*, *supra*, 94 *N.J*. at 142.

VIII. DURATION AND EFFECT OF COMMITMENT ORDERS

Any court order of involuntary commitment, including a temporary order, authorizes but does not compel a hospital or facility to detain a patient. The patient shall be administratively discharged if the treatment team determines that involuntary commitment is no longer necessary. *N.J.S.A*. 30:4-27.17.

A judgment of involuntary commitment does not act as an adjudication of incompetency. *N.J.S.A*. 30:4-24.2(c) expressly states: "[n]o patient may be presumed to be incompetent because he has been examined or treated for mental illness, regardless of whether such evaluation or treatment was voluntarily or involuntarily received." *See also, In re Commitment of S.W.*, 158 *N.J. Super*. 22 (App. Div. 1978).

IX. REVIEW HEARINGS

A. PROCEDURE — SEE DISCUSSION ABOVE AT IV. INITIAL COMMITMENT HEARING - PROCEDURAL

N.J.S.A. 30:4-27.15.a. requires that the court, upon ordering the continuance of involuntary commitment or entering a judgment of conditional extension pending placement, shall schedule a date for a subsequent court review hearing.

1. Scheduling

Periodic review hearings regarding the issue of continuing need for involuntary commitment are required at three, nine and twelve months post initial court hearing and annually (from the date of the initial hearing) thereafter. Additional review hearings may be scheduled at the court's discretion so long as at least 30 days separates hearings or there exist "extraordinary circumstances." *N.J.S.A*. 30:4-27.16; *Matter of Commitment of P.D., supra,* 381 *N.J. Super.* at 394; *R*. 4:74-7(f)(2).

2. Notice Requirements

The notice requirements contained in *N.J.S.A*. 30:4-27.13(a) apply to review hearings.

3. Court Order

Following any review hearing, the court shall execute a new order: (a) continuing the involuntary commitment; (b) discharging the patient; (c) discharging the patient subject to conditions; (d) entering a judgment of conditional extension pending placement; or (e) entering an order converting the involuntary commitment from inpatient to outpatient. *N.J.S.A*. 30:4-27.15, *R*. 4:74-7(h) and R. 4:74-7(f). Therefore, with respect to any involuntarily committed patient, there should always be a court order no less recent than twelve months.

4. Format

Absent an individualized reason to proceed in person based on the facts and circumstances of the case, involuntary inpatient commitment review hearings will be conducted virtually. *See* October 27, 2022 Supreme Court Order on the Future of Court Operations (attached in Appendix).

B. SUBSTANTIVE

1. Burden of Proof

   a. State continues to have the burden of proof at periodic review hearings. *State v. Fields*, 77 *N.J.* 282 (1978).

   b. State must also establish its proofs by "clear and convincing evidence" at the periodic review hearing. *N.J.S.A*. 30:4-27.15(G). *See* Section VI.B. *supra*.

   c. The State must meet the same substantive standard of commitment at the periodic review hearing as it met at the initial hearing. *N.J.S.A.* 30:4-27.16(a). *See* Section VI.C. *supra*.

2. When Testimony of a Psychiatrist is Not Required.

   The testimony of a psychiatrist is not necessary in certain review hearings. Advanced age of the patient or the cause or nature of the mental illness may render it appropriate to rely on the testimony of a non-psychiatrist physician to support the court's findings, if it is impractical to obtain the testimony of a psychiatrist. *N.J.S.A*. 30:4-27.16(b). The physician must have examined the individual no more than five days prior to the hearing. *N.J.S.A*. 30:4-27.16(b).

X. VOLUNTARY COMMITMENT

A. HEARINGS REQUIRED

Rule 4:74-7(g) requires hearings for voluntary adult patients in the following two situations:

1. When a patient wishes to convert to a voluntary status after being involuntarily committed to one of the following:

    a. a short-term care facility (a facility so designated by the Commissioner of the Department of Human Services, *N.J.S.A*. 30:4-27.2(bb));

    b. a psychiatric facility (a state hospital, a county psychiatric hospital, *N.J.S.A*. 30:4-27.2(u)); or

    c. a special psychiatric hospital (a public or private hospital licensed by the Department of Health to provide voluntary and involuntary mental health services, *N.J.S.A*. 30:4-27.2(cc)).

    These hearings are to be held within 20 days of the date of conversion from involuntary to voluntary.

2. When a patient has been evaluated by a screening service and is thereafter admitted as a voluntary patient (no court order of temporary commitment) to one of the following;

    a. a short-term care facility; or

    b. a psychiatric facility.

    These hearings are to be held within 20 days of the date of voluntary admission to the short-term care facility or psychiatric facility.

    Patients must be represented by an attorney at hearings in both instances.

B. ISSUES DETERMINED

The purpose of a voluntary hearing is to determine (1) whether the patient had the capacity to make an informed decision, and (2) whether the decision was made knowingly and voluntarily. *R.* 4:74-7(g)(1) and (2). *See Matter of Commitment of A.A.,* 252 *N.J. Super*. 170 (App. Div. 1991); *In re M.D*., 251 *N.J. Super.* 19 (Ch. Div. 1991).

C. RATIONALE

The rationale for these hearings is set forth in the provisions of the *1990 Civil Practice Committee Report* and the *1989 Mental Commitments Subcommittee Report*. *See also, In re G.M.*, 217 *N.J. Super* 629 (1987)(where the court ordered judicial review of voluntary psychiatric patients although not required by statute or court rule at that time); *Zinermon v. Burch*, 494 *U.S.* 113, 110 *S.Ct*. 975, 108 *L.Ed*. 2d. 100(1990) (where U.S. Supreme Court held that the allegations in the patient's complaint were sufficient to state a §1983 claim in that employees at a state mental treatment facility admitted him as a voluntary patient without ascertaining if he was mentally competent to sign admission forms).

D. PROCEDURES

R. 4:74-7(g) (1) and (2) provide that a voluntary patient must attend the hearing to ascertain that the patient is truly voluntary unless the court is satisfied that the patient does not wish to attend. Hearing notices are to be issued as with involuntary hearings except that the notices for patients voluntarily admitted to a facility (as opposed to those who were involuntarily committed but then converted to voluntary status) are not to be sent to the relatives of such patients unless the patients request so in writing.

E. COURT ORDER

Following the voluntary hearing of an adult, the court shall execute an order stating that (1) the voluntary admission/conversion is approved, or (2) the patient is not voluntary and is thus discharged, or (3) that the patient is not voluntary but meets the standard for involuntary commitment.

F. DISCHARGE OF VOLUNTARY PATIENTS

If a voluntary patient requests discharge, the facility shall discharge the patient as soon as possible but in every case within 48 hours or the end of the next working day from the request, whichever is longer. However, if the treatment team determines that the patient needs involuntary commitment, they shall initiate proceedings for commitment. No patient may be detained more than the 48-hour period unless the court issues a temporary order of commitment. *N.J.S.A.* 30:4-27.20.

XI. INVOLUNTARY OUTPATIENT COMMITMENT

In 2009, Involuntary Outpatient Commitment, or "IOC" was codified into statute. IOC was phased into statewide operation with full implementation achieved in 2015. The purpose of this section is to provide an overview for judges of the applicable law and description of processes and procedures related to IOC.

Under the amended statute, the due process standard for inpatient and outpatient commitment is the same. This section is designed to address only the IOC procedures and judges are encouraged to consider this section in conjunction with the other portions of this manual with respect to inpatient civil commitments.

Once the trial court makes sufficient findings of fact to support its conclusions of law that a patient is mentally ill and dangerous as a result of the patient's mental illness based upon its consideration of the relevant statutory factors, and if the court concludes that the proofs establish that the patient is committable, then a secondary issue is placement. Should the commitment be inpatient or outpatient? Commitment proofs and placement proofs will likely be presented simultaneously, not consecutively.

Judges need to keep them separate, so the appropriate findings are articulated. If inpatient commitment is necessary, the Commissioner of Health will determine the facility. If inpatient commitment is determined to be the correct course of action, the individual is placed into the custody and control of the Commissioner of Health. If outpatient commitment is determined to be the correct course of action, the individual is placed into the custody and control of a State approved outpatient service provider. All twenty-one counties have involuntary outpatient civil commitment service

providers. For outpatient placement, judges must review and approve the treatment plan.

Outpatient treatment plans may include: case management services; community treatment team services, medication; periodic blood tests or urinalysis; individual or group therapy; day or partial day programming activities; educational and vocational training or activities; alcohol or substance abuse treatment and counseling; supervision of living arrangements; and any other services within a local services plan developed to treat the individual's mental illness and to assist the individual in living and functioning in the community, or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in the need for hospitalization. It is a judge's responsibility to determine if the treatment plan is appropriate and adequate to treat the individual.

A. IOC CRITERIA

1. To be committed to outpatient treatment, a person must:

    a. Be an adult (age 18 and over);
    b. Be in need of involuntary commitment;
    c. Not be immediately or imminently dangerous to self, others or property, as determined by the screening medical provider;
    d. Be able to be treated in an outpatient treatment setting, which is the least restrictive setting sufficient to render the person unlikely to be dangerous in the reasonably foreseeable future; and
    e. Be accepted by an appropriate and available IOC provider. *N.J.S.A.* 30:4-27.5.

2. IOC is not appropriate when:

    a. An IOC provider does not offer services adequate to render the person unlikely to be dangerous, including, but not limited to, the kind or intensity of monitoring needed, or a lack of provider openings; or
    b. A person is on Conditional Extension Pending Placement (CEPP) status because the individual no longer meets the involuntary commitment standard; or
    c. An IOC provider's ability to communicate with the person

on a regular basis is significantly impaired because the person lacks stable housing.

d. IOC status is only available for adult consumers; no parental commitments or Children's Crisis Intervention Services "CCIS" hearings should be affected by the existence of IOC. *See R*. 4:74-7A.

B. INVOLUNTARY OUTPATIENT COMMITMENT PROCESS

A person may be involuntarily committed to IOC from the community (through screening or an independent application) or through a change in placement from inpatient commitment to outpatient commitment, which is known as conversion.

IOC from the community most frequently occurs through referral by a screening service; in fact, this is the preferred process for entry into IOC from the community. *N.J.S.A*. 30:4-27.4. Absent an individualized reason to proceed in person based on the facts and circumstances of the case, involuntary outpatient commitment hearings will be conducted virtually. *See* October 27, 2022 Supreme Court Order on the Future of Court Operations (attached in Appendix). The procedures and requirements for initiating IOC through a screening service referral are described in Section D, below.

The procedures and requirements for initiating conversions are further described in Section E, below.

The legal proceedings for involuntary outpatient commitment insure adequate due process protections and generally are the same as those established for involuntary inpatient commitment. *N.J.S.A*. 30:4-27.3. The following is an overview of the process:

- A temporary order of commitment must be obtained within 72 hours of execution of a screening certificate.

- An initial hearing must be held within 20 days of the initial commitment unless the patient is administratively discharged prior to that time. The court will determine whether there is clear and convincing evidence that the patient needs involuntary

commitment to treatment, *N.J.S.A.* 30:4-27.12, and, if yes, determine whether the patient should be admitted to inpatient care or assigned to outpatient treatment. In so doing, "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." *N.J.S.A.* 30:4-27.15(a). If the determination is that the patient should be assigned to outpatient treatment, then the court also must review and approve the proposed plan of outpatient treatment before ordering IOC. *N.J.S.A.* 30:4-27.15a(b).

- Periodic court review hearings for patients committed to outpatient treatment must be held to determine whether there is a continuing need for involuntary commitment and, if yes, the least restrictive environment.

    - The first review hearing is held not more than 6 months after the initial hearing date, the next reviews are at 9 months and 12 months from the first hearing date. Review hearings are held at least annually thereafter.

    - The county adjuster will notify the IOC provider, the patient, attorneys, family members and other interested parties as ordered by the court at least 10 days before each review hearing of the date, time and location of the hearing.

    - The hearings may be held at a courthouse, a hospital, or another place designated by the court.

- The patient in IOC has the same rights with respect to the court hearings as a patient involuntarily committed to inpatient treatment, i.e., the right to be represented by counsel, the right to be present unless the proceeding cannot continue because of the patient's conduct; the right to present evidence and cross examine witnesses, and the right to an in-camera hearing.

- The role of the county counsel is to present the case to

continue commitment. A public defender or attorney paid for by the patient or county represents the patient and can argue for a change in commitment status, a dismissal of the commitment, or a change in the treatment plan.

More specific information regarding the role of the various participants in the IOC process (screening centers, IOC providers, state and county psychiatric hospitals, short term care facilities) is provided in the sections below on those participants.

C. DISCHARGE (FROM LEGAL COMMITMENT STATUS)

1. Judicial discharge

A patient who is subject to an IOC order must be discharged if a court finds that the patient no longer meets the commitment standard. The IOC provider must create a discharge plan that meets the patient's current mental health care needs and must provide the patient with an opportunity to participate in the development of that plan. *N.J.S.A.* 30:4-27.18. When the court discharges a patient against the IOC provider's recommendation, the IOC provider still must provide a discharge plan for the patient.

A. Conditional discharge: A court may discharge a patient from IOC with conditions pursuant to *N.J.S.A.* 30:4-27.l5(c). In such cases, a community-based provider (e.g., Programs of Assertive Community Treatment (PACT) or Integrated Case Management Services (ICMS)) is identified to monitor the patient's adherence to the discharge plan. The court is no longer supervising the discharge plan under the authority of a civil commitment. Adherence to clinical conditions for a conditional discharge is the responsibility of the community-based provider. In sum, neither the court nor the IOC provider is directly involved in supervision conditions once the individual is discharged.

2. Administrative discharge

Between hearings an IOC provider must administratively discharge a patient if the provider determines that the patient no longer needs involuntary commitment to treatment. *N.J.S.A.* 30:4-27.17. An administrative discharge requires the provider to create a discharge plan and offer the patient an opportunity to participate in development of the plan. *N.J.S.A.* 30:4-27.18. The administrative discharge should be reported to the county adjuster for purposes of maintaining an accurate calendar and disposition for the patient.

D. SCREENING SERVICES AND IOC

1. Initial screening commitments to IOC

If the person is deemed in need of commitment, then the screening service staff, in consultation with the psychiatrist, determines the least restrictive environment for appropriate treatment. The following should be considered in making that determination:

A. IOC should not be considered if the person poses an immediate or imminent danger to self, others, or property. Examples of behaviors indicating that a person does not meet criteria for outpatient commitment include actively suicidal; actively destructive of property or threatening to screening center personnel or other people or manifesting intent to do either when able to leave the screening service. If the person poses an immediate or imminent danger, then referral should be made to the short-term care facility or a state, county, or private psychiatric facility.

B. However, if the likelihood of danger is foreseeable but more remote, and the person has a history of improving when treated in the community, the screening center psychiatrist should be asked to evaluate for possible referral to IOC. If the psychiatrist agrees that the person presents a danger

in the reasonably foreseeable future but the danger is not imminent and the person has a history of positive response to outpatient treatment, the screening document and screening certificate should state that the person meets the IOC commitment standard. *N.J.S.A.* 30:4-27.5.

The screening center must determine whether the person is in need of commitment to treatment and, if yes, whether to refer to an inpatient setting or to an outpatient provider within 24 hours of the completion of the screening certificate.

If the screening service determines that the individual is in need of involuntary commitment to outpatient treatment, then it immediately contacts the appropriate IOC provider. *See N.J.S.A.* 30:4-27.5. The IOC provider will determine whether it will accept the person (further detail regarding the IOC provider's role is provided in Section E). If the person is not accepted by the IOC provider, then the person should be referred to an inpatient unit unless the person no longer needs involuntary commitment because of clinical changes occurring since presentation to the screening center. The screening document and certificate should be updated to indicate that the IOC provider rejected the person.

2. Evaluation of patient from an IOC provider

As further discussed in Section E, below, an IOC provider may send a patient committed to IOC to the screening center if it determines that the patient is too dangerous to be treated in the community. Alternatively, the IOC provider may call the screening service and request that it send mobile outreach to assess the patient's condition and the necessity to transport the patient for evaluation for inpatient commitment. DMHAS recommends that the IOC provider and the screening center(s) with which it interacts enter into an affiliation agreement describing this alternative arrangement.

In these cases, the screener should evaluate for both equal and less restrictive alternatives (e.g., changes to the treatment

being provided, different medications or different methods of administration, treatment for side effects, etc.) and for possible need for inpatient care. If the IOC provider is unable to provide alternative treatments; then IOC is unavailable to that person at that time.

If the patient needs inpatient care, the screener may begin an entirely new screening process. However, if the most recent clinical certificate is available and the demographic information is still accurate, the IOC psychiatrist and screening psychiatrist may use pages 12-14 of that certificate (signed by both the IOC psychiatrist and the screening center psychiatrist indicating the new clinical condition) to change the patient's status from outpatient to inpatient and refer the consumer to an STCF, or other hospital as appropriate given the patient's condition.

E. IOC PROVIDER OPERATION

1. Interaction with screening centers

As described above, a screening center promptly will contact the IOC provider when it determines that a person meets criteria for IOC. Before accepting a person, the IOC provider must arrange for a psychiatrist to conduct an evaluation on-site at the screening center or by telepsychiatry to determine whether the IOC program agrees with the screening center's determination that the person is appropriate for IOC. If the IOC provider decides to accept the person, then the IOC psychiatrist completes a clinical certificate. The IOC provider, in consultation with screening center staff, then develops an interim plan of outpatient treatment.

The IOC provider must initiate proceedings for a temporary order of commitment by submitting the following documents to the court within 72 hours from the time the screening center clinical certificate was executed:

- Screening Certificate from the screening center psychiatrist;
- Clinical Certificate from the IOC psychiatrist;
- IOC interim treatment plan; and
- Proposed temporary order of commitment.

It is strongly encouraged that the facility or hospital also submit a screening document prescribed by the DMHAS executed by the screener providing information on the patient's history and available alternative facilities and services deemed inappropriate for the judge's consideration.

The signed temporary order of civil commitment will authorize the person's assignment to IOC; however, it does not authorize the program to detain the person or to medicate the person without consent. The temporary order also will set the date for the initial commitment hearing, which must be within 20 days of the person's admission to IOC from the screening center.

The IOC provider must immediately send the signed temporary order of commitment and supporting documents to the county adjuster, who will then notify the appropriate persons regarding the hearing.

2. Coordination of care and treatment

The primary clinical task of an IOC provider is to directly provide and/or coordinate care through the implementation of a plan of outpatient treatment based on a needs assessment done by IOC staff or as presented by the screening service or referring inpatient facility. The plan must be approved by the committing court. *N.J.S.A.* 30:4-27.8a sets forth how an IOC provider should proceed if, upon monthly review of the plan, if the IOC provider determines that an approved plan is inadequate to meet the patient's mental health needs.

3. Interaction with the courts

The IOC provider has several responsibilities with respect to the courts, including:

A. Submitting the application for a temporary order of involuntary outpatient commitment as described in Section E. 1.

B. Participating in the initial and any periodic review hearings. The patient's treating psychiatrist shall be expected to provide a report and testify at the hearings. In addition, the IOC program should facilitate the patient's appearance at the hearing and appear with the patient.

C. The IOC provider should timely notify the adjuster if an interpreter is required for the hearing.

D. Obtaining court approval of modifications in the treatment plan, unless the modification consists only of a minor adjustment.

4. Material noncompliance assessment

A major responsibility of the IOC provider is to monitor the patient's compliance with the treatment plan. Whenever the IOC provider assigned to a patient believes that the patient is materially noncompliant with the treatment plan approved by the court, it should notify the court, and it has the following options:

A. If the patient does not pose an immediate or imminent danger, consider whether the patient's non-compliance could be addressed through modification of the treatment plan, e.g., modification in the schedule, a change in treatment provider. If the patient poses an immediate or imminent danger or modification to the treatment plan will not increase compliance and mitigate the danger, the IOC provider shall refer the patient to a screening center. *N.J.S.A.* 30:4-27.8a.

F. PSYCHIATRIC FACILITIES AND SHORT TERM CARE FACILITIES

The least restrictive environment for a patient who continues to need involuntary commitment for treatment may change with time. Therefore, facilities providing inpatient psychiatric services to persons in need of involuntary commitment must assess whether or not placement in an inpatient setting continues to be the least restrictive environment for the patient. If the inpatient facility determines that the patient still needs involuntary commitment, but the inpatient setting no longer is the least restrictive environment, then it should seek judicial approval of a change in placement from the inpatient setting to the outpatient setting. This change in placement is referred to as a "conversion."

1. Conversion procedure generally and at Short Term Care Facilities

   It is important to emphasize that conversion from inpatient commitment to outpatient commitment is available only for patients who meet the commitment standard. If a patient at a facility no longer is dangerous because of mental illness, the facility should administratively discharge the patient pursuant to *N.J.S.A.* 30:4-27.17. If a patient under commitment at the facility is willing to voluntarily accept treatment but otherwise meets the standard for inpatient commitment, then the facility should follow the procedures for conversion to voluntary status at *R.* 4:74-7.

   As further described below, conversion may be recommended at the scheduled initial or periodic review hearings or the facility may apply to the court for a conversion during the time period between review hearings. In either case, prior to seeking conversion, the facility must contact the IOC provider in the county where the individual will reside so that it can assess whether the patient is appropriate for its program and if there is capacity to accept the patient and, if yes, develop an initial treatment plan.

No clinical certificates are required to support a request for conversion in either a short-term facility or a state or county psychiatric hospital. However, a psychiatrist on the patient's treatment team at the facility who has examined the patient within 5 days of the hearing must submit a report to the court and the patient's attorney at least one business day before the hearing, and must be available to testify as to the patient's condition. The psychiatrist must set forth the basis for' the psychiatrist's opinion that the patient continues to need involuntary commitment to treatment, but is clinically appropriate for treatment in a less restrictive community environment. In addition, the treating psychiatrist from the facility must testify that the appropriate IOC program has accepted the patient and that the treatment plan prepared by the IOC program is sufficient to ameliorate the dangerousness the patient will present to self, others, or property in the community. Other facility staff, as appropriate, may be called upon to testify to the patient's history of noncompliance with treatment in the community, if any, and the patient's history of progress when participating in community care.

In sum, the following documents must be submitted when a facility is recommending conversion to the court:

- Treating physician's hearing report recommending IOC conversion;
- Plan of outpatient treatment; and
- Proposed order for conversion.

A change in placement from the inpatient to outpatient setting may not be effectuated until the court has signed an order directing the change in placement and approving the plan of outpatient treatment and the appropriate county adjuster(s) have been notified of the change in placement. A patient who is converted from involuntary inpatient commitment to IOC is not discharged from legal commitment status. The hearing schedule will be adjusted, as necessary, to reflect the different

time frames for periodic court review hearings for inpatient versus outpatient commitments as set forth at *N.J.S.A.* 30:4-16.

In addition to seeking conversions at regularly scheduled hearings or between such hearings, there is a third, judicially-created option available to STCF's seeking conversion of a patient from inpatient to outpatient commitment prior to the initial hearing, which is referred to as the "amended temporary order process" and also is further discussed below.

2. Amended Temporary Order Process for Short Term Care Facilities

This process was created by the Administrative Office of the Courts (AOC)[21] to mitigate the conflict between the short stays in STCF units and the length of time necessary to either schedule a conversion hearing or await the person's initial hearing. This process is available to convert patients under a temporary order of commitment at a STCF, who are dangerous but have stabilized to the point where the danger is not imminent, to IOC status prior to the initial hearing. The patient must be accepted by an IOC provider and the IOC provider must create an interim plan of outpatient treatment before this process is initiated. Through this process, the patient will be temporarily committed to outpatient care through issuance of an amended temporary order signed by the court without having to wait for the initial hearing. As noted above, this process may be used only when the patient had been accepted by an IOC provider and the IOC provider has created the interim plan of outpatient treatment. As such, it is critical that IOC provider staff be in regular contact with the patient under temporary commitment at an STCF who is being considered for referral to IOC.

The STCF must submit the following proofs to the court with the unsigned amended temporary order form (except for

21 See Memorandum from Hon. Glenn A. Grant, J.A.D., Acting Administrative Director of the Courts, dated October 17, 2013 describing the amended temporary order for short-term care facilities.

unusual circumstances, this should be submitted to the judge who signed the original temporary order):

A. An amended clinical certificate from the STCF treating psychiatrist stating that (a) the patient still meets the commitment standard; (b) the patient is not imminently dangerous; and (c) the patient is now appropriate for IOC after a period of days of inpatient treatment; and

B. The interim plan of outpatient treatment created by the IOC provider in consultation with the patient's treatment team at the STCF.

Once the judge accepts the proofs and signs the temporary order ex parte, the change in placement from inpatient to outpatient treatment should be effectuated. The date for the initial hearing will remain as stated in the original temporary order and IOC provider is responsible for transporting the patient to the hearing, which will take place at the STCF or at another location established by the court. The county adjuster will send copies of the amended temporary order to the attorneys and other people who had received notice of the hearing when the original temporary order was signed.

The IOC psychiatrist will appear as the expert witness at the initial hearing. As such, this process should be used only when the change in placement from the inpatient to outpatient setting will be effectuated at least five (5) days before the initial hearing so that the IOC psychiatrist can prepare the court report.

3. Conversion process at the state and county psychiatric hospitals

A conversion at the state and county psychiatric hospitals has a slightly different process from the short-term care facilities. The conversion at the state and county psychiatric hospitals is governed by *N.J.S.A.* 30:4-27.15a(d) and is initiated by CEO application to the court in between the time period for periodic court review hearings. Since a STCF does not have a CEO, the process described in Section F. 1. governs for purposes of change in status.

An inpatient facility may apply to the court for conversion between the time periods for the scheduled review hearings if the treating psychiatrist determines from any evaluation that outpatient commitment is appropriate and the patient has been accepted by an IOC provider in the county to which the patient will be discharged. The process is as follows:

- The treatment team should contact the CEO's office when it has determined that the patient is appropriate for IOC and confirmed the patient's acceptance at an IOC program. As a matter of practice, IOC does not accept a person until after the application is submitted in the form of a referral;
- An application for conversion is submitted by the CEO of the facility, or the CEO's designee (e.g. chief of psychiatry, medical director) to both the court and the county adjuster, who schedules a hearing. *N.J.S.A.* 30:4-27.l5a(d);
- The standard application for conversion provided by DMHAS initiates the process for state and county psychiatric hospitals;
- At the hearing, the patient's treating physician will need to provide a hearing report recommending IOC conversion with an examination five (5) days prior to the hearing;
- A proposed plan of outpatient treatment must be submitted to the court; and
- Proposed form of order for conversion.

4. Conversions at scheduled hearings

During every commitment hearing, the facility's treating psychiatrist will be expected to offer an opinion regarding the least restrictive environment for a patient that continues to need involuntary commitment. As noted above, if the recommendation is for conversion to IOC, then a plan of outpatient treatment must be submitted to the court for approval.

The court may find that IOC is appropriate for a patient without or against the recommendation of the facility's treating psychiatrist. When that occurs, the court may order that the patient's treatment team explore the feasibility of IOC for the patient The team must then contact the IOC provider and make the referral. If the IOC provider accepts the patient, then the county adjuster should be contacted to schedule a hearing for the patient on the next available hearing date. If the IOC provider rejects the patient, the treating psychiatrist should be prepared to explain the reasons for rejection to the judge at the next scheduled hearing.

G. IMMUNITY, CUSTODY, CONSUMER SIGNATURE ON TREATMENT PLAN

1. Immunity

The immunity for negligence conferred on all non-profit corporations in New Jersey extends to IOC providers. *See N.J.S.A.* 2A:53A-7 *et seq.* In addition, specific statutory immunity is extended to designated staff persons (and their employers) of a screening service, IOC provider, or STCF who in good faith "...take steps to assess, take custody of, detain or transport an individual for the purposes of mental health assessment or treatment..."

2. Custody

When a person is ordered into involuntary commitment to outpatient treatment, the person is not in the custody of the IOC provider. However, if the patient is materially noncompliant with the IOC treatment plan, the IOC provider can authorize law enforcement to take the patient into custody for purposes of transporting the patient to a screening service for evaluation by certifying that it has "reasonable cause to believe the person is in need of evaluation for commitment to treatment." *N.J.S.A.* 30:4-27.6(d).

3. Consumer signing treatment plan

A consumer's signature is not required by the law and should not be required as a matter of policy because to do so would violate the patient's right to treatment in the least restrictive setting. That said, the court or IOC provider may request that the patient sign the treatment plan as long as the patient is informed that signing the treatment plan is not required and serves only as an acknowledgement of, not consent to, the treatment plan (which arguably would void the involuntary commitment).

XII. PATIENTS' RIGHTS

A. AN ORDERLY AND DIGNIFIED COMMITMENT HEARING

1. The purpose of the commitment hearing is to determine whether the individual before the Court meets the legal standard for commitment. An order of commitment should be entered only after a careful weighing of the facts and application of the "dangerous to self" or "dangerous to others" standard. Strict adherence to that standard is required.

2. The decision to commit an individual, if made, deprives the patient of the patient's most fundamental legal right—liberty. Accordingly, maintaining a solemn and dignified judicial atmosphere is essential. If the patient does lose the patient's liberty, the patient should feel that the patient had a full and fair hearing, and that it was a court proceeding. Utmost care should be taken to ensure that the atmosphere remains judicial and that

the participants do not view the proceeding as akin to a medical review or a treatment team meeting.

3. Because involuntary commitment to a mental hospital deprives the committee of important liberty interests, the procedural and substantive safeguards established by statute and Court Rules "...must be scrupulously followed." *Matter of Commitment of Raymond S.*, *supra*, 263 *N.J. Super.* at 432. It is inappropriate for the judge to advance the case for commitment "...because it places the judge in the role of an adversary rather than that of a neutral decision maker." *Ibid*.

4. The judge presiding at the hearing should:

   a. Wear judicial robes.

   b. Have all witnesses sworn.

   c. Insist that those in the courtroom not interject or raise their hands to "add something" they think may be "helpful" or "background". All witnesses should testify in turn, and all testimony should be elicited by counsel.

   d. Remind court personnel, if necessary, that the dignity of the individual patient must be respected at all times. Odd or unorthodox statements by a patient are not justification for laughter or snickering.

   e. Refrain from lecturing the patient.

B. THE PATIENT'S BILL OF RIGHTS — N.J.S.A. 30:4-24.2[22]

1. This comprehensive set of rights — while not directly related to the question of whether the patient is mentally ill and dangerous to self or dangerous to others — may be raised at a "treatment hearing" (see Section XIII, *infra.*) and commitment judges should be generally familiar with the bill's provisions.

[22] *See N.J.S.A.* 30:4-27.11 amended and enlarged by legislation signed into law July 31, 1991 to give mentally ill adults involuntarily at screening centers and short-term care facilities the same rights as such patients at County and State psychiatric hospitals.

2. Key features include:

   a. Commitment in and of itself is not a basis for depriving a patient of basic civil rights such as voting, driver's license, and other licenses, permits or privileges of citizenship.

   b. The right to be presumed competent. Commitment for mental illness does not of itself give rise to a finding of incompetence.

   c. The right to be free from unnecessary or excessive medication. Medication shall not be used as punishment, for the convenience of staff, as a substitute for a treatment program, or in quantities that interfere with the patient's treatment program. Voluntarily committed patients have the right to refuse medication.

   d. The right to be free of shock treatment, psychosurgery, experimental research or sterilization[23] unless the patient gives express and informed consent after consultation with counsel. Exception: if a patient has been adjudicated incompetent, a court of competent jurisdiction can order these procedures. The patient, however, has the right to counsel, and right to plenary hearing before any of these can be administered. *N.J.S.A*. 30:4-24.2(d)(2).

   e. The right to communicate with an attorney, physician or the courts.

   Rights a. through e. above may never be abridged, suspended or denied. *N.J.S.A*. 30:4-24.2.

3. Other rights include the right to privacy and dignity, to treatment in the least restrictive conditions necessary; to keep and use personal possessions; to see visitors each day; to have access to telephones and letter writing material; to regular physical exercise; to be outdoors at frequent intervals; to practice the religion of the patient's choice; to receive prompt and adequate medical care. *N.J.S.A.* 30:4-24.2(e). These rights can only be denied when the director of the program determines it is

[23] Additional substantive criteria apply and are set forth in *In re Matter of Grady,* 85 *N.J.* 235 (1981).

imperative to do so and a notice of denial filed in the patient's treatment record contains an explanation of the reason for the denial. *N.J.S.A.* 30:4-24.2(g)(1).

a. Rights denials shall not exceed 30 days unless renewed.

b. Notice of rights denial must be given to patient's attorney.

4. Every individual who is mentally ill is entitled to medical care and other professional services in accordance with accepted standards. *N.J.S.A*. 30:4-24.1 "It is the policy of this state that persons in the public mental health system receive inpatient treatment and rehabilitation service in accordance with the highest professional standards and which will enable those hospitalized persons to return to their community as soon as it is clinically appropriate." *N.J.S.A*. 30:4-27.1(c).

5. 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.

C. A QUALIFIED INTERPRETER

1. For deaf or hearing impaired.

2. For individuals who do not speak English as their primary language.

D. THE "DUALLY-DIAGNOSED" PATIENT

1. Patients who are "dually diagnosed" (mentally ill and developmentally disabled) may petition the commitment judge to order the Division of Developmental Disabilities (DDD) in the Department of Human Services joined as a party to the commitment hearing for the purposes set forth in paragraph 3 below.

2. This joinder is generally an order to show cause and is most frequently sought by patients who have been ordered CEPP (judgment of conditional extension pending placement) and are awaiting placement by DDD.

3. The commitment court may enter orders overseeing DDD's performance of its ministerial obligations for the dually diagnosed, but it may not order DDD to accept an individual who does not meet the statutory and regulatory criteria for DDD eligibility. *In re Matter of B.R.*, 202 *N.J. Super*. 182, 187 (App. Div. 1985), *certif. denied* 102 *N.J*. 354 (1986).

XIII. RAISING "TREATMENT ISSUES" AT COMMITMENT HEARING

A. STANDARD OF TREATMENT

All psychiatric patients are entitled to receive medical treatment in accordance with accepted standards. *N.J.S.A*. 30:4-24.1; *In re D.J.M.*, 158 *N.J. Super*. 497 (App. Div. 1978). Those in the public mental health system are entitled to receive inpatient treatment and rehabilitation services in accordance with the highest professional standard and which will enable them to return to their community as soon as it is clinically appropriate. *N.J.S.A*. 30:4-27.1(c).

B. NOTICE REQUIRED

Patients may challenge whether the medical or psychiatric care they are receiving is in accordance with the standards stated in the preceding paragraph so long as they give adequate notice to the Court, county counsel, the hospital, and the hospital's attorney of their intention to do so. *In re D.J.M.*, *supra,* 158 *N.J. Super*. at 502. If funding is involved, the officials overseeing it should also be notified. *In re D.J.M.*, *supra,* 158 *N.J. Super*. at 502.

C. SCHEDULING

Such challenges are generally heard at the time of the patient's regularly scheduled review hearing.

D. SEPARATE PLEADINGS

The Appellate Division did not decide whether it is necessary to file a separate pleading or complaint in lieu of prerogative writ to review treatment issues. *In re D.J.M.*, *supra*.

E. POSSIBLE ISSUES

Among the treatment issues which can be raised are whether the treatment plan effectively addresses the need to eradicate behavior which prevents discharge, whether proper medical care for a specific

physical ailment is being provided and the adequacy of treatment for drug or alcohol abuse.

XIV. COMMITMENT OF MINORS

A. COMMENCEMENT OF AN ACTION

1. Screening Service Referral — Most applications for an order of temporary commitment are brought by a children's crisis intervention services unit or psychiatric facility or special psychiatric hospital to which a minor has been involuntarily admitted from a screening service referral. The minor will have been assessed and a screening document will have been completed. The minor would have then been evaluated by a psychiatrist or other physician who will have completed a screening certificate indicating that the person is in need of involuntary commitment. Upon completion of the screening certificate, screening service staff will have determined the appropriate facility into which the person will be placed. A second screening certificate will be completed by a psychiatrist or physician at the facility. A minor cannot be detained at the facility for more than 72 hours from the time the screening certificate was completed. Accordingly, the facility must obtain an order of temporary commitment within 72 hours or the minor must be discharged. *R*. 4:74-7(b)(1).

2.. Alternate Referral — If a screening service procedure is not used, the application for an order of temporary commitment must be supported by two clinical certificates, one of which must be prepared by a psychiatrist, stating that the minor is in need of involuntary commitment. If the application is made after a voluntary patient requests discharge from a facility or hospital, the minor may be detained for not more than 48 hours after the request or until the end of the next working day, whichever is later. If proceedings are instituted by independent application, there shall be no involuntary commitment prior to the entry of a temporary commitment order by the court. *R*. 4:74-7(b)(2).

B. STANDARD OF COMMITMENT

Pursuant to *R*. 4:74-7A and the Supreme Court in *In the Matter of the Commitment of N.N.,* 146 *N.J.* 112 (1996), a minor in need of involuntary commitment:

1. Is under the age of eighteen. *R*. 4:74-7A(a)(1).

2. Suffers from childhood mental illness, defined as a current substantial disturbance of thought, mood, perception, or orientation which differs from that which is typical of children of a similar developmental stage, and which significantly impairs judgment, behavior, or capacity to recognize reality when also compared with children of a similar developmental stage. *R*. 4:74-7A(a)(2).

    a. A seizure disorder, a developmental disability, organic brain syndrome, a physical or sensory handicap, or brief period or periods of intoxication caused by alcohol or other substances is not sufficient by itself to meet the criteria for childhood mental illness. *Ibid*.

3. Is dangerous to self, others or property as a result of the childhood mental illness. The same standards that apply to adults apply to children. See Section VI.C.3.

    a. If a minor is under 14 years of age, dangerous to self also means that there is a substantial likelihood that the failure to provide immediate, intensive, institutional, psychiatric therapy will create in the reasonably foreseeable future a genuine risk of irreversible or significant harm to the child arising from the interference with or arrest of the child's growth and development and, ultimately, the child's capacity to adapt and socialize as an adult. *R*. 4:74-7A(a)(3); *In the Matter of the Commitment of N.N., supra.*

4. Is in need of intensive psychiatric treatment that can be provided at a psychiatric hospital, special psychiatric hospital or children's crisis intervention service and which cannot be provided in the home, the community or on an outpatient basis. *R.* 4:74-7A(b)(1).

C. CONTENTS OF CERTIFICATES FOR MINORS

The certificates must state with particularity the facts on which the psychiatrist, physician or mental health screener relies in concluding that:

- The minor suffers from a childhood mental illness;
- The childhood mental illness causes the patient to be dangerous to self or others or property as defined by *R.* 4:74-7A(a)(3); and
- The minor is in need of intensive psychiatric treatment that can be provided at a psychiatric hospital, special psychiatric hospital or children's crisis intervention service and which cannot be provided in the home, the community or on an outpatient basis. *R*. 4:74-7A(b)(1).

A person who is a relative by blood or marriage of the person being examined shall not execute any required certificate. *R*. 4:74-7(b)3(B).

If a screening service referral is used, the same psychiatrist shall not sign both the screening certificate and the clinical certificate unless that psychiatrist has made a reasonable but unsuccessful attempt to have another psychiatrist conduct the evaluation and execute the certificate. *Ibid.*

D. ORDER OF TEMPORARY COMMITMENT FOR A MINOR

The court may enter an order of temporary commitment authorizing the admission to or retention of custody by a facility pending the final hearing if it finds probable cause, based on the certificates filed that the person is in need of involuntary commitment. The order of temporary commitment must include the following:

- A place and day certain for the commitment hearing, which shall be within 14 days after the initial inpatient admission to the facility, which date shall not be subject to adjournment except that in exceptional circumstances and for good cause shown in open court

and on the record, the hearing may be adjourned for a period of not more than seven days. *R.* 4:74-7A(b)(2).

- Assignment of counsel to present the case for involuntary commitment.
- Appointment of a guardian *ad litem* to represent the minor and, if the guardian is not an attorney, shall appoint counsel for the guardian *ad litem* as well. *R.* 4:74-7A(b)(3).
- The persons to be notified by the county adjuster of the time and place of hearing, the mode of service of the notice, and the time within which the notice must be served.
- The notice shall be served not less than five days prior to the date of the hearing. *R.* 4:74-7A(b)(2).
- The form of notice served upon the patient and patient's counsel shall include a copy of the temporary court order, a statement of the patient's rights at the hearing and the screening or clinical certificates and supporting documents. *R*. 4:74-7(c).

E. REVIEW OF ORDER OF TEMPORARY COMMITMENT FOR MINORS

Referral from a Screening Service:

- Is the individual under the age of 18? If the person is eighteen years or older, the procedure for the involuntary commitment of an adult must be followed.

- Has the minor been detained in a facility for more than 72 hours from the time the screening certificate was completed? If yes, the minor must be discharged.

- Has a screening certificate been completed by a psychiatrist or physician affiliated with the screening service?

- Has another clinical certificate been completed by a psychiatrist or physician on the patient's treatment team?

- Was at least one of the two submitted certificates completed by a psychiatrist? If not, the application is not complete and the order should not be entered.

- Were the screening certificate and the clinical certificate completed by the same psychiatrist? If yes, has the psychiatrist made a reasonable but unsuccessful attempt to have another psychiatrist conduct an evaluation and execute the certificate.

- Is any person completing a screening or clinical certificate related by blood or marriage to the person being examined? If yes, the certificate may not be accepted?

- Were copies of the documents filed with the office of the county adjuster?

It is strongly encouraged that the facility or hospital also submit a screening document prescribed by the DMHAS executed by the screener providing information on the patient's history and available alternative facilities and services deemed inappropriate for the judge's consideration.

Contents of the Screening and Clinical Certificates:

- Are the certificates in the prescribed form (see screening document and clinical/screening certificate for involuntary commitment)?
- Do the certificates state the conclusion that involuntary commitment is needed, *i.e*. that the minor suffers from childhood mental illness, that the childhood mental illness causes the minor to be dangerous to self or others or property, and that the minor is in need of intensive psychiatric treatment that can be provided at a psychiatric hospital, special psychiatric hospital or children's crisis intervention service and which cannot be provided in the home, the community or on an outpatient basis?
- Are there specific facts supporting the conclusion that commitment is needed?
- Are they properly certified in accordance with *R*. 1:4-4(b)?

Standard of Review

- Is there probable cause to believe that the minor is in need of involuntary commitment, *i.e*. is there probable cause to believe that the minor suffers from childhood mental illness, that the childhood mental illness causes the minor to be dangerous to self or others or property, and that the minor is in need of intensive

psychiatric treatment that can be provided at a psychiatric hospital, special psychiatric hospital or children's crisis intervention service and which cannot be provided in the home, the community or on an outpatient basis.

Contents of Order of Temporary Commitment

- Is there a place and date certain for the initial commitment hearing?
- Is the initial commitment hearing scheduled within 14 days of the in-patient admission to the facility or hospital?
- Is there assignment of a guardian *ad litem* to represent the minor? (the guardian *ad litem* cannot be the applicant for commitment)
- If the guardian *ad litem* is not an attorney, has counsel been appointed to represent the guardian *ad litem*?
- Does the order contain a list of persons to be notified by the county adjuster of the time and place of the hearing?
- Is the mode of service of the hearing notice specified?
- Does the order contain the date by which the hearing notice must be served, at least five days prior to the court hearing?
- Does the order specify that copies of the clinical and screening certificates, as well as any other supporting documents, the order for temporary commitment, and statements of patient's rights at the court hearing be served on the patient and the patient's attorney?

Alternate Referral (not from screening service)

- Are there two clinical certificates completed by physicians, one of whom must be a psychiatrist? There will be no screening certificate.
- Are the certificates prepared and executed by a psychiatrist or physician who has conducted an examination of the person within three days of presenting the person for admission to a facility. If no, the application must be rejected. The required contents of the certificates and order are the same as for a screening service referral.
- If the application is made for a voluntary patient who is seeking to be discharged, but whose treatment team believes is in need of involuntary commitment, has the patient been detained for more than 48 hours after the request or until the end of the next

working day, whichever is later? If yes, the minor must be discharged.

F. INITIAL HEARING

1. Discovery

The patient's counsel or guardian *ad litem* shall have the right to inspect and copy all records relating to the patient's mental condition, including the patient's clinical chart. The court may also order testing or examination of the patient by an independent psychiatrist, psychologist or other expert. The cost of such examination and the expert's fee for testifying, if any, shall be borne by the person or public body charged with the patient's legal settlement. *R*. 4:74-7(d).

2. Hearing

- The application for involuntary commitment shall be supported by the oral testimony of 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. *R*. 4:74-7(e).
- If a licensed psychologist has examined the patient, the court may also require the psychologist to appear and testify in the matter. *Ibid.*
- Any expert witness who is to testify shall prepare a written report and shall make it available to the court and all counsel no later than one business day prior to the hearing. *Ibid.*
- The report shall be in a form prescribed by the DMHAS and subject to approval by the Administrative Director of the Courts. *Ibid.*
- Other members of the patient's treatment team may also testify at the hearing. *Ibid.*
- Members of the minor's family may testify if the court so determines. *Ibid.*
- The minor has the right to be present at the hearing, but may be excused from the courtroom during all or any portion of the hearing if the court determines that the because of the patient's conduct at the hearing, it cannot reasonably continue while the patient is present. *Ibid.*

- In no case shall the patient appear *pro se*. *Ibid.*
- The patient, through counsel, shall have the right to present evidence and to cross-examine witnesses. *Ibid.*
- The hearing shall be held in camera, except as otherwise provided by *R*. 3:19-2 (acquittal by reason of insanity). *Ibid.*

G. ORDER OF COMMITMENT FOLLOWING INITIAL HEARING

1. For a minor <u>fourteen years of age or older</u>

   The court may enter an order of commitment for a minor fourteen years of age or older if it finds that:
   (a) the minor suffers from a childhood mental illness,
   (b) the childhood mental illness causes the minor to be dangerous to self or others or property as defined by *N.J.S.A*. 30:4-27.2(h) and -27.2(i), and
   (c) the minor is in need of intensive psychiatric treatment that can be provided at a psychiatric facility, special psychiatric hospital, or children's crisis intervention service and which cannot be provided in the home, the community or on a outpatient basis;

2. For a minor <u>under fourteen years of age</u>

   The court may enter an order of commitment for a minor fourteen years of age or older if it finds that:
   (a) the minor suffers from childhood mental illness,
   (b) the childhood mental illness causes the minor to be dangerous to self or others or property as defined by R. 4:74-7A(a)(3), and
   (c) the minor is in need of intensive psychiatric treatment that can be provided at a psychiatric facility, special psychiatric hospital, or children's crisis intervention service and which cannot be provided in the home, the community or on an outpatient basis.

3. The commitment shall be judicially reviewed no later than every 3 months from the date of its last entry until the minor is discharged or reaches the age of 18. *R*. 4:74-7A(b)(5).

4. The hearings on an application to convert to voluntary status pursuant to *R*. 4:74-7(g) shall be held within 14 days rather than the 20 days for adults. *R*. 4:74-7A(b)(6).

H. VOLUNTARY ADMISSION

Any minor 14 years of age or older may request admission to a psychiatric facility, special psychiatric hospital, or children's crisis intervention service provided that the court finds that the minor's request is informed and voluntary and enters an order approving the admission. If voluntarily admitted, a minor may discharge himself or herself from the facility in the same manner as an adult who has voluntarily admitted himself or herself. An order approving a voluntary admission shall be reviewed judicially in summary manner no later than every 3 months from the date of its last entry. *R*. 4:74-7A(c).

I. PARENTAL ADMISSION AND DISCHARGE

1. Admission – No court approval is needed for the admission of a minor by the minor's parent, parents, or other person *in loco parentis* to a psychiatric facility, special psychiatric hospital, or children's crisis intervention service for the evaluation or diagnosis of a childhood mental illness provided the admission is independently approved by a physician on the staff of the facility and does not exceed 7 days. No court hearings are conducted during this 7-day evaluation period. If further hospitalization is needed, a hearing must be conducted, in accordance with *R*. 4:74-7(e). If an application for commitment is made during the admission, the final hearing should be held within 14 days of the initial inpatient admission to the facility. No adjournments will be granted unless the application meets the requirements of *R*. 4:74-7A(b)(2).

2. Discharge – The admitting parent or other person *in loco parentis* may have the minor discharged upon oral or written request. Discharge shall take place as soon as practicable, but no later than 48 hours after the request unless the facility obtains a temporary order of commitment. *R*. 4:74-7A(d)(2).