P U B L I C H E A R I N G

before

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

To assess the conditions and care provided at residential health care facilities and boarding homes in the State and examine the State's regulation of these facilities

March 5, 1987
Room 424
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Richard J. Codey, Chairman
Senator Francis J. McManimon, Vice Chairman
Senator C. Louis Bassano

ALSO PRESENT:

Eleanor H. Seel
Office of Legislative Services
Aide, Senate Institutions, Health
and Welfare Committee

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February 19, 1987

NOTICE OF A PUBLIC HEARING

THE SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE
ANNOUNCES A PUBLIC HEARING
TO EXAMINE CONDITIONS AND STATE
REGULATION OF BOARDING FACILITIES

Thursday, March 5, 1987
Beginning at 10:30 A.M.
Room 410 of the State House Annex
Trenton, New Jersey

The Senate Institutions, Health and Welfare Committee will hold a public hearing on Thursday, March 5, 1987, beginning at 10:30 A.M., in Room ~~410~~ 424 of the State House Annex, Trenton, New Jersey, for the purpose of assessing the conditions and care provided at residential health care facilities and boarding homes in the State and examining the State's regulation of these facilities.

Address any questions or requests to testify to Eleanor Seel, Committee Aide (609) 292-1646, State House Annex, Trenton, New Jersey 08625. Persons wishing to testify are asked to submit nine copies of their testimony on the day of the hearing. The chairman may find it necessary to limit the number of witnesses or the time available to each witness.

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SENATOR RICHARD J. CODEY (Chairman): Good morning. We would like to start the hearing now.

Since 1979, we have developed a fairly extensive system for regulating residential health care facilities and boarding homes. We have enacted various laws to protect the rights, and ensure the safety and well-being, of those vulnerable persons residing in these facilities.

But, with all of these well-intentioned laws, we have constantly heard that residents of residential health care facilities and boarding homes are not getting the care they need; that they are subject to both abuse and financial exploitation; and that many of these facilities are still unsafe today.

Therefore, the purpose of this hearing is to determine how the various State agencies are implementing these reform laws, and whether the State agencies are carrying out their respective responsibilities under the laws now. We are also here today to determine why such serious problems in obtaining needed social and health care services continue to exist for the very vulnerable residents of our State's residential health care facilities and boarding homes.

Our first witness this morning will be the Commissioner of Health, Dr. Molly Coye. Doctor, good morning, and thank you for coming.

C O M M I S S I O N E R M O L L Y J O E L C O Y E: Thank you, Senator Codey. Thank you very much for providing this forum to discuss the problems facing residents, providers, and regulators of the residential health care and boarding home system.

I would like to introduce Deputy Commissioner Charlotte Kitler on my left, and Assistant Commissioner Paul Langevin, who is with me this morning in order to answer your questions.

The Rooming and Boarding House Act of 1979 was landmark legislation. It laid the regulatory foundation for

efforts to reform this system and to improve the lives of the thousands of elderly and disabled citizens who are dependent on it for residential and other kinds of care. Since the time that legislation was enacted, there has been steady progress in the difficult task of systematic reform of the State's residential and boarding home system. This progress has been greatly assisted through interdepartmental cooperation and coordination by the three major State departments with regulatory responsibilities under the Act -- the Department of Human Services, which places residents in the facilities, oversees the county welfare agencies which furnish or arrange for social services to the residents, and receives complaints of suspected abuse of residents; the Department of Community Affairs, which is responsible for licensing rooming and boarding houses and administering the Life-Safety Improvement Loan Program; and the Department of Health, which is responsible for the licensing of residential health care facilities.

While progress has been made, there remain serious problems. The need for residential health care facilities far outstrips the current supply. The costs of maintaining the facilities and boarding homes at upgraded levels are estimated to be far greater than the amount of reimbursement the operators currently can expect to receive. And, the mechanisms and resources for investigations and enforcement of compliance with regulatory standards are still too limited to achieve immediate and comprehensive remedial actions by those facilities.

To give you a picture of the regulatory jurisdiction of the Department of Health, as well as the nature of the problems encountered, I would like to describe briefly the facilities which we regulate.

We are responsible, as you know, for licensing residential health care facilities. These are among the most

highly organized types of residential arrangements, yet at the same time they are the least sophisticated form of institutional health care regulated by the Department of Health. Residential health care facilities are similar to the Class C boarding homes licensed by the Department of Community Affairs, or rather, similar to those Class C boarding homes which are permitted to offer a full range of boarding home services. These Class C boarding homes, like residential health care facilities, provide varying levels and combinations of shelter, meals, structured environment, supervision, housekeeping, assistance in activities of daily living, and assistance in supervising self-medication. Residential health care facilities, however, provide a level of health care and supportive services for individuals not needing nursing home care, but requiring more services than would be routinely available in Class B boarding homes. Residents of these facilities are supposed to receive supervision of medications, health maintenance and monitoring services, and access to other services which may be needed on an intermittent basis.

In order to do that, a registered professional nurse must be available to provide a minimum of -- in the regulations -- .20 hours, which translates into 12 minutes, per resident per week to evaluate the health care needs of each resident, monitor their conditions on a continuing basis, and arrange for referral for necessary diagnostic or medical treatment.

At the present time, there are 249 residential health care facilities licensed by the Department of Health, providing services to approximately 10,100 persons. Half of these residents are recipients of SSI. The incomes of the remaining residents vary from those who are only on general assistance to those with some source of private income averaging between $400 and $600 per month. About three-quarters of the residents of the facilities are over 65 years of age. All of the residents are functionally impaired individuals who need a living

environment with supportive services. They are not only typically elderly, but they are characterized by declining function, often decreased vision or mobility, incipient senility, or disabilities associated with chronic conditions. Old or young, many of these residents are deinstitutionalized mental patients who suffer from conditions of mental confusion, disorientation, paranoia, schizophrenia, and depression.

These residents are frail, both physically and mentally, and are at risk of a profound and continuing functional decline which will ultimately lead to placing them into higher, and more expensive, levels of care. They are also -- as you noted in your introductory remarks, Senator -- an extremely vulnerable population and, as such, they must be protected against unacceptable behavior of all kinds by operators, staff, and other residents of the facility, and from antagonistic elements of the community. At a minimum, conditions at the facility must be at a level to assure that all residents will have decent food, a safe, sanitary, and pleasant environment, and reasonable custodial and personal care free from abuse or exploitation.

Unfortunately, our current payment mechanisms do not contain sufficient incentives to stimulate the provision of services at optimal levels. In fact, the reimbursement available to some facilities may not even be sufficient to enable decent services to be consistently maintained at a minimum level. If any new, more rigorous and costly standards were imposed, this would tend to exacerbate, rather than help, with the problem of ensuring adequate sources of funding for the operations at residential health care facilities and developing economic incentives and disincentives to influence the desired kinds of behaviors on the part of providers.

In addition to the problems with funding these operations, the trend to deinstitutionalize patients and to provide care in a more personal and homelike setting, has

created a heavy new demand on the residential health care system -- a tremendous influx of persons in need into this system. The system was not prepared for this sudden and rapid increase in demand for services, and it has not yet been able to respond with a supply of beds equal to the need for such services. Assemblyman Rooney recently pointed out the high demand for residential health care beds, and he accurately observed that in some geographic locales there are long waiting lists for entry into these facilities.

Our Department's Health Planning Program, in assessing the need for residential health care beds, estimates that, on a statewide basis, there are at least 3000 fewer beds that are required to satisfy the current and growing needs of our population for residential health care services. In recognition of this great need, the Department has rarely denied those reputable applicants who file for certificates of need to expand, convert, or build new residential health care beds. Further, for the past two years, the Department has required that any applicant who is applying for a certificate of need for nursing home beds must include a component for residential health care as well. So, in most circumstances, an applicant who wishes to build a nursing home of 120 or 180 beds, is required to include 20 to 60 residential health care beds, in order to receive a certificate of need. This requirement, in fact, accounts for almost all of the new construction of residential health care facilities now under way in the State.

In the meantime, however, until these new projects are built to meet some of the large need for residential health care, there remains a shortage of licensed residential health care beds. The supply of beds is unlikely to keep pace with the aging of our population and their growing need for residential health care. While the Department of Health continues to insist that new nursing homes must include

provision for residential health care beds to provide a continuum of health care services within the long-term care facility and to try to meet a portion of the residential health care needs in the future, the bulk of residential health care services are, and will remain, provided by freestanding facilities. That is the predominant pattern. One hundred and seventy-eight of the 249 residential health care facilities licensed by the Department of Health are freestanding buildings. A large number of these have been converted from former hotels and private residences. As you can imagine, many alterations and improvements in their physical plants are necessary, in order to make these structures safe. In addition, new and very well-planned fire safety regulations have necessitated further improvements in those same structures.

Given the shortage of residential health care beds that I just described, and given the limitations upon reimbursement for residential health care services, the essential dilemma is that very rigorous enforcement of regulatory requirements could cause many facilities to close, since the funds necessary in order to comply with those standards, in some cases, may not be available to the operators. This can result in the displacement of large numbers of these highly vulnerable residents, many of whom will have great difficulty finding new places to reside and to obtain the care they need.

In acting to assure the safety and well-being of residents of these facilities, our Department has had to consider the frequently conflicting goals of mandating and enforcing compliance with upgraded facility standards, yet avoiding major dislocations of residents into the ranks of the homeless or into placements inappropriate to meet their needs. We have attempted to facilitate a smooth transition for many of the residential health care facilities with physical plant problems, while closely monitoring the residents' safety. The

alternative to this approach is the immediate closure of non-conforming facilities. This alternative, which would, in fact, create a new class of homeless or displaced persons, is unacceptable to us, particularly in light of the scope of the shortage of residential health care beds, and the limited number of facilities which have yet to comply with upgraded fire safety standards.

A review of our records shows that there are 36 licensed residential health care facilities, out of the total of 249, which are required to have sprinklers due to their size or construction, but which still do not have them installed. Of these 36, 24 are in the Boarding Home Life-Safety Improvement Loan Program and are in the process of obtaining a loan or installing a sprinkler system. Four homes are installing sprinklers with their own private financing, and the remaining eight facilities are applying for inclusion into the Housing and Mortgage Finance Agency Loan Program.

I hope that this overview will provide you, Senator, with a broad perspective in identifying and distinguishing the types and degrees of the problems in the residential health care delivery system. The system is an extensive one in the number of residents served, yet it is not large enough to accommodate all of the people statewide who need residential health care. It is a system which is subject to pervasive regulation, and in some areas of operations, regulation has led to substantial improvement, yet advances in other areas proceed at a slower rate because of dependence upon limited financial resources.

To maximize the Department of Health's funds, we work closely with the Department of Human Services and the county welfare agencies to investigate complaints of abuse, neglect, and exploitation of residents. In turn, we receive referrals reporting operational, life-safety and physical plant deficiencies from other State agencies for follow-up. In

particular, our participation in the Interdepartmental Boarding Home Committee has helped to foster better communications among all the regulatory agencies and to improve regulatory efficiency and effectiveness.

We would certainly agree that further improvements in the system are needed. However, we are not willing to formulate and enforce policies which merely shift the problem elsewhere. A regulatory compliance program which makes the closure of facilities a primary enforcement mechanism will have the effect of leading to the displacement of numbers of people who are very difficult to relocate at all, let alone relocate into appropriate placements. Any change in policy which does not merely aggravate the existing problems will require a balanced consideration of the ultimate objectives, the likely short-term effects, and the resources available to deal with some of these intractable problems.

On a more positive note, one of the changes we have been working on has the potential for offering an upgrading of care at residential health care facilities and a new funding source for this care. The Department of Health has been investigating the possibility of establishing a new type of residential care environment which would blend the kinds of services provided in residential health care facilities and nursing homes. This blend of services would open the door for potential Federal reimbursement of the program and, hopefully, realize an actual net savings to the health care system by reducing the amount of money spent on Level B intermediate nursing home care, while at the same time vastly improving the amount and array of services available to residential health care facility residents. This approach would result in a shifting of patients out of Level B nursing home care into the new service system, while continuing to meet patient needs.

This particular change requires further time to explore and develop, working with Federal officials. We are

working on it now and will continue to work towards permanent and effective change. In the meantime, we believe it is important to understand and evaluate the critical problems in these areas, and continue to work towards steadily bringing them under control.

In summary, we recognize the seriousness of the problems in residential health care facilities. The major steps we have taken to improve residential health care facilities in New Jersey are increased monitoring and improved enforcement. Some of this was made possible, Senator, by your legislation -- S-1971 -- which was signed into law last August. It raised the penalties, abolished the seven-day waiting period for taking action, and created the Health Facility Improvement Fund, which allows us to make improvements ourselves, without waiting for the owner to make the improvements.

We have achieved better coordination with other State agencies through the Interdepartmental Boarding Home Committee. We have required new nursing homes to include a component for residential health care facilities in their certificate of need application. We are developing a plan to upgrade residential facilities by reclassifying them to a lower level nursing home status, in order to improve the amount of nursing care and supervision available to the residents, and to maximize use of Federal funds.

Unfortunately, as you know, Senator, I can't stay for the entire hearing this morning. I would be glad to take a few questions, and ask Deputy Commissioner Charlotte Kitler and Assistant Commissioner Paul Langevin to answer more detailed questions in my absence.

SENATOR CODEY: Commissioner, you mentioned the Health Care Facilities Improvement Fund. Has the Department used any of these moneys to make life-safety improvements in these residential facilities?

COMMISSIONER COYE: Except for the fire-safety improvements which are covered by the Loan Act, it is my impression that our plans are to do that. We have been implementing it since October. For an update on whether funds have actually been expended for that, I would have to ask Paul Langevin.

A S S T. C O M M. P A U L R. L A N G E V I N: Senator, we have about $40,000 in the Improvement Fund at this time. As you know, it applies not just to residential facilities, but to all licensed health care facilities. We have used it once so far, in a nursing home I believe. We have not had an opportunity to use it in a residential facility, but we have only had the money available for about three to four months.

SENATOR CODEY: Do you anticipate using it?

ASSISTANT COMMISSIONER LANGEVIN: We certainly do, sir.

SENATOR CODEY: Do you feel there is sufficient money there?

ASSISTANT COMMISSIONER LANGEVIN: At this time, the moneys are generated from the penalties that are issued. As time goes on and the regulatory actions we take go into the Fund, we will have more and more funding there. It is a little bit slow starting up right now.

SENATOR CODEY: Commissioner, with regard to the number of residential health care facilities and the number of beds in the State, especially for SSI recipients, those beds have been decreasing over the past few years. Let me ask you why you think this is happening?

COMMISSIONER COYE: Why what is happening?

SENATOR CODEY: The decrease in available beds in these facilities.

COMMISSIONER COYE: Well, a major problem is the incentive, as I mentioned. The reimbursement does not offer much incentive for an owner to operate a residential health care facility with the requirements we have for providing

nursing and supervision, plus the discharge of the former mental patients makes running a facility much more difficult, as you have a higher proportion of your patients being people who are former mental patients.

SENATOR CODEY: What can we do to change the trend, though?

COMMISSIONER COYE: Well, the best tool we have at hand is the certificate of need. That is why we have been requiring the nursing homes to try to build more residential beds into their CN applications. In addition to that, I think the Improvement Fund we talked about will allow us to help those homes actually improve the conditions. Our problem is, when we go in to do an inspection, we find that there are conditions we would like to see improved, but the current reimbursement system does not give enough margin to the operator to be able to make those investments, in many cases. I think this Improvement Fund will help with that.

SENATOR CODEY: Commissioner, the populations in the Class C boarding homes are really very similar to the residential health care facilities' populations. They both have the same types of facilities, and cater to a high degree of former mental patients. Yet the residential health care facilities receive about $120 per month more for each SSI resident. Given the obvious similar facilities basically, do you think the difference is justified at all?

COMMISSIONER COYE: Well, that is one of the reasons we are looking at this new system I was describing at the end of my formal remarks. We feel that some of the patients who are now in residential care probably could be taken care of in a Class C boarding home. There wouldn't be a problem in that. There are a substantial number of patients, though, who are in residential health care facilities, who really need more than what is required or provided in most Class C boarding homes, in terms of medical supervision, or nursing supervision, and

having someone 24 hours a day in -- a supervisory person in that facility.

For those people, the current requirement of 12 minutes of care is a borderline requirement. If it is done well by the operator of a home -- if it is set up very well -- it may be helpful to those patients. But it is a very thin margin of safety for patients who need real supervision. If we can take those patients who do need supervision and nursing care, and upgrade them into this higher level, by the lower end of the nursing home spectrum, we ought to be able to really take care of them.

A one-sentence answer is, there are people who need this help, who should not be in boarding homes.

SENATOR CODEY: Commissioner, as you know, we presently have two State agencies looking at these facilities. Do you think we should have just one?

COMMISSIONER COYE: I think our answer to that would depend on whether we are successful in developing the system that I was just talking about. To the extent that the facilities are similar to Class C boarding homes, or the needs of the patients are no greater than those in a Class C boarding home, then there is no need to have two agencies supervising it. But the second part of my remarks concentrated on the fact that there are a lot of people in the residential health care facilities who really do need medical supervision. They need the nursing care, and they need someone in the home 24 hours a day. Those are the key distinctions between the boarding home and the residential health care facility.

If you took all of those patients and, in effect, put them in a boarding home, you would really be depriving a substantail proportion of patients of services they truly need. The distinction of what is supposed to come under the purview of the Department of Health is whether health services are provided. I would say that to the extent that we can

develop this new plan, and a substantial proportion of these patients are going to be given the services they need -- those services are health care services -- then it should be license-inspected by us. Those patients who need nothing more than boarding homes should be in a boarding home, and that should be inspected and taken care of by DCA.

SENATOR CODEY: Well, Commissioner, your Department has been criticized for not aggressively assessing or collecting penalties for violations at the residential health care facilities, and for allowing the violations to continue. What exactly is the Department's policy on collecting these fines, and on assessing these fines?

COMMISSIONER COYE: I would argue that we have, in fact, been very vigorous in our enforcement, and I would like to ask Charlotte Kitler to reply in more detail on that.

DEPUTY COMM. CHARLOTTE KITLER: We do have data on the penalties--

SENATOR CODEY: Would you take that mike, please?

DEPUTY COMMISSIONER KITLER: Oh, sure. Senator, we do have data on penalties that have been assessed, that have been compromised, as is typically the case in any process, through an administrative hearing -- a court process -- and the amount of penalties that have been collected for the past two years.

SENATOR CODEY: I mean, do you think the Department has been aggressive in pursuing these things over the past couple of years?

DEPUTY COMMISSIONER KITLER: Aggressive in the sense of imposing-- We impose penalties when we believe it will lead to the purpose of influencing the behavior of providers, without the risk of the providers getting imposed with enormous penalties where they take it out in the services provided to the residents. We do not want to have the penalties so onerous that the operators cannot pay them, or that they will take the money out of the operation and then deprive the residents of the services.

SENATOR CODEY: Yeah, but that sounds like operators who we don't want anyway.

DEPUTY COMMISSIONER KITLER: That's right, so instead of penalties, we would think of other options, such as very frequent surveillance visits, calling down to office conferences, imposing minimal penalties and combining that with an action for discipline against the licensee, such as a suspension or revocation of the license. If the operator is so bad, penalties may not work. They can work only if you can stimulate that provider to change the behavior, to bring about the kinds of behavior you want. I think you are absolutely right, Senator Codey, if we have an operator who just will not comply, and who cannot bring the operations into accordance with our regulations, yes, we do consider things other than penalties, per se.

SENATOR CODEY: Have we suspended or removed any operators?

DEPUTY COMMISSIONER KITLER: Yes, we have.

SENATOR CODEY: How many?

DEPUTY COMMISSIONER KITLER: In 1986, I believe it was three revocations -- three revocations of licensure and closure of residential health care facilities. Seven others closed voluntarily; that is, of their own accord, without any formal action having been initiated by the Department. We lost 170 beds.

SENATOR CODEY: Okay. Do we have a printed policy with regard to the penalties -- with regard to how many penalties would lead to a revocation of a license, or is each case taken on itself?

DEPUTY COMMISSIONER KITLER: I can't say that we have any kind of formal written policy. We have a regulation, and we have a statute which provides for the amount of penalties that can be assessed. We have not reached the point that some agencies, and even the Department itself in other programs has

reached of itemizing in a policy certain factors that would count for certain points that would be used toward a penalty assessment. No, we haven't reached that level of sophistication in penalty assessment with this program, nor with any other health care facility licensure program. We don't have that policy for nursing homes, nor for hospitals. It is all case by case.

COMMISSIONER COYE: Senator, I am afraid I am going to have to excuse myself. Thank you for the opportunity to appear here.

SENATOR CODEY: Okay. Thank you, Commissioner.

One last question: Would you recommend a mix of patients at these institutions, or rather elderly all in one, former mental patients in one -- or is a mix better?

DEPUTY COMMISSIONER KITLER: Senator, I don't that we are in the best position to be able to comment on that. I know the Department of Human Services has been studying placement kinds of screening. Obviously, the mix of the elderly with people who have some mental disabilities, under the present circumstances, certainly does not make for ease in terms of the operators being able to provide a consistent level of services. It does not enable us to be able to do all of the regulation and all of the monitoring we would like to do.

Under the plan that Dr. Coye indicated earlier, however, where we would have the upgrading into what is essentially a type of nursing home care, it may be much better to be able to have all the types of people who need care -- who need health care in the program. But on that I am afraid I really should defer to the people from Human Services, who have studied it and who have more expertise to offer in the area of the screening and placement of individuals.

SENATOR CODEY: Okay. Thank you very much for your testimony this morning.

DEPUTY COMMISSIONER KITLER: Thank you, Senator.

SENATOR CODEY: Our next witness will be Assemblyman John Rooney. Assemblyman?

A S S E M B L Y M A N J O H N E. R O O N E Y: Thank you very much, Senator, for hearing me this early in the program. I know you have a long list of witnesses here.

This is an issue I have been very concerned with as the Assembly Committee Chairman of the Senior Citizens Committee. I want to compliment you on the excellent job you did and the undercover work you did, which was absolutely necessary in bringing full focus and attention of the State of New Jersey to this issue.

I have been involved in this issue, probably, since the middle of last year, when we found some irregularities in what was happening in the RHCFs. I am sorry I do not have a prepared text. I didn't realize your hearing was today.

The issue I ran across was a closing of a residential health care facility in my own area. It was brought home very closely by the fact that my father-in-law was one of the residents. The residential facility was closed within a matter of two weeks, and we found out, after the fact, that there were a lot of problems that probably were caused, and could have been prevented by the State of New Jersey.

I don't want to throw any problems at Commissioner Coye, because she is really new on board with the Department of Health. But, in the Ombudsman's report at our Committee hearing back last November, it was very clear that the Department of Health had absolutely responsibility for many, many problems at that facility. One of the problems was the employees. This is something I am addressing in a bill which I will be hearing, coincidentally, next week in my Committee. It is my bill regulating the closing of health care facilities, which also regulates the employees, and having some background checks on employees.

There is another bill which I have sponsored, which I believe is also going to be heard at that Committee meeting, on background checks for home health aides. One of the things we did last year in our Elderly Abuse Program -- where we investigated the elderly abuse complaints in the State -- was find that there were home health aides coming into the homes of the most vulnerable population in our State -- in our society -- who were proven criminals. They were abusing these people. They were going through horrible, horrible situations.

So what you found is typical of what we found in our hearing on elderly abuse. We have been walking down the same path and, believe me, I am so glad you brought attention to this issue.

One other item I would like to bring up is the Ombudsman. Last year there was a bill sponsored by Assemblyman Felice, that would have allowed the Ombudsman's office to go in and do undercover investigations.

SENATOR CODEY: Tell him to leave that to me.

ASSEMBLYMAN ROONEY: You did an excellent job, no question about it. I supported that. I tried to get support for it in my Committee. Unfortunately, it failed in Committee. I am going to try to see if we can resurrect that bill, to see if we can get the Ombudsman's office to do that. But, as you have heard today, so far through the-- You asked the question, "Are we having a problem with split responsibilities?" I believe that is part of the problem.

I will offer the Committee hearings and the testimony we had in our Committee to your Committee for inclusion in this report. I want to thank you again for the time you have allowed me today, and also for your bringing much needed publicity to this issue. We need to protect the most vulnerable population in our State.

Thank you, Senator.

SENATOR CODEY: Thank you very much, Assemblyman.

Our next witness will be Mr. Jack D'Ambrosio, Ombudsman for the Elderly. Mr. D'Ambrosio?

J A C K R. D ' A M B R O S I O: Thank you, Senator. Before I begin, I would like to say-- I, too, would like to commend and thank you for the work you did within the last couple of weeks, in exposing some of the problems that a lot of us are aware of. I hope that gives added impetus and support to my concerns about the need to do some of these undercover operations in uncovering problems that relate to patient care, not criminal activity, because we have a Division of Criminal Justice that can handle that just fine. But, there are patient care problems out there that we can only detect with some undercover activity. I am very happy that you highlighted that issue in the way you did.

Senator, as I frequently do, I recently visited a facility of the kind we are discussing today, together with some members of my staff. While I would be the first to admit that not all our facilities throughout the State are like this one, there are many that are. I would like to tell you about some of the things that I saw during my visit. Though my remarks on what I saw there may sound somewhat exaggerated, I assure you that what I observed is not as unusual as it may sound.

As I approached the building itself, I saw a structure that was old, run-down, and obviously in need of repair. It was just the kind of building that, from the outset, gives one the impression that what one is going to find inside is not the kind of thing with which he is going to be happy. After entering the facility, which is licensed as a residential health care facility, my staff began looking it over for possible violations of health and safety regulations. I walked into a room that was bare, in need of repair, in need of painting, with a dilapidated television set playing away and a few people watching in a community-type setting. I identified

myself, and was told that it was lunchtime and everyone would be entering the dining room shortly. When I entered the dining room, I saw a larger room that I found very dull and depressing, a room that had basic tables and chairs and tablecloths that, though clean, appeared to have been there for a very long time, and had deteriorated from wear and tear and overuse. There the residents sat, anxiously awaiting their meal, clearly the highlight of the day for most of them. Some were sitting quietly. Some were talking to themselves. Some were talking to each other. A few made it obvious that they were anxious to eat by continuously yelling for food until it was actually served.

I chose, as I often do, to try to converse with some of the residents. Some did not want to speak to me at all. Some would not even answer me. But I did find several who would speak. One told me everything was fine, that the food was great, but did so under his breath as if he were very much afraid to tell me otherwise. I spoke to one middle-aged female resident who insisted that she was a direct descendant of Cleopatra, with whom she regularly communicated. As a visitor and a new face, you can well imagine that I was the subject of a lot of attention. Within a few minutes, I was told by another resident that she was an actress, and that she could not stay much longer since her limousine was awaiting her outside.

I left the dining area of the building and went upstairs to the second floor. I walked up a set of stairs that were not clean and were in obvious need of some repair. The hallway was dark, and when I got to the second floor, there was the same stuffiness in the air that was present downstairs. I saw room after room that contained nothing but the absolute minimum; in some cases, just a bed, a chest of drawers, and a lamp. Some of these rooms had two or three beds each, so close to each other that it made me wonder what these individuals do when they truly desire or require some privacy.

On the second floor, a young man, in his late 20s at most, approached me, practically in tears. He asked whether I was from the State, and I replied that I was. He became very nervous and said he was afraid I would evict him for not having made his bed that morning. He begged my forgiveness and a second chance. I assured him that I certainly had no intentions of evicting him. He was very thankful and obviously relieved. The fear in his voice is something I will recall for quite a while.

There were very few smiles, but the smiles I did see in that RHCF were smiles that told me how happy those residents were to see someone new visiting. It was clear to me that the people in this facility were not unlike the people in many of the same kinds of facilities that I have visited throughout the State.

These are sad stories, but stories that graphically reflect a segment of our State's boarding home population. These are some of the people we are placing in the community, free to roam about with a minimum of in-house supervision and 12 minutes of nursing care a week.

Being quite upset with what I saw during my visit to the facility, I spoke to the operator, who did, in fact, seem concerned. He told me that a good number of his residents did not belong there, as they were "not ready" for the community; however, refusing them admission would simply mean empty beds and a negative cash flow. So, placements were sought and accepted by him.

As I stood back to reflect upon what I was seeing and hearing, I wondered if this was at all what we meant by "deinstitutionalization." Has deinstitutionalization, as we now see it, failed us? Many of the boarding home residents I see are not necessarily a danger to themselves or others, but they certainly need more help than 12 minutes of nursing care per week. Functional support services are definitely required

to permit adjustment to community living. Without such support services, I believe we are doing a great disservice to the residents and to the communities in which we place them. Without these needed services, we are placing residents in even greater danger because we are merely changing the setting and providing even less than they received in our institutions. It is unrealistic, and even cruel, to think that one single approach can meet the needs of such a mixed population, composed of elderly residents, young residents, the handicapped, former mental patients, and disabled persons.

We make the distinction between the "boarding home" and the "residential health care facility" appear so vast in theory when, in fact, it is difficult for one to realistically see any practical differences between these two types of facilities. I believe it is time to either remove this artificial distinction or, in the alternative, truly create one by offering the health care that can, and should, be offered in a residential health care facility.

The RHCF can serve a most needed and valuable purpose if it is indeed required to offer health care. That can be possible only if we set higher reimbursement levels and mandate specific services that must be in place at such facilities, with no exceptions. Raising payment should be accompanied by minimum staffing requirements and the licensure of RHCF operators. In addition, because some of our facilities are structurally unsound, rather than pouring money into expensive systems and repairs for these antiquated buildings, we should be providing innovative programs allowing for low-interest or no-interest loans that will serve as seed money so that new facilities can be built.

Not too many years ago, similar problems were being discussed and, at that time, the Legislature responded to those problems strongly and swiftly, with legislation that would adequately address the situation. Strong fire codes and safety

regulations were enacted. I believe it is reasonable to conclude that, because of these codes, we have not seen fatalities in the few boarding home fires which New Jersey has suffered during the last few years. It is in the enforcement of these codes and regulations, however, where improvement is urgently needed. Those who violate these regulations must be punished, so that a clear message is sent to the few operators who refuse to accept the fact that laws exist for the protection of residents.

I believe it is unreasonable to expect field personnel to continue to do the good job they are doing in finding violations if their superiors are going to continue to take weak action, if any action at all, in punishing violators. There is only one thing worse than not having tough laws where they are needed, and that is having tough laws which an enforcement agency is unwilling to enforce. Enacting new laws is not necessarily the answer to this problem. Rather, those entrusted with the task of enforcing licensure standards should be called upon to account to the Legislature for the enforcement of existing laws and regulations.

A decade ago, our lawmakers saw the need for legislation and responded. Because the Legislature addressed the problem, we no longer have individuals dying due to the lack of a sprinkler system. Instead, now we have people who are dying within because they need help and compassion that most of them are unable to ask for on their own -- individuals who are alive, but whose quality of life is shamefully low. These boarding home residents deserve to be helped for as long as they need help, and I feel it is the State's obligation to provide that help. This is the problem I hope the Legislature will now address.

While I am dismayed by the problems in New Jersey's boarding homes and residential health care facilities, at the same time, I am encouraged by the fact that they are now the

subject of public discussion. I am often reminded by patient advocates in other states that New Jersey is doing much to provide services. However, it is also apparent that there remains more to be done. Our goal should be to provide the best we can for our residents.

Not all of our facilities are bad. Many want to do even a better job but, unfortunately, lack the resources to do so. I am hopeful that we can find a way to provide those resources, thus eliminating the need to suggest excuses for inadequate care. I believe we can make the model facilities, which are the exceptions of today, the common ground of tomorrow. We must not only make life safe for the residents of our health care facilities, we must make life worth living, with the same respect and dignity that you and I expect in our lives.

Thank you.

SENATOR CODEY: Thank you, Mr. D'Ambrosio. Two questions: One, do you think some of these individuals who have been placed in these facilities should be in mental institutions?

MR. D'AMBROSIO: Well, I am certainly not a proponent of keeping anyone in a mental institution longer than they have to be, but I do believe that if we are going to allow them to leave the mental institutions, we have an obligation to provide the continuum of services to allow them to properly adjust to their new environments.

SENATOR CODEY: Also, you mentioned about enforcing licensure standards. Do you think we have not done that in the past? Have we been derelict in our duty there?

MR. D'AMBROSIO: I believe that in the past we have not enforced the regulations to the point that we could have. I am hopeful that that will improve.

SENATOR CODEY: So, we let some operators off the hook?

MR. D'AMBROSIO: I think we tend to make excuses for what the system provides or does not provide, and sometimes the operator tends to benefit from those excuses.

SENATOR CODEY: Okay. Thank you very much.

MR. D'AMBROSIO: Thank you.

SENATOR BASSANO: Mr. Chairman, one question.

SENATOR CODEY: Oh, excuse me, Senator; I'm sorry. Mr. D'Ambrosio?

SENATOR BASSANO: I don't think my microphone is on, so I will try to speak loudly. You mentioned in your report that you felt that some of the residents were not ready for the community. What can be done to make them ready, in your opinion? What should be happening that is not happening now?

MR. D'AMBROSIO: Well, I think the whole answer, again, is the services we are able to provide these people, if we are going to let them leave the mental health facilities. I think we expect someone who has been in a mental institution for 10 years to be able to come out on a decision -- possibly a judicial decision -- that they are ready-- We expect them, after 10 years, to be able to adjust to a new setting without that continuum of care they need to help them to adjust.

I don't think any of us could adjust to a new setting after being in a completely different one for such a long time. So, we do need a follow-through. We need more-- If we are going to put them in a residential health care facility, let's assure them that the health care they are going to need, and the counseling they are going to need, is available to them in those facilities.

SENATOR BASSANO: Thank you.

MR. D'AMBROSIO: Thank you.

SENATOR CODEY: The next speaker will be William M. Connolly, Deputy Director, Division of Housing and Development, Department of Community Affairs.

W I L L I A M M. C O N N O L L Y: Mr. Chairman and members of the Committee: It is an honor to be before this Committee again to address our boarding home problems, for the first time -- at least in my personal experience -- in six years. This Committee has taken the lead in most of this State's boarding home reform efforts, particularly the Rooming and Boarding House Act itself, which, as some of you may recall, was sponsored by the entire membership of this Committee, as well as the Boarding Home Life-Safety Loan Program.

The Rooming and Boarding House Act was the single most important and most comprehensive piece of reform legislation that has been passed on this subject in this State or, for that matter, in any state. It provided the basis for a vigilant, committed, and sustained attack on the terrible conditions in unlicensed boarding homes, which outraged us all when they were brought out before the State Commission of Investigation and this Committee in the late 1970s.

That all-out attack was no doubt the most important thing that I ever had the privilege to be a part of. But recently, however, our State's largest newspaper has called some things to our attention, and at least somewhat indiscriminately, we think, dragged some of those efforts through the mud. We understand that enforcement is nonexistent; that the boarding home industry can thumb its nose with impunity at the State's laws; that there is a maze of agencies unable to respond; and that abuse goes uncorrected.

I would just like to take a little bit of the time we have here this morning to share with you about five things from the perspective of the Department of Community Affairs: 1) What it is that we do under the Rooming and Boarding House Act; 2) to review with you a little bit our enforcement record under that law; 3) to discuss the Boarding Home Loan Program and the successes and difficulties we have had with it; 4) to share with you a little bit of what we have learned about this

problem in and out of boarding homes over the last five years; and finally, 5) to leave you with a few recommendations we think would be helpful.

Our role under the Rooming and Boarding House Act was to set standards and to bring up the standards of what was then estimated to be 1500 unlicensed rooming and boarding houses in New Jersey. There were, at that time, about 270 licensed boarding homes, which were regulated by the Department of Health. We have set standards for building maintenance, for sanitation, for food service, for fire-safety, for residents' rights, and for the care of residents. We went to every address in this State where three or more SSI checks were sent, and it took us to 10,000 buildings across the face of this State. In the course of that search, we found 2050 unlicensed homes, and we went to work trying to bring them up to standards.

I think it is very important to note that we are the only regulatory agency with responsibility and accountability for these places. Even the roles of our local fire departments and our local building departments are closely coordinated with these efforts, because of the very close working relationship the Department of Community Affairs has with those local officials. There is no maze of regulatory agencies. There are three State regulatory agencies -- and this Legislature is in the process of adding a fourth -- which have some responsibility for these kinds of homes, but there is no jurisdictional overlap. It is clear and distinct who is responsible for a given home.

There is, however, quite a maze of social service providers, funding agencies, advocacy organizations, and organizations with oversight responsibility with regard to ourselves, who do go through these facilities on quite a regular basis. From the owners' perspective, we can understand that it is difficult to tell, sometimes, the fish from the fowl. We are the one regulatory agency, but there are three

public -- or publicly funded -- oversight agencies, which also come through these homes, in order to check out whether or not we are on the job, in addition to all of the providers.

What we found in those 2050 unlicensed boarding homes was often appalling indeed: The conditions that led to 70 fire deaths in one six-month period in late 1979 and early 1980; abuse and neglect and conditions that bordered on the medieval. We moved often and we moved quickly against these facilities. Often we closed homes and removed the victimized residents within 24 hours of having discovered those conditions. Five years later, most of those horrors are history. One out of every six unlicensed boarding homes in this State in 1980 has been closed by the Department of Community Affairs. One out of every 16 rooming houses which existed in 1980 has been closed by the Department of Community Affairs. One out of every 10 rooming or boarding house residents in this State has been moved by the Department of Community Affairs to a decent place to live, because when we close a facility, we accept complete responsibility for every resident in that facility, and they are under our care and are our responsibility until we have placed them in a decent home. That is what we have done for 2000 residents of these homes.

More than $900,000 in penalties has been collected from the owners of rooming and boarding houses, in order to compel compliance with the law.

We can't guarantee a good life, and quite frankly the $320 or so that this State provides to these unfortunates does not buy much of a life. But we can make sure that the people are not victimized and are not deprived of the benefit of what little they do have.

We've responded before dawn on Sunday mornings, and we have worked until two o'clock in the morning, without paying our staff overtime. Our staff often equips themselves, and often assists residents with their own money. I don't call

that bureaucratic indifference, and I don't think it is really fair for the editors of The Star-Ledger to call it bureaucratic indifference either.

The worst is behind us, but there are 1900 rooming and boarding houses which remain. They are far better than they used to be, but we still have some problems. This business is simply far too marginal for it to be otherwise. But, we accept our responsibility to root those conditions out, wherever and whenever we find them.

Let me turn now, for a moment, to the Boarding Home Loan Program. Back in 1981, we reported to this Legislature, after a careful study of the tragic fires which had occurred, that in our judgment only a fire suppression system could prevent tragedy in many of these homes when a fire would occur, and that the economies of the homes were such that those systems were not likely to be provided. The Legislature responded with the Boarding Home Life-Safety Loan Program. This has been a life-giving law, there is no question about it, but it is a very complicated program from a statutory standpoint. It was made complicated by the desire to keep yearly costs to a minimum -- yearly costs to the taxpayers of the State.

The law resorted to doing this by two things: First, tax-exempt bond financing, to try to raise money in the first place; and second, long-term rental assistance to retire the bonds, using primarily casino revenue funds. Taken together across a period of great turmoil in our tax structure, these decisions made the program, administratively, very complex. Nonetheless, our Housing and Mortgage Finance Agency has made the best of a difficult situation. Of the 142 homes which have needed loan assistance from HMFA, they have made loan commitments to 110. The agency loan processing times have been reasonable, considering the complexity of the program. But, there have been some problems which we need to address, because overall, it is taking too long in our judgment.

Some of the problems include: Unsophisticated owners who have a great deal of difficulty in putting a construction project together; architects, engineers, and contractors, who are not much interested in these very small and very difficult jobs; and severe labor shortages in this State's construction industry, especially in the sprinkler trades. Finally, laxity of owners in showing some initiative and some commitment in getting the work done. There have also been some problems with public water supply, being able to find and provide adequate water to support the sprinkler systems, and local zoning officials, who suddenly discover that the facility is not in conformance with the local zoning requirements, and take time to try to decide whether they are going to try to close on a local basis, which holds us up in deciding whether we are going to make an investment in the facility or not.

We find that a lot of technical assistance and enforcement prodding is necessary, even with the Boarding Home Loan Program, which is very deeply subsidized. That, we think, simply reflects the very unsophisticated nature of the industry. It is sort of like having to take a gun and order people to show up at the Christmas tree on Christmas morning, but that is what it takes to get at least some of these facility operators to participate quickly in the Boarding Home Loan Program.

The Housing and Mortgage Finance Agency has recently taken a number of steps to try to simplify the program. It has adopted a short form application process for smaller jobs. We are looking into reducing the amount of architect/engineer responsibilities in smaller jobs, since getting them to do the work has proven so difficult. We may need to look for a funding source with fewer complications than bond revenue and the Casino Revenue Fund, in order to really accelerate the program.

But, the loan program and the enforcement of the standards really have had an effect. As the Ombudsman has just pointed out, last year we didn't have a fire death in a boarding house. In 1980, we had 65. That is not an accident. It is not just luck. We will undoubtedly have some fire deaths in the future in boarding homes, but we had a number of fires last year, that would have been tragedies in the old days, but were not tragedies because of enclosed stairways, fire alarm systems, and fire suppression systems that have been built into those facilities since 1980.

We have learned a few things in the last five years which I think should be of interest to this Committee. Most importantly -- and we have already shared a copy of this with the Committee staff -- the Department financed an in-depth look at boarding homes and what their costs are, and what kind of money it really takes to run a decent boarding home. Careful study of the costs that were collected in the course of that research indicates that general assistance support is insufficient to cover the minimum costs of running a decent home in 100% of the rooming and boarding houses in the State. The rate of SSI reimbursement for the residents of these homes is insufficient to cover the average costs of a decent home -- 70% of the homes in this State.

Another thing we found was that there is no significant difference between RHCFs and C boarding homes insofar as resident characteristics or resident service needs are concerned, but the RHCFs do get $119 more per month per bed.

Boarding homes exist at all because many owners are service motivated, rather than profit motivated. For a large proportion of these homes, from a business standpoint, it doesn't really make sense to be doing what they are doing. They tend to be service motivated.

To get very specific, in 1986, the average shortfall in per resident costs between the SSI payment level and the

average of running a decent home was $104 per resident per month. Forty percent of the residents in these homes are supported by the SSI system. The cost to the State of correcting this would be about $2.5 million a year. The State is currently expending something between $5 million and $6 million a year for fire safety improvements, just to put it in perspective.

As a result of all this, we have had, since 1982, a 16% reduction in the number of boarding homes, and a 12% reduction in the number of beds in boarding homes. So long as these operations are this marginal, it is going to take a lot of vigilance and enforcement, but that is really only a palliative.

Let me just close with five recommendations which we think are worth looking into:

1) An SSI payment adjustment, roughly the $2.5 million figure I mentioned earlier. We think that really needs to be looked at to provide a level of funding that would allow someone to at least stay in business, without subsidizing the operation themselves, and run a decent home.

2) We think the State needs a boarding home construction program that will construct new, smaller boarding homes. The Department is about to launch an effort in that direction, utilizing funds from the Balanced Housing Fund -- a dedicated fund that was recently -- about a year ago -- created by the Legislature to provide for low- and moderate-income housing needs.

3) We think that some social services targeted to these new homes -- and we would expect to take on populations with particular needs -- are necessary, over and above what the social service network can provide to those homes at the present time.

4) We think we ought to look hard at whether we ought to find a different funding mechanism -- a different source of

funds -- to support the Boarding Home Loan Program, due to the tremendous amount of bureaucratic complexity that is introduced by utilizing Casino Revenue Funds and tax-exempt bond financing.

5) We need greater involvement of nonprofit organizations, both in the operation of these homes and supporting those profit motivated operators who provide these kinds of services.

Finally, we think we need no further proliferation of regulatory agencies. We thought three was enough. We think four is certainly enough.

Thank you very much.

SENATOR CODEY: Thank you very much, Mr. Connolly. Our next witness will be Mr. David Lazarus, Director of Litigation for the Community Health Law Project.

D A V I D P. L A Z A R U S, E S Q.: Good morning, Senators. Thank you very much for this opportunity to present some testimony before you today. The Community Health Law Project is a private, nonprofit organization which has, over the last 10 years, represented about 10,000 disabled and elderly individuals living in the community. Many of these individuals live in RHCFs -- residential health care facilities -- and boarding homes.

After many, many frustrating attempts to get the Department of Health to correct some of the violations and some of the problems in the residential health care facilities, I finally went to The Star-Ledger, repeated some of my experiences to Mr. Jaffe, who investigated the situation on his own, and obviously chose to write a series of articles. I would like to recount to you two of the specific cases I told him about, which sparked the investigation.

One of our clients, an 84-year-old woman who is senile at times, was discharged from a psychiatric unit in a Union County hospital into a residential health care facility in Linden. She agreed with the residential health care facility

operator that if she turned over her entire life savings of $32,000, plus gave the operator her Social Security check of $800 per month, she could stay in that home for the rest of her life.

Well, two and a half years after she moved in, the operator told her that she had used up all of her money and would have to move out. The case was referred to the Law Project by the Ombudsman's office, and we started litigation on her behalf.

During the course of litigation, and during the investigation, we found out that the operator had several felony convictions. The felony convictions are described in the materials I provided to you, including those of embezzlement and drug distribution. We found that he had been serving time in Danbury Federal Penitentiary and, in fact, that was the place where he had met the prior owner of the facility, who was also doing time in Danbury.

SENATOR CODEY: It sounds like he could work at Marlboro. (laughter)

MR. LAZARUS: On October 22, our attorney who was representing this woman, called the Department of Health, Bureau of Licensing and Inspections, and reported the circumstances and the background of a criminal record. Our attorney was told by the Department that they already knew of the criminal background of this individual, but because RHCFs were in short supply, they had no intention of intervening.

In another case, one of our staff was visiting a client in a residential health care facility in Elizabeth. While she was on the premises, she witnessed an assault by the manager against one of the residents. Upon witnessing the assault, she reported it immediately to the County Board of Social Services, as well as to the Department of Health. The Board of Social Services, despite regulations requiring a 24-hour follow-up and investigation, took five days to

investigate the complaint. When she called the Department of Health, Licensing and Inspection Bureau, she was told that it would take about two weeks, because someone was out sick.

Both of these cases are well-documented, and I have provided that information to you.

I, together with staff from the Department of Human Services, met with the Commissioner of Health on April 15, 1986. The purpose of that meeting, gentlemen, was to inform the Commissioner of Health of some very severe problems in enforcement by the Department of Health's Bureau of Licensing and Inspection Standards. We cited both of the cases to her, and thereafter I also met with an Assistant Commissioner of Health.

Senators, when I checked several months ago, the residential health care facility operator with the criminal background, operating the Linden facility, was still operating that facility and, in fact, was listed on Department of Health's own records as the current manager of the operation. The operator who assaulted the client who we represented in the Elizabeth residential health care facility, was still acting as the manager when Herb Jaffe and myself visited the facility several months ago.

Unfortunately, this is the tip of the iceberg. I am sure you are going to hear, after my testimony, incident after incident. However, getting the regulators just to enforce the regulations is not the whole -- doesn't even come close to solving the problem. Residential health care facilities and boarding homes are being used as bargain basement housing for the mentally ill and the elderly. Of the 10,000 people who live in RHCFs, half of them are over the age of 75; a quarter are over the age of 85; at least a half are mentally ill. Yet, for these vulnerable adults we provide only $300 to $400 per month in SSI payments for them to purchase food, shelter, and personal care. They are among the State's most vulnerable

population. It costs the State about $50 a day -- assuming there is a Medicaid match -- for a person in a nursing home; about $70 a day -- assuming there is a county match -- for a person in a psychiatric hospital -- $50,000 a year. Yet, this State pays for a person in a boarding home, who yesterday may have been in a psychiatric hospital, $1 per day to provide food, shelter, personal care, and financial services. For a person in a RHCF, the State provides less than $4 a day.

I do not see -- although I have seen particular pieces of legislation -- a broad, coordinated government plan to redress this problem. I would like to suggest seven areas that would merit concern in my mind for investigation and reform of this particular problem.

First, we must recognize that most of the individuals living in the home simply do not belong there. They are too functionally disabled to expect them to survive in this kind of a setting. What they need are small, homelike settings, where there is a great degree of personal care by people who are professionally trained.

Second, as it exists now, the Departments of Health, Community Affairs, and Human Services, have regulatory power over the home. This basically has not worked. There are three different masters -- being three different Commissioners -- with three sets of agendas and three different sets of priorities. It simply does not work. I would suggest that you look into recommending collapsing these three different Departments into one department. I might suggest -- if it could be done -- that it be the Department of Human Services, for the reason that most of the services required by these people in the home, are either provided directly by Human Services or are contracted through the Department of Human Services. Human Services also licenses other kinds of residential facilities in the community.

Thirdly, most people are suggesting that you raise the SSI rate across-the-board. Senators, I believe this is a monumental mistake, because to raise the SSI rate across-the-board benefits the good operators too little, and benefits the bad operators too much. It would just encourage the bad operators to stay in business as they are now year after year.

I would suggest that a program be set up where supplemental payments can be targeted to specific operators with good homes, proven track records, who want to obtain professional credentials and can meet upgraded licensure standards.

Fourth, I would suggest that many of these facilities have turned into mini institutions in the community. They have outstripped the resources of local communities to deal with them. Towns such as East Orange, Long Branch, Plainfield -- I could go on -- have been reeling under the effect of them. I would suggest imposing a strict limit and siting regulations on where these places can be located. The Department of Health's own long-term care plan suggests -- in fact, mandates -- that residential health care facilities contain no more than 100 beds. Yet, very recently, they licensed what was an already constructed 250-bed residential health care facility.

Fifth, I would suggest expanding services to boarding home and residential health care facility residents through private, nonprofit service organizations. It has been shown, time and again, that people living in RHCFs and boarding homes mostly will not go on beyond their four walls to seek services, yet the service providers, in many instances, are hampered to go beyond their four walls to provide services on site. One of the problems is Medicaid reimbursement, which will not provide off-site reimbursement for many of these service providers.

Sixth, I would require the funding of advocacy organizations outside of government to monitor the facilities

and to really look over the shoulders of the State Departments which are charged with enforcing the regulations. It is unrealistic to believe that an organization charged with enforcing its own regulations will police itself. We must also amend laws to allow outside organizations to bring suits against operators of these facilities who are in substantial violation, without the necessity of a plaintiff. It has been shown, time and again, that the people who live in these homes are just too intimidated to stand up to a lawsuit.

Lastly, I would suggest that the Legislature demand that the Departments do their job. The Legislature really must commit some ongoing legislative oversight in this area until we see substantial remediation.

Thank you very much.

SENATOR CODEY: Mr. Lazarus, in your testimony, you said that someone in the Department knew about the criminal background, and said he had no plans to remove that operator. Are you saying that he condoned it?

MR. LAZARUS: Yes, sir. There were three people who knew about it -- three people in the Department who knew about it.

SENATOR CODEY: The Department of Health?

MR. LAZARUS: That is correct, sir.

SENATOR CODEY: Obviously, from your testimony, you would say the Department felt that an absolutely poor job, shall we say--

MR. LAZARUS: In my experience, that is correct, sir.

SENATOR CODEY: You brought many of these things to their attention?

MR. LAZARUS: Absolutely. I brought them to the attention of the Commissioner, together with people from the Department of Human Services, because they were very concerned about the same thing I was.

SENATOR CODEY: As far as you are concerned, the Department failed that?

MR. LAZARUS: Absolutely.

SENATOR CODEY: Okay.

MR. LAZARUS: Two years after they learned about a felony conviction, admittedly so. One of their few regulations is that someone cannot operate a facility with a record of a felony conviction, and they failed to take any action.

SENATOR CODEY: Thank you very much, Mr. Lazarus.

Our next witness will be Mr. Michael Laracy, Assistant Commissioner for Policy and Program Evaluation for the Department of Human Services.

A S S T. C O M M. M I C H A E L L A R A C Y: Good morning, Mr. Chairman. With your permission, I would like to have Lynn Kiernan, who is the Administrator of Community Services from our Division of Mental Health and Hospitals, and Tom Blatner, who is our Boarding Home Coordinator, join me at the witness table.

Mr. Chairman, members of the Committee, I am Michael Laracy, Assistant Commissioner for Policy and Program Evaluation for the Department of Human Services. I am before you today to discuss the Department's responsibilities to the residents of the State's boarding homes and residential health care facilities, and our progress in meeting those responsibilities.

I also wish to address areas that require our attention, and those which represent new challenges.

Today, there are 14,000 residents of boarding homes and residential health care facilities, and another 18,000 in our State's rooming houses. These individuals represent, without a doubt, many of our most needy and vulnerable citizens. Since the implementation of the Rooming and Boarding House Act seven years ago, it has been the responsibility of the Departments of Community Affairs, Health, and Human Services, and the Office of the Ombudsman, to ensure the well-being of these residents by upgrading the conditions in

some homes and closing others, by ensuring fire- and life-safety standards are met, by identifying and resolving problems in the facilities, by training operators, and by seeing that income, social, health, mental health, and other services are delivered to the residents.

I have been directly or indirectly involved in our efforts to improve the quality of boarding home care since 1978. I am, therefore, familiar with the mandates of the Rooming and Boarding House Act, as well as with the reports forwarded to the Legislature on boarding home reform in 1982 and 1983. I would like to report on our progress since then. In 1984, our three Departments, together, expanded their State level planning process to include local service providers and boarding home operators themselves. At the same time, we began planning and coordination efforts at the county welfare agency level. Today, as a result, we have initiatives in virtually every county to identify the needs of residents, to coordinate inspections of homes and services to residents, to cooperatively solve problems with boarding home operators, and to increase the level of services in homes with unmet needs.

In addition to these planning and coordination activities, limited maintenance and monitoring of health services have been added to residential health care facilities. As Dr. Coye testified, further upgrading of services to those facilities is presently under consideration.

Furthermore, two programs are currently under way to increase the number of beds for residents. One quite successful effort involves adding residential beds to nursing homes seeking certificates of need for new construction or expansion. The other is a proposal by the Department of Community Affairs for capital construction of boarding homes, which would add 400 needed new beds to our diminishing supply.

I would like to briefly cite some of the other areas in which we have made significant strides:

Staff Training: Over 150 social service and mental health staff were trained in 1986 alone on how to investigate abuse and neglect in facilities.

Demographic Information: Surveys and assessments have been completed which provide New Jersey with the best data on this population in the nation. For example, our information has revealed that 76% of facility residents are elderly, 50% of the population are deinstitutionalized from mental hospitals, 45% are on SSI, and 5% are alcohol abusers.

Adult Protective Services: Legislation has been introduced which will significantly enhance the legal protection of this population, as well as other vulnerable adults in the community.

Service Coordination: Coordination meetings among licensing and provider agencies are held at regular intervals in almost all counties. These meetings are designed to remediate issues with problem facilities and to develop formal agreements among service providers and licensing agencies. Coordination has helped to define roles and ensure better accountability for service provision among agencies at both the State and local levels.

Needs Assessments: County welfare agencies have completed over 10,000 service needs assessments during 1985 and 1986. These assessments provided an understanding of residents' needs, and have resulted in service interventions such as case management and counseling, and referrals to outside agencies for health, mental health, and coummunity-based services.

I spoke earlier of remaining challenges. During the past few years, economic changes have negatively impacted on the boarding home industry. These include increased real estate values, building costs, and quadrupled liability insurance rates.

While facility owners have faced these added financial burdens, reimbursement rates for SSI clients have not fully kept up with increases in the cost of living. While we, as State officials, press for better, more qualified staff in these facilities, many owners must rely on help paid at the minimum wage.

Simultaneously, the populations we hope these homes will serve are becoming more needy and more dependent. We have increasing numbers of elderly in the State, and as they live longer, they tend to need more care. Twenty-five percent of the population of these homes is over 80 years old. And the community mental health population is changing as well. The growing population of young chronic mental health clients no longer undergo long-term institutionalization. These clients, who have serious multiple problems, are frequently in and out of boarding homes and shelters. We need better staffing and increased support to homes caring for these most vulnerable groups. Yet, the reality we face is that small and mid-size homes, which often offer family type settings and personalized support, are rapidly disappearing. Some homes that remain choose not to care for SSI recipients. Without new services to meet specific client needs and to support operators in dealing with their problems, these housing resources, sometimes the only alternative to homelessness, will continue to be at risk.

Through operator and staff training, through increased attention and coordination by social services and mental health agencies, through rigorously enforced fire-safety standards, and through sheer dedication of the majority of boarding home operators in providing quality care, we have come a long way. Recent headlines remind us of our shortcomings in terms of enforcing, and upgrading, critical standards of care.

We need to focus renewed attention and energy, and resources, on the challenges presented by our successes and failures, so that we can continue the progress begun by this Committee in 1978.

Thank you.

SENATOR CODEY: Thank you, Mr. Laracy. The people we are taking from our mental institutions and placing in these facilities, do you think some of them should have stayed in our mental institutions?

ASSISTANT COMMISSIONER LARACY: I think it is fair to say that in individual cases, placements were made, particularly in the past, that were inappropriate. I think that is largely a thing of the past. A lot depends on the services available to the residents. The residents who are placed in these facilities are, for the most part, entirely appropriate for the setting, provided services are available. For more details, I would defer to Lynn Kiernan.

L Y N N K I E R N A N: We have made several recent initiatives to tighten up the discharge process for a client -- to ensure that when a client does go into the community, services are in place. What we have done is designate one individual who works with a community agency, to work with the client before the client's discharge from the hospital, and to follow-up in the community to ensure continuity of care and to make every effort to finalize a treatment plan for the client, so that if one mental health client discharged from a State hospital does go into a boarding home, the services are there for the client, and are monitored to be sure the client is receiving those services.

One of the other things we have initiated is in terms of the discharge process at the hospital. A client is taken to the facility before he or she is discharged from the hospital to meet the boarding home operator, to be sure that that particular facility is best suited to the client's needs in terms of what the boarding home operator feels he or she can effect for the client, in terms of the client's stated needs, and also in terms of the community services that are available in that area, in the event the boarding home operator would need them, and the client would need them.

SENATOR CODEY: Mr. Laracy, would you say the Department of Health has not been doing its job in enforcing the laws which are presently on the books?

ASSISTANT COMMISSIONER LARACY: No, I would not say that. I think that in the vast majority of facilities regulated by both the Department of Health and the Department of Community Affairs quality care is provided because of the attention paid by the Departments, and because of the inclination of the operators. I think it is fair to say that there have been failures. I don't think they are systematic or widespread. Enforcement has been sometimes uneven. Part of the problem faced by the Department of Health is that they face the burden of proof, in many cases, and that is difficult to establish. The Department of Community Affairs, because they are licensing facilities that heretofore have not been licensed, has the reverse situation. The burden of proof is on the operator as to why he should obtain a license, why he should be permitted to enjoy a license. The Department of Health is dealing, in almost all cases, with facilities that have been operating for 20 or 30 years, and they have a burden of proof to show that the facility is inadequate.

SENATOR CODEY: Senator Bassano? (negative response) Thank you very much, Mr. Laracy.

ASSISTANT COMMISSIONER LARACY: Thank you.

SENATOR CODEY: Our next witness will be Mr. William Schultz, from the New Jersey Fire Prevention and Protection Association. Mr. Schultz?

W I L L I A M S C H U L T Z: Good morning, Senators. I am here this morning on behalf of the New Jersey Fire Prevention and Protection Association, an organization which represents the majority of the fire protection sub-code officials and the fire prevention officials throughout the State of New Jersey. The remarks I am going to make are from a prepared statement on behalf of that organization.

The proposed subchapter 4, New Jersey Administrative Code 5:18-4.1 et seq., also known as the Fire Safety Code, commonly referred to as retrofit regulations, proposed to require Class C rooming and boarding homes and residential health care facilities to comply with a number of retroactive fire-safety provisions. This compliance is to be completed within one year of the effective date of the adoption by the Commissioner of Community Affairs. This proposal as modified and recommended by the New Jersey Fire Safety Commission and supported by this Association, was sent to the Commissioner of Community Affairs following a Fire Commission meeting early in January of this year, to enlist the Commissioner's approval.

Many of the proposed retrofit requirements already exist, either in current State regulations or as licensing requirements. Some of the proposals are new, resulting from hearings and deliberations of the Fire Commission and its advisory councils.

For the first time, however, all of the fire-safety regulations will be contained in a single reference. Furthermore, and more importantly, the new fire code will be enforced by local fire officials and fire prevention inspectors, whose respective departments are responsible for the life-safety and the fire fighting at these facilities. Also, the local fire officials must, under the regulations, inspect these structures at least once annually, instead of the current inadequate scheduled inspections.

Among the requirements which will be mandated under the proposal recommended for adoption to DCA's Commissioner -- but which have not yet been acted upon -- are the following: The existing fire alarm system regulations are to be adopted, pending further review and recommendations by an ad hoc committee of the Fire Commission. The proposal includes a strengthening of the requirements to have these systems supervised; that is, connected directly to the local fire

department, to eliminate the delay of fire department notification and to prevent tampering or disconnection by owners or tenants.

The second item is the strengthening of remote secondary means of egress or exiting requirements in Class C homes, and certain R-2 uses with floors more than 16 feet above grade, to provide a second way out.

The third is more stringent provisions for emergency lighting of exitways. The fourth is for elimination of lights in Class C homes and exit lights in residential health care facilities with more than 20 occupants. The fifth is minimum thickness requirements for all corridor doors in all rooming and boarding homes, to provide added protection to escape corridors in the event of a rooming unit fire.

This Association has recommended also that all of these doors be required to have self-closing devices, but this is not a proposal at this time. Requirements for fire-rigged enclosures for boiler and furnace rooms will be increased. Flame spread requirements for interior finish, which will inhibit the spread of flame across walls, sides of stairs, etc., will be increased.

In addition, this Association and the Fire Commission have recommended an increase in protection in all of these types of facilities in two critical areas. Both of these, however, are considered substantial changes which must be reproposed. There is no date available when these recommendations, if adopted, would become effective.

The first of these is the incorporation of sprinkler provisions for all Class C homes and residential health care facilities classed as I-1 use group with more than 20 occupants. Adoption of this provision would be a truly significant step toward increasing safety in these facilities, and should be encouraged.

The second item is a fire-rated protection requirement for all interior stairs and other floor-to-floor openings, and has been recommended. This is a major factor in guaranteeing the usability of stairs and corridors and in delaying fire travel from floor to floor.

To these ends the New Jersey Fire Prevention and Protection Association recommends to this Committee the following: Call for the Bureau of Rooming and Boarding Home Standards in the Department of Health to comply with the provisions of N.J.A.C. 5:18A-3.6, which would require them to notify the local fire official prior to their inspection for coordination. Also, to notify the local fire official of any violations found; furnish the local fire official with a listing of all licensed facilities within his jurisdiction; and obtain approval of the local fire official concerning any variations from the code to be granted.

Second is to recommend to the DCA Commissioner a timely adoption and reproposal of subchapter 4, as recommended by the Fire Safety Commission.

Third is to recommend to the DCA Commissioner adoption of a sprinkler and vertical opening requirement, as recommended by this Association to him.

Fourth is to recommend to DCA to review, and possibly reclassify, more of these types of facilities as use group I-1, instead of R-2, which would require more of these safety features to be involved.

Thank you.

SENATOR CODEY: Thank you very much, Mr. Schultz.

Our next witness will be Mr. Arthur Sieblist, President, Concerned Families with Family Members in Boarding Homes, Essex County. (Mr. Sieblist not present) Oh, he's not here, okay. Our next witness then will be Mr. James Cunningham, President, New Jersey Association of Health Care Facilities. Mr. Cunningham?

J A M E S E. C U N N I N G H A M: Thank you, Mr. Chairman. My name is James E. Cunningham. I am President of the New Jersey Association of Health Care Facilities. The Association represents more than 200 nursing homes and licensed residential health care facilities across the State.

I am pleased to appear today on behalf of the residential health care facilities -- RHCFs -- that are licensed by the Department of Health.

We are here with the same concerns that this Committee has as a result of the recent Star-Ledger articles that examined conditions in RHCFs and questioned the effectiveness of State regulations governing them. In that series, the author, Herb Jaffe, acknowledged that many quality RHCFs do exist. But there is one point he made that merits clarification; that's the difference between a RHCF and a boarding home.

RHCFs provide shelter, food, one hour of personal care for each resident everyday, a minimum of 12 minutes per week of nursing monitoring for each person, oversight of residents' medication, as well as 24-hour-per-day supervision of the facility and its residents.

In contrast, boarding homes -- even C, the highest level -- only provide shelter, food, and, if required by an occasional resident, outside personal care services -- which were mentioned before -- for which special arrangements must be made.

Such broader services in RHCFs are needed because our residents, many of whom are former psychiatric patients, require fewer services than a nursing home, but need more care than available in boarding homes. These additional services provided by RHCFs largely account for the difference in SSI reimbursement rates.

The Department of Health's idea, which they mentioned earlier, on the upgrade of these types of facilities-- They

have that already. That would be an intermediate care facility, and there is no way they are going to do that legally under Federal law, without making them intermediate care. The buildings these people are housed in wouldn't qualify.

Mr. Chairman, we appreciate your responding to the concerns raised in these reports and are here to offer our suggestions for upgrading RHCF standards.

We have been actively trying to build an acceptable level of quality for RHCFs. Not only did we support, but we also helped to draft, the eight-bill residential health care package that was unanimously approved by the Legislature last session. That set of bills required licensing of, and training programs for facility operators, and established other procedures to help them provide upgraded care. The Governor vetoed the package, asserting that he hadn't had time to review it.

These bills have now been reintroduced. Their passage is essential in order to advance the quality of RHCF care. Some of their provisions include: establishing a mandatory training program for RHCF operators; denying a license to an applicant whose license has been revoked; and establishing a support services program to help residents live more independently. We urge the Legislature to approve these bills and allow the Governor ample review time.

An equally critical step the Legislature must take to foster residential care is to update New Jersey's Supplemental Security Income reimbursement rate. As you know, most of the people living in proprietary RHCFs are totally dependent on the SSI program, which has two components: a Federal share and a State supplement. While the Federal share has steadily increased since 1977, the State's has not.

The State pays $150 per month into the SSI reimbursement program for RHCFs -- less than one-third of the total $490 monthly rate. The Federal government pays $340.

Residents keep $53 as personal allowance. In the end, $437 from a resident's SSI monthly check is paid to the RHCF. This translates to $14.50 per resident per day to cover expenses of food, shelter, personal care, and nurse monitoring.

In 1981, a study commissioned by the Legislature itself, and released by the Department of Health, showed that daily reimbursement rates for these services should be $18 to $24. That was prior to six years of continued inflation. Earlier this year, the Governor deleted an appropriation from the Department of Human Services' budget for RHCF and boarding home level C care. That money could have increased the State's SSI compensation.

We are planning ourselves to commission a new, impartial reimbursement rate study that will show what the current amount of the State's SSI share should be. We have frequently asked the State to recognize its responsibility to the needy residents of these facilities. When the study is completed, we would like to submit it to the Legislature. We hope you will review this report and consider the rates recommended as a guideline for establishing new SSI State reimbursement rates.

As Senator Codey has so clearly demonstrated in regard to public institutions, adequate funding is a crucial element in a facility's ability to attract competent staff. Today, most RHCFs are engaged in a seemingly unending battle to properly meet personnel requirements and still balance their books.

Some of the other things which were mentioned earlier today about the new beds in nursing homes through the CN program-- Most of them are not available to SSI recipients. They are not financially feasible in that status and, to tell you the truth, most of those beds are going begging. They are having trouble filling them.

While an increase in the overall reimbursement rate is needed urgently, A-3092, currently being considered by the Assembly, is also important. This bill will guarantee an automatic increase in the State's SSI payment share by the same percentage as the Federal government's. This measure will ensure, along with an appropriate increase in overall reimbursement rates, that RHCFs will be in a better position to deliver the quality residential care we all seek. We request your support of A-3092.

The reform package, plus adequate reimbursement that comprehends steadily improving services, we think, will break the cycle of media expose, legislative study, and governmental inaction. In my 20 years here -- and it didn't start, I don't think, until the last 15 -- I have been in this chair, sitting here doing the same thing, three times -- just about every five years. Hopefully, this thing will be solved.

We stand ready, as we always have, to assist this Committee in any way possible. We hope, under your leadership, reforms in licensing and reimbursement will soon be enacted; that you will approve the eight-bill RHCF package and Assemblyman Felice's A-3092, and increase the State's SSI reimbursement program.

Thank you.

SENATOR CODEY: Mr. Cunningham, you see those bills as one way to overcome this particular problem obviously. Is that correct?

MR. CUNNINGHAM: Absolutely. We supported those bills wholeheartedly, and actually we were very, very surprised when they were vetoed. There was not a great amount of money in there, but there was some for new beds and for the upgrading of facilities. There was nothing for a reimbursement rate increase.

SENATOR CODEY: Thank you, sir. Our next witness will be Jack Fay, the former Ombudsman for the Institutionalized Elderly. Mr. Fay?

J O H N J. F A Y, J R.: Senator, like Jim Cunningham, this is like deja vu after 15 years, and also reporting, for the tenth time, on the inherent weaknesses in the boarding home world and the boarding home population. The recommendation I am submitting to you and the Committee and to the Governor is a recommendation we made five years ago and three years ago through the State's Ombudsman's office, that the Governor and the State Legislature remove the residential boarding homes from Health and place them under-- What is badly needed is a central authority -- one department and one office for all of the boarding home population.

SENATOR CODEY: Who should that be?

MR. FAY: The Department of Community Affairs, from the beginning of the boarding home law-- The Department of Community Affairs has convinced me, both while I was in the Ombudsman's office and since I have left it, that they are much more diligent, much more vigilant, and much more committed to enforcing the law, both in the spirit and in the letter of the law.

I make this part of my recommendation, too, that while they move all of the boarding homes over to DCA, they also upgrade the boarding homes to a division, and that mental health advocates be moved along, and the professional people -- the nurses, the RNs who have this kind of public health experience -- be moved along with them. I think this is a much needed move. I think the State Department of Health, with the hospitals and the nursing homes-- Properly, those are their major obligations and responsibilities.

Again I would say under oath, as I have said from the beginning-- Jim Cunningham spelled out the differences in rules and regulations between the residential boarding home and the C boarding home. I would move the C boarding homes up to that category. I would move the SSI up with them. Twelve minutes of nursing care per week, and if you are real sick you get 14 minutes a week. There is other needed help there.

Regarding the Mandatory Abuse Reporting Act, again, reading Mr. Jaffe's columns and other articles-- The fact that the State Ombudsman does have a Mandatory Reporting Act-- Unfortunately, to the boarding home population, you have that "60-year-old" sentence in the statute. I would amend that statute to include all patients and/or residents in both the C boarding homes and the residential boarding homes, which could be one license, and then have that main statutory reporting Ombudsman law put into effect. There was a remarkable increase in the reporting of abuses from nursing homes, and some residential boarding homes, when that adult abuse reporting law passed four years ago. So I think that is badly needed, too.

What bothers me the most, though, is the cavalier attitude about fire-safety. When you talk about boarding homes, there is such a night and day difference between the boarding home and the nursing home. The tragedy in Keansburg, where 30 people died-- There was a nursing home attached to that. There were three people on duty for 30 people in that nursing home. There was one person on duty for 50-some people in the residential boarding home. There were three people on duty for the people in the nursing home.

When you realize that the average nursing home in the State is an old wooden building, whether it is Asbury Park, whether it is East Orange-- No matter where we find a boarding home, I would say that 98% of them -- off the top of my head -- are old, wooden buildings. The fire tragedies where the 63 people died-- These were better than average boarding homes. These were not bad boarding homes. When I heard on the radio on my way down to Trenton that there had been a boarding home fire and that either four had died, or 12, or 20 had died-- Fifteen other boarding homes rushed through my mind, not the one in Keansburg, not the one in Bradley, not the one in Point Pleasant. The only one that had a real bad record was the fire in Camden.

It is for that reason that when you recognize-- Here is an old, old wooden building, and what is the population? Mr. Laracy gave you the statistics of people old and sick, but not sick enough for a nursing home, but yet into their 70s, into their 80s, on the second or third floor. Then, the rest of the population, the former mental patients, whether they are 25 years old or 85 years old, are all heavily tranquilized. This was a major thrust for the sprinklers, just to give them a fighting chance. The fact of the matter is, most of the people in the boarding homes, especially the former mental patients, are being tranquilized, sometimes heavily tranquilized. Therefore, the smoke alarm; therefore, even more so, the sprinklers. To hear bureaucratic rhetoric about two to three years to get a sprinkler, or to get a loan, is also frightening.

I would just like to conclude to you, to the Senators, the Assemblymen, and the Governor, if you stay with the status quo, and if the Otlowski bills are ignored-- They will be coming around and will be open to amendments. If there aren't some significant changes, I think we will be right back where we started from. All of the laws we are talking about, all of the tragedies, the beatings, the robbing of their checks during the winter season-- All of the laws that were passed in the late '70s and early '80s-- Mr. Jaffe's articles dealt with after these laws were passed. So, there is that gap. I think it can be filled; it can be filled just by a few major movements, or at least a beginning. There is no panacea here.

SENATOR CODEY: Thank you very much. Ella Hilton, from the Camden City Boarding Operators. Good afternoon.

E L L A H I L T O N: Good afternoon. Senator Codey, I would like to commend you for going into the hospital and assuming the disguise you did, so that you became acutely aware of a lot of the situations that I have been involved with for the last 29 years.

In 1958, the mentally ill were deinstitutionalized. At the beginning, there were supposed to have been supportive services for those residents who were coming out of the mental health hospitals. There should have been case management, follow-up service, and monitoring of boarding homes, RHCFs, and wherever a mental health client was going.

I have been a boarding home owner/operator. I saw a lot of things that were being done to the operators and to the clients, and I decided to go into the field myself and get a little firsthand experience. I worked as an operator and saw a lot of the ills. I left the operator's job and began to work in an emergency shelter. There at the shelter, I saw clients driven up in hospital vans, dropped off at the door of the shelter in their bare feet, and sometimes in their hospital gowns.

I saw taxicabs pull up and drop people off at the shelter. I saw police drive up and drop them off at the doorstep. I saw hospitals from Pennsylvania send clients over to New Jersey, and drop them off at the borderline for them to go into the emergency shelter. The majority of these clients were mental health clients, clients who were receiving SSI income only.

The Class C operators in Camden City, for some reason, have received the brunt of the SSI clients, perhaps because of the rates that the operators there charge for SSI clients. They do not get by $363 a month; therefore, you can't really charge them but so much money.

I have seen the steady increase of other operators who refuse to take SSI clients because they cannot be reimbursed for clients who act up, who are unruly, who damage their property. The operators become irritable, and they just simply say, "You can't come back here any more." The operators' liability insurance skyrockets. The mortgage company is not happy that they have mortgaged a house for single occupancy

use, and they term it as going into a business. That puts you into a different category.

The SSI clients who are there-- I feel they should receive sufficient after-care once they are discharged from the hospital. They need a transition period before they leave the hospital to go into a boarding home or into a residential health care facility, or into some other private mental health facility that takes clients who are on SSI.

I have seen, and I have documented, the young, chronic psychiatric adults, and there is no place for them to go. The day care programs that provide mental health activities and recreation for those clients will not take a disruptive client. There are no services now -- in our area, in the South Jersey area -- for the dual-diagnosed client; that is, a mental health client who has alcohol and substance abuse combined together. None of those issues have been addressed.

There is one facility in Willingboro, New Jersey that has 10% for indigents. As you can imagine, they have a long waiting list of clients to get into that program. There is no one at all in our area who is servicing that particular type of client. Ultimately, these clients wind up going back into hospitals, such as Marlboro, Ancora, and other hospitals. I am not saying they are, but I am assuming that the staffs there are aggravated because these are disruptive clients, and they do need certain specific care.

I could see the State providing training, getting input from those people who are directly involved with their clients on a daily basis, who are aware of the conditions when a client begins to deteriorate and go into crisis. They should prepare people to deal with those situations, because once they go into crisis at the hospitals, they are stabilized in 24 hours. They are given triple injections of medication to calm them down. The boarding home operator is told, "Come and pick up your client. He is ready to go home." At that point, he

doesn't even know his name, he doesn't know where he is going, he doesn't know anything, but that operator's responsibility is to take that client back home and deal with that client on his own, where a majority of the time the hospitals they are coming from are not able to deal and cope with that particular problematic client.

That type of client needs specific one-on-one counseling. I have not, to this time, seen emphasis put on the nutrition that goes into the mental health clients' bodies, which attributes to their behavior, the types of medications they are taking. The majority of them are not aware of the effects on their bodies, the shuffling of their feet when they walk, the dryness in their mouths, the salivating. They are not aware of that. When other people look at them, they become inhuman; they become "them," or "those people." There is a stigma attached to mental illness. I see the public being more educated in exactly what mental illness is all about, that anyone in any of our families, at any point in time, can become mentally ill simply by striking your head on your sink in the morning when you are washing your face. So, it is not something you are born with. It is just something that is here, and it is something that has to be realistically dealt with before there is a continuation of people either commiting suicide or deliberately doing harm to themselves, and to others, simply to be committed into a hospital. Once they get into a hospital, they begin to get familiar with the hospital, and they don't want to leave the hospital because a lot of times there is a lack of restraint there, and they can do basically what they want to do. Once they come back out into society, they go under rule again.

The majority of the clients you find in the shelters are SSI recipients, because the operators get tired of taking care of them. The outpatient programs discharge them. Once they are there in a shelter, there is no adequate staffing

there for them; no psychiatric nurse on duty there to monitor those clients who need those specific services. The clients will refuse to go to the programs.

So, these are some of the ills I have dealt with and that I have faced and seen on a daily basis. Yes, there should be a separation for clients who have mental problems. I am not saying that all of them should be in a mental institution, but some, no matter how much you do, will remain in that same particular situation, and they should remain where they can receive those supportive services. Those clients who are not there need, and have a right -- as do all of us here -- to have those supportive services, because they cannot deal with the realities on the outside.

I see a lot of improvement from before, but I also see that there is a vast area of improvement that still needs to be addressed. I agree with Mr. Lazarus, I believe, on the SSI increases going to specialized boarding homes, because I believe it takes a specific type of person to work with a specific type of client. Some can, and some can't. Those operators, I believe, should receive that extra in the SSI checks for the recipients, because with the SSI energy checks the clients receive, they usually wind up-- They go out and get drunk, or they have a pot party, or they have a beer or booze party. The money is not really used as it was intended to be used. Those funds should be toward the betterment of that client, and not just simply for a good weekend.

SENATOR CODEY: Thank you very much.

We are going to take a break. We will reconvene at exactly 1:30.

(RECESS)

AFTER RECESS:

SENATOR CODEY: Good afternoon. We would like to reconvene our hearing, please. Our first witness this afternoon will be Dr. Meyer Schreiber.

D R. M E Y E R S C H R E I B E R: Good afternoon. My name is Dr. Meyer Schreiber. I am an Associate Professor at Kean College of New Jersey in Union. I appear before you in a private capacity as a concerned citizen in the public interest.

As a person who has been very, very much involved in boarding homes for the past 10 years, it is very interesting to me to see how problems seem to haunt us and come back, and how bureaucracies persist -- not only persist, but grow and increase to an incredible amount in terms of what they do.

It is also interesting to me to hear the people from the State agencies tell about all of their achievements, and not confront some of the basic issues involved in terms of persons in boarding homes. Schreiber's theorem would be that the Commissioners and all the others should be required to stay until the end of the hearing, so they can be exposed to the views of other people, particularly some of the consumers who will be following.

At any rate, I recall very vividly, that I attended the State Commission of Investigation hearings in the summer of 1978, when the Commission, which only deals with criminal activity, investigated boarding homes because patients or residents were being abused and their money and property confiscated. This series of hearings had an important impact on me, because it seemed to me that at that particular time, there were really no individuals or groups advocating for the residents. The residents were not only old, vulnerable, and frail, but they were superfluous people, not attractive, and basically not the kinds of people that the Junior League and other organizations would rush out to serve in a way that these organizations ordinarily would do.

The SCI hearings led to the development of a boarding home bill which was developed in this Committee -- as has been stated today -- under the leadership of Senator Anthony Scardino, who worked at considerable length to fuse the diverse views of the three Departments -- Health, Community Affairs, and Human Services. He tried to get some kind of a working agreement, because he stated often during the development of the bill that there had to be some central authority. This could not be included in the bill, but there was an informal agreement with him that there would be an interdepartmental committee which would work on these matters and develop it on their own, even though it wasn't legislatively mandated.

I would submit that the Departments never morally met their obligation to Senator Scardino. In my view, not only the Departments didn't, but they still struggled for turf. Not only that, there was an Ombudsman, who testified earlier -- an ex-Ombudsman -- who went even further, because he saw boarding homes as an opportunity to create headlines and further his own interests. No matter what the headlines said, no matter what the Department said, the boarding home residents suffered considerably, because there were consistent policies, consistent confusion, dismay, and neglect. While everybody was fighting, the person at the bottom was not getting the kind of care we associate with a humanitarian society.

Later on, the Assembly Corrections, Health and Human Services Committee, led by Assemblyman George Otlowski, developed what in my mind was the most unusual bipartisan arrangement, and attempted to bring these Departments together. In fact, in response to that Committee's efforts, the three Commissioners submitted a 1983 report to the Legislature. I would like to quote briefly what they said:

"There is a lack of communication and trust among State departments. There is a lack of understanding of each other's roles. There is a random hit and miss service delivery

system. State and county staffs are working at cross purposes, and as a result of these problems, confusion of or manipulation by boarding home operators as they attempt to relate to various staffs."

I would say that from what I understand, my own visits, and discussions with people who are residents or work in the homes, the three Commissioners' survey of the situation seems to be valid today. We heard it as we saw two programs go at it publicly.

In 1984, Assemblyman Otlowski appointed me as a consultant to work with his Committee. There was a task force made up of a broad group of agencies and organizations involved in boarding home service. I met with Commissioner Albanese and suggested that perhaps his Department might want to take over the entire boarding home scene in an arrangement with the other Commissioners. He seemed to indicate acceptance, but when the three Commissioners appeared at the hearing in August, 1984, he was the spokesman and they told the Assembly Committee that they would work out the problems on their own; that they had an interagency committee, or an interdepartmental committee that met regularly; and that there was no need to worry. He was quite reassuring, but today's testimony indicates that the reassurance certainly didn't stick.

As an individual concerned about this problem area, my own view is that the only way out of this mess, because two years ago we heard the same things about the nursing homes in Bergen County, with three offices of the Executive Department-- They did not do anything about the nursing homes which were providing substandard service. The Governor said they would get their acts together, and they would report. We haven't heard yet about that.

Depending upon the Departments, it seems to me, is no longer feasible. My own suggestion is that the Governor has to appoint a special person with direct authority through him, and

accountable to him. You may call this person a czar, but the person would have complete authority to take emergency control of the program, and to ensure the people of the State that they would not be getting periodic headlines.

You know, it's great to read the stories in The Star-Ledger, and I think Mr. Jaffe does a swell job, but I think one of the latent functions of these stories is, it makes the man or woman in the street feel good to hear how poor off people are in boarding homes, and perhaps their lives aren't so bad.

But, I think we have a moral responsibility to do something. I think the only way we are going to do it is if someone comes in with a big stick, with the authority to be able to tell Community Affairs and the Health Department to stop their bickering and spell out the specific directions. We don't need any more reports; we don't need any more studies. I think what we need is to act on the things which have to be done.

Before I leave, I would like to suggest four areas which, it seems to me, have not been fully discussed, which are vital if we are going to talk about maintaining the program and improving it. One, there is a complete lack of planning whether there will be housing stock available in the years to come for boarding homes. Already we see in certain counties, like Bergen, that the value of land has increased so much, that even these old buildings can command a price that makes it almost imperative for the owner to consider selling the boarding home.

Two, there is a lack of planning around the demographics of boarding home residents. No one really knows what will happen in 1990, 1995, 2000. No one knows exactly today how many people there are in the boarding homes. When Senator Scardino held the hearings, the State agencies told him 44,000 to 60,000. DYFS and the Department of Human Services

say 8000 to 10,000. The Department of Community Affairs says 20,000. But no one has looked carefully at where the people are coming from into the boarding home situation. Are they going to be deinstitutionalized persons? Are they going to be elderly persons? Are they going to be mentally ill people? There is no grasp of what is needed. We heard about boarding homes being closed. This supply, without expanding-- Will it handle what is needed?

Third, one of the areas I have always talked about, involvement in the nonprofit sector -- not only social service agencies, but religious agencies, veterans' groups, and so on -- has been strangely missing. I think we would be in great shape if some of the State agencies would fund a few nonprofits to set up model boarding homes, which would be used for demonstration, for training, and to indicate what could be done under ideal conditions.

Finally, Mr. D'Ambrosio mentioned that there was a person convicted of a felony running a boarding home. Others spoke about incompetent operators. It may interest you to know that the task force that Assemblyman Otlowski got together, on which I served as a consultant-- The recommendation was that operators be licensed, because with the kinds of populations that come into a boarding home, the operators should know something about medications, should know something about reading a discharge summary, should know something about first aid, should know something about making linkage. To this day, there are no qualifications for someone to be in charge of a boarding home. It all comes back to who is available and who the owners or the operators will select. It seems to me that a minimum set of qualifications is really overdue.

This hearing, I think, is a good step in keeping us abreast of the fact that we haven't met our commitments to our fellow-man. My concern is -- Assemblyman Rooney was here this morning -- I find that the Legislature must be kept just as

accountable as the three Departments we spoke about. The Assembly Health and Human Resources Committee, had it co-sponsored the hearing, I think the hearing might have had more impact. The Legislature has not really had any track record in legislative oversight. You take any social problem, whether it is child abuse, elderly abuse, nursing homes, boarding homes-- We have hearings all the time. The Legislature does not have the staff to do the different types of oversight. Our Chairman had to go undercover, which is a form of oversight, and which is commendable. But, there is no real firm oversight in which the Legislature -- which commits the resources and also builds the hopes of the people of the State of New Jersey -- really looks at what is happening and nips problems in the bud.

Instead, we are always responding to emergency kinds of situations, which are called to our attention by people like Dave Lazarus or Herb Jaffe or our Chairman or others. But, it seems to me, we have to do more than merely listen to a parade of witnesses bringing very human and very touching testimony. We also have to say, with all of the might at our command that we will be willing to do something about what is going on.

Mr. Chairman, I want to thank you for this opportunity to appear, and hope that your efforts will spearhead new thrusts which will finally succeed.

SENATOR CODEY: Thank you very much, Dr. Schreiber. Mr. Samuel Addeo, Manager, City of Asbury Park. Is Mr. Addeo here? (affirmative response)

S A M U E L A D D E O: Good afternoon, Mr. Chairman. My name is Sam Addeo, and I am the City Manager and Chief Executive Officer of the City of Asbury Park. I should feel at home here in Trenton because this is the eighth time I have been down here to appear before a committee of the Legislature looking into various aspects of deinstitutionalization or the regulation of rooming and boarding homes. I cannot begin to

relate to you the frustration we feel at a local level in dealing with the policies, or lack of policies, put forth by Trenton in these two areas.

Since 1974, there has been, in my opinion, a rather clear signal that Trenton is not prepared to make the really tough decisions necessary to overcome the problems attendant with the deinstitutionalization of the State's mental patients and the regulation of the boarding and rooming house industry.

That is not to say that there are not those who care about the problem. The fact that this Committee is here today is testimony to the concern by some that change is needed. Also, I would be less than honest if I did not admit that over the past few years there have been some real attempts to bring about change from within the State's Departments. But, in my opinion, it is usually too little and too late.

This might be due, in part, to the fact that for the first few years after the deinstitutionalization of our State mental hospitals, you couldn't find anyone who would even admit that there were problems. After that, instead of bold initiatives to address the lack of adequate alternative housing in the State, there were faltering attempts to react to problems that were already five years old.

Through all of this, the City of Asbury Park has born a disproportionate burden. The city almost collapsed under this burden. At one time, fully 10% of our population was deinstitutionalized. An additional 3% were socially disadvantaged living in rooming or boarding homes. Add to this population 30% living on some sort of assistance, most in subsidized housing, and you get some idea of the problems we have had to grapple with.

I will not bore you with the history of why this happened, when it happened, or how this population ended up in the City of Asbury Park. It has been told many times before. The bottom line is that most of these people were placed in

Asbury Park by outside agencies. It was easier for the State bureaucracy to create and maintain social ghettos than to bite the bullet and initiate change. In fairness, the task might have been beyond many of the bureaucrats who were working from within the system. The leadership should have originated here in the State House with the Legislature and the Governor's office.

But, this aside, the problems are still there. Admittedly, the situation is not as bad as it once was. There are in place regulations covering rooming and boarding homes. I am unsure if the situation is better because of the regulations or because of the sophistication that has been developed on the local level. Personally, I have a lot more faith in local government than I do in State government, if you will excuse my bias.

SENATOR CODEY: Does that include Asbury Park?

MR. ADDEO: Yeah. Thank you. (laughter)

Today, I did not come here to relate horror stories, but you have to believe that they do exist. You have to know that they exist. There are so many, that after a while you become callous. At some point, you even treat them as if some of the conditions, some of the places you see day in and day out-- They almost become humorous. I think the humor, the laughter, is to hide what could amount to an awful lot of tears, because some of the stories are pathetic. I believe this Committee is very well aware of what is going on down there.

Still, right up to this present time, people are being placed in Asbury Park. To add insult to injury, we find there are State-funded agencies that are actually trying to stop us from closing down substandard units. It seems that this course is a lot easier and less expensive than building alternative housing -- something this State has needed for years.

As to the existing regulatory effort, there are glaring deficiencies with the program. Those deficiencies existed the day the program started, and they still exist today. Before the implementation of S-3111, I met with Senator Scardino. We told him, and we told the Committee looking into drafting the legislation, that the numbers of physical inspectors they were calling for were inadequate. We made that same claim after the program got under way. The problem is worse today. Social inspectors outnumber code inspectors by a very large ratio. There is a reluctance to close buildings because of the lack of beds in the State. Therefore, we settle for fourth- and fifth-rate facilities. Second-rate facilities are usually rewarded for their excellence.

Most, if not all, of the upgrading in our city has been done by local code effort. Of course, as a result of this, we carry a very "bad guy" reputation. There is an operator in our city who our municipal judge has put in jail for some of the conditions in his buildings. He has been fined locally over $5000, and yet he is still allowed to operate some of the worst buildings in our city.

There is little coordination of effort between State and local enforcement. We are not notified when inspections are done, or of the results.

In one instance, we had been going after an operator for over three years before the State decided to take action. We finally obtained a copy of the State inspection, and it showed a total of five violations. Had that inspector checked with us, he would have determined that when we conducted our own inspection one week later, there were 53 violations, many of them life-safety violations.

The State, based on the inspection report, directed that the hallways in this building be painted. The city had to go to court and have the building closed.

We have a woman in town who came to a hearing here in Trenton in September of 1985 and was ordered to make repairs to her building. This was after almost two years on our part to get her here. We put pressure on for reinspection and, of course, as I said, we put pressure on for the hearing. As of today, the repairs have still not been completed in that building.

There are inspectors out there who do little more than "window inspections." Many of these are done by necessity. The building with the five violations was a window inspection. It really shouldn't surprise anyone, since one man has to cover the area between Raritan and Cape May.

We brought another operator to court 10 times in two years, and during that time the State took no action against her. When they finally realized how bad the conditions were, the tenants were relocated to a motel, many of them in overcrowded conditions. A statement was issued by a DCA official that they were trying to locate the owner. Had they taken the time to talk to us, we could have told them that the owner had died four months before. To this day, that building is still unsecured, and the people are still living in overcrowded conditions. We are being criticized for trying to cut down and close some of those motels that have overcrowded conditions.

Today I would just like you to consider certain recommendations we have. First, I would ask that you urge the creation of a special panel to develop policy on deinstitutionalization and the sheltering of socially disadvantaged persons. This panel should be made up of representatives of the Senate, the Assembly, the Governor's office, as well as the State agencies, the private sectors, and local government. Their findings should serve as a basis of statewide policy directives that should be implemented directly on the orders of the Governor.

There should be developed one agency to license and regulate housing for socially dependent people. There is ample documentation to point out that our present layered bureaucratic approach just doesn't work.

Make no mistake, I am not suggesting that we hire any more people. We have more than enough talent on the State payroll. Just redirect the ones who are there.

We should also attempt to wipe out an all too pervasive attitude that these residents do not have a right to anything better than what they have now.

State inspection efforts must be coordinated with the appropriate local government. If there is some failing on the part of the local government, then the State should move to correct that failing. But, absent that, there is no reason why there can't be coordination.

The State of New Jersey should implement a fee for service system of reimbursement to residential health care facilities and rooming and boarding houses. At this time, there exist few compelling reasons for any owner/operator to fully comply with the existing regulations mandating service provisions. Though there are many owner/operators who are skilled, compassionate, and caring, these are not qualities which can be quantified for licensure, thus creating an atmosphere ripe for exploitation and abuse, with residents vulnerable to pressure and harassment as a result of standing up for themselves in any way against the owner.

Finally, I would ask that the State of New Jersey abandon its effort to reduce State psychiatric hospital populations, and accept the fact that long-term institutionalization, in some form, is the only appropriate means to deal with some of the chronic mentally ill. I am not advocating that we abandon deinstitutionalization totally. I don't think that in New Jersey we gave it a good start when we set it off without long-range planning. But I think we must

realize that there are some people who must be institutionalized for a period of time.

I would also ask that the Senate and the Assembly join in some sort of an oversight, as was called for by the previous speaker. I pointed out that a lot of the people we have working -- especially since 1980 -- for the State are very caring and they are involved in this problem. They are trying to come up with solutions. Unfortunately, State government is so departmentalized, and the fight for responsibility is so fierce, that many of them are hampered in what they can do.

So, I would ask that we break down some of these barriers we have placed in front of the people we are hiring to solve some problems.

Thank you very much for your time.

SENATOR CODEY: Thank you, sir. May we have a copy of your statement?

MR. ADDEO: Yes.

SENATOR CODEY: Our next witness will be Assemblyman Singer. Assemblyman?

A S S E M B L Y M A N R O B E R T W. S I N G E R: Thank you, Senator. I appreciate your allowing me to testify.

I just have three quick points, and certainly I know you are hearing a lot of repetitive testimony about this problem. I address you today as the Vice Chairman of the Assembly Senior Citizens Committee, as well as the Deputy Mayor of Lakewood. As you know, Lakewood is down in the shore area, and we have some similar problems to those of Asbury Park and some of the former resort communities throughout the shore area.

One thing I think we have to look at, which has certainly been a disturbing factor to me, is the entire certificate of need process and how residential health care facilities are granted certificates of need. I think it is important to understand that this process does not give proper input by local officials as to whether residential health care

facilities should be located in a town or not. We kind of skip over that. As has happened in Lakewood many times, we do not know that a residential health care facility is going to be built or converted in our town until it has already been done.

I certainly don't think it is fair to a local municipality not to have input, at least about where that facility should go.

Number two which is a disturbing factor to us is the ratio. In the County of Ocean, where Lakewood is located, we have 90% of the residential care beds in the entire county. Certainly that is disproportionate in a county. I think there has to be some type of ratio. No one municipality should have to take the burden.

The money that is paid to the owners of these facilities is not enough to make it feasible to build new facilities. So, instead of building new facilities, they convert former hotels, and that is why Asbury Park, like Lakewood, ends up with a large proportionate amount of these residents. It is just not fair. It is not safe for the residents in certain cases, and it is not fair to a municipality to have to take on this burden.

The reason I say that is, the services needed to the municipality are just not given. In our particular case, with some of these facilities, these residents wander our streets. They add an extra burden to our police department. They add an extra burden to our hospitals, and everything else like that, yet we do not receive extra money from the State to take care of this.

I think deinstitutionalization, in this case, has not worked well. We find ourselves flooded with an excessive amount of patients -- former inmates from the Marlboro Psychiatric Hospital -- who really should not be in large homes. We should have created mini institutions in our community. They should be in smaller places -- smaller

designs. When you speak to the Commissioners about it, they say it was never their intent that residential health care facilities should go as large as 200 beds, which they have in our community. They had expected them to be 30- or 40-bed units in small areas.

We have not seen the construction of one new residential health care facility within our community. We have seen only the requirement to have new nursing home beds, and to add on the residential beds in those new nursing homes. But no one has been able to build a new residential health care facility, because of the kind of money given the operators.

We must realize that if the money is not there to allow them to build new facilities, they are not going to. Therefore, we are stuck with the conversion of former hotels or former rooming houses, which really, in many cases -- not all, but in many cases -- are substandard. I certainly hope you understand the plea of these municipalities -- such as Lakewood, Asbury Park, and others -- which are dealing with this problem on a day-to-day basis, and are not receiving the backup aids from the State that we should.

One other thing you must understand also: These residents require seven-day-a-week service. For example, Easter Seals operates a sheltered workshop in our community, which helps greatly five days a week, but what do these residents do on Saturday and Sunday? There are distinct problems to them. Certainly I have found in our community that deinstitutionalization has not worked. It has not been fair to the municipality. I hope you understand that the plea from the local level is, "We need help." We need help with dollars. We also need help from the State to change some of the plans, so that no one municipality is burdened with this problem.

I thank you, Mr. Chairman, and I appreciate the fact that you gave me a chance to testify.

SENATOR CODEY: Thank you, Assemblyman Singer.

Our next witness will be Judith Scully. Is Ms. Scully here? (affirmative respone) Go right ahead, Ms. Scully.

J U D I T H S C U L L Y: As you can tell, I have never done this before, so I hope you will bear with me.

SENATOR CODEY: That's all right.

MS. SCULLY: I would like to thank Senator Codey for conducting these hearings. I think it's wonderful.

SENATOR CODEY: Please talk as loud as you can, and into that mike. Okay?

MS. SCULLY: Okay, is this better?

SENATOR CODEY: Yes, that's better.

MS. SCULLY: My name is Judith Scully. I am a member of the Pioneers in Mental Health, which is a support group for family members of the mentally ill. I am also the parent of a young, adult, chronically mentally ill son.

I would like to relate an incident that occurred while our son was residing in a boarding home. Some people would call these horror stories; I call them tragedies. Late in the evening on January 29, 1987, our son and one of his roommates were having a verbal argument, when a 17-year-old young man decided to intervene by attacking our son. This young man does not work or live in the boarding home. It is my understanding that he goes there because of an interest in a young female staff member.

The first attack involved the young man beating our son, and the female staff member kicking him in the groin two times. After the young man left the house, he returned and attacked again, this time with another resident, who kicked our son in the head. He was wearing work boots. After leaving and returning one more time to the bedroom, he found our son laying on the bed, grabbed his head and banged it against the steel rail that held the matress, splitting his head open.

The juvenile was arrested. Our son was taken to the hospital by ambulance. When I picked him up the next day,

among other bruises he had marks on his neck from being choked. This is what happens when you have poor staff. When they are not trained, they are certainly not qualified to handle this kind of a situation, and this is only one of many you could possibly hear of.

When I told the staff member who was involved that I was going to notify the police about her abuse, her words to me were, "I don't care who you tell." The staff didn't care at all. She probably doesn't care that I am here today. The Welfare Board of Adult Protective Services was notified, and is recommending that the case be prosecuted.

I would like to make two suggestions: Since a large percentage of the people residing in boarding homes only have limited access to only mostly pay phones, I would like to see an 800 number be made available so they can report physical or mental harassment or abuse. I would also like to see the same 800 number posted in all boarding homes and hospitals and nursing homes. Most people would only be willing to report incidents anonymously -- most people being family members -- because of a fear of harm coming to their loved one.

I would also like to make a recommendation as a possible model program for housing the mentally ill. The Hatfield House supplies 24-hour supervision, and the Cope House supplies three hours a day supervision. These are located in Lansdale, Pennsylvania. If you wanted to, you could find out more information by contacting Carmen Carlone (phonetic spelling). I have his number, if you would like it.

That is the end of my testimony. I would like to thank you for your time. I appreciate what you are trying to do.

SENATOR CODEY: Thank you very much for coming, Ms. Scully. I appreciate it.

Our next witness will be Mr. Jack Bucher, Program Coordinator, New Jersey Consumer Operated Self Help and Advocacy Program. Mr. Bucher?

J A C K B U C H E R: Thank you, Senator. My name is Jack Bucher. I am Program Coordinator for the New Jersey Consumer Operated Self Help and Advocacy Program.

NJCOSHAP, in response to the request for testimony regarding this subject, submits the following comments:

1. First, there would be no boarding home/residential programs without the population whom they serve. Given that very basic premise, we feel that residents of such facilities are entitled, as per the Rooming and Boarding House Act effective August, 1980, to certain basic rights and conditions as outlined therein. Often, these basic rights and conditions are violated or compromised. We would like to bring to the attention of this body, some of our major concerns. This list is by no means complete, and our program, in cooperation with mental health consumers throughout the State, intends to study this problem in a more detailed manner.

a) Boarding homes are providing a service to residents for a monthly fee. We believe residents should be entitled to a sanitary, well-maintained environment. Additionally, conditions -- rooms, etc. -- are often small, overcrowded, and do not provide adequate privacy and dignity to residents. Bottom line: Profit making should be changed to nonprofit alternatives.

b) Consumers are struggling against the long-held opinion of the public that they are "second-class" citizens. The boarding home/RHCF phenomenon often perpetuates that notion. We want to do something about that. Some RHFCs and boarding homes have become extensions of the State hospitals. This is counter to the move toward normalizing the lives of the mental health consumers in the community, a concept which is strongly supported by both consumers and the New Jersey Department of Human Services, as well as other concerned parties, i.e., professionals and families. In many cases, boarding homes and RHCFs have been relegated to the position of

being a quick-fix for housing for mental health consumers -- formerly called patients.

c) We feel there have been violations of the Rooming and Boarding House Act of 1980, as reported by consumers themselves. We also feel there is a need for further improvement in the conditions available within the boarding home/RHCF system. Below, we have outlined a few of these inequities:

1) Residents have often complained of a safe, well-ventilated place to smoke within a facility, especially during inclement weather;

2) Residents have often complained of unreasonable curfews placed upon them by boarding home operators;

3) There have been occasional complaints in regard to the quantity/quality of food provided within facilities;

4) Boarding home residents have often been "punished" by eviction, for asserting their legitimate rights; and,

5) Boarding home residents are often restricted all day from being allowed to remain in the home for legitimate reasons, i.e., inclement weather, physical illness, or a "day off" from their program. However, NJCOSHAP does not sanction or condone withdrawing or self-isolating behavior.

2. In addition, reliance on the boarding home industry is not only continuing, but increasing, through recent legislative and policy decisions. This reliance is underscored by the displacement of several hundred boarding home residents in Asbury Park's redevelopment plan, with a lack of housing alternatives.

3. Finally, if, as a result of these hearings, a State committee is formed to study this problem in greater depth, mental health consumers request to be involved in that process. As mentioned earlier, we intend to study this problem ourselves in an in-depth and ongoing manner.

I have put a footnote on my written testimony: I have lived in boarding homes, large and small, for about five years in Asbury Park, so when I started off I was a little rusty. At present, I share an apartment, where I have lived for three years.

Thank you very much.

SENATOR CODEY: Thank you, Mr. Bucher. Our next witness will be Leah Weiss, President of the Board of Directors of the Mental Health Association of Essex County. Ms. Weiss?

L E A H W E I S S: Thank you very much, Senator Codey. I would like to introduce Arnold Rabin -- Dr. Arnold Rabin -- who is Executive Director of the Mental Health Association of Essex County.

In looking at the boarding home situation, I am reminded of the man who, when asked how the food was at a wedding reception he'd recently attended, said it was awful; but even worse, there wasn't enough of it.

Our agency has long been committed to improving the care and treatment of the mentally ill. For almost 20 years, we have operated Prospect House, a psychosocial rehabilitation agency, serving people who have had serious mental illnesses, many of whom live in boarding homes. For over seven years, we have been working to assist the families of the mentally ill through a support group called Concerned Families, and a counseling and education service called the Family Resource Center, which receives support through the New Jersey Division of Mental Health and Hospitals. Families, we must realize, along with boarding home operators, are the major providers of housing services to the mentally ill in the community.

In addition, we developed a fire-safety program specifically designed for this population in boarding homes, in cooperation with the East Orange Fire Department, and with help from the Prudential Insurance Company and the New Jersey Department of Human Services.

I believe these experiences are a valuable background for today's hearing, and I welcome this opportunity to appear before you. As your constituents, Senator Codey, we are particularly proud of the concern you and this Committee under your chairmanship have shown for the conditions of the mentally ill.

Here are some of our observations:

1) A major problem is that we have placed large numbers of deinstitutionalized mentally ill in boarding homes which are ill-equipped to deal with the serious problems these people have. We ought not to be blaming them for being unequal to that challenge. Many boarding home operators are sensitive and caring people.

2) Real estate and community resistance issues play a large part in our failure to provide supervised housing alternatives. Prices have soared, leaving psychiatric patients and those who would create housing programs for them out of the running.

In addition, community resistance prevents new boarding homes and housing programs from being opened, even in communities with lower priced houses, such as East Orange and Newark.

3) These factors, and the lack of major State support have left us with a critical shortage of alternative supervised housing placements, such as supervised apartments, group homes, and home care. We have a grand total of 87 such beds for the entire County of Essex.

4) In the face of the shortage of housing, boarding home owners are experiencing rising costs, especially skyrocketing insurance problems. Meanwhile, the SSI and welfare payments remain woefully low.

In 1986, in Essex County, four boarding homes with a total of 100 beds were closed. This is a very significant loss for a county with only 1037 licensed boarding home beds

altogether. They are not only not being replaced, but we hear reports of additional homes -- good ones -- planning to close. Furthermore, hospitals, in response to their internal pressures of numbers, are increasingly tending to discharge psychiatric patients to shelters for the homeless, further serving to compound the problem.

5) With increasing demand and fewer alternatives, the better boarding homes are more selective, tending to accept less troublesome, elderly persons, thereby leaving the younger psychiatric patients in the least desirable homes. These tend to be the homes which are least able to meet physical and safety standards. The threst of a fire calamity is all too real.

The quality of life in boarding homes, as you have heard, is too often bleak, with little or no privacy, with young residents sometimes teamed with elderly roommates. Life goes from meal to meal to TV to bed. Little or nothing in the way of social rehabilitation is available. This can, and should, be remedied, and these are some of our recommendations:

1) The economic, real estate, and community resistance issues can only be addressed if we have a serious commitment by the Legislature and the Governor. Moral leadership and money are needed.

2) Incentives must be created to upgrade the boarding homes physically, and active help offered, especially to unsophisticated operators who have problems dealing with the complex requirements for State financial aid. We heard this morning from Deputy Director Connolly about some of the support offered by the Department of Community Affairs.

3) Encouragement, through incentives, must be given to the development of other housing alternatives, such as supervised apartments, home care, and respite housing for families. Furthermore, the State needs to reduce the incredible obstacle course which has been placed in front of those who would develop and operate group homes.

4) The fire threat has to be addressed on two levels. Physical upgrading -- including sprinklers and rigorous inspections and follow-up -- is needed. However, the Fire Safety Education Program, which the Mental Health Association has developed, has to be implemented aggressively. You would be appalled at the answers boarding home residents give to such questions as, what would you do if the fire alarm went off? Should they look for their friends? What if they are in the shower? What would they do if they remembered they had left $50 hidden in their rooms? Our fire-safety program helps them anticipate these and other possibilities, and helps them also to rehearse their responses.

5) Finally, we need to recognize that it is unreasonable to expect boarding home operators to be able to provide the case management, counseling, and social rehabilitation their residents need. Our Prospect House staff went into boarding homes which have a large proportion of deinstitutionalized elderly who barely talk to one another and seldom, if ever, leave the boarding homes. Over a period of months, we developed relationships and trust with the operators and the residents. We discovered serious unattended health problems which we helped to remedy. We engaged them in social activities which brought them out of their isolation and helped them eventually to risk coming to our day treatment program at Prospect House. This cannot be done without patience and skill, but it pays off in positive changes in their lives.

We should have a system of contracting with community agencies such as Prospect House to encourage boarding home operators to participate. We found that boarding home personnel were eager to have help in how to better deal with their residents. Knowing and talking to our staff gave regular access to knowledgeable people who they found they could trust. This tells us that the benefits of such an arrangement could extend in many, many directions.

Katherine Puder, of the Mental Health Association of New Jersey, will now discuss some additional legislative recommendations which the MHA supports.

Again, I thank you very much for this opportunity to share our ideas with you.

SENATOR CODEY: Thank you. It was very well done. I appreciate it. Ms. Puder?

K A T H E R I N E P U D E R: Mr. Chairman, thank you for allowing me the privilege of speaking to you today. My name is Katherine Puder. I am the Director of Public Policy and Legislation for the Mental Health Association in New Jersey. The MHANJ is a private, volunteer citizens' advocacy organization, with chapters and programs in 14 of New Jersey's counties, and hundreds of volunteers statewide. The MHANJ serves to help to protect the mentally ill, prevent mental illness, and promote mental health for New Jersey's residents. Some of the conditions described about boarding homes in Essex County are representative of conditions statewide.

Due to inadequate housing options in New Jersey, the MHANJ finds that 50% of previously institutionalized mentally ill persons live with their families, even though this may not be the most appropriate living arrangement. In addition, there are 70 community residences adveraging five to six clients apiece, housing a total of 400 persons. The majority of housing for the deinstitutionalized poor and elderly comprise boarding homes and residential health care facilities. Five thousand residents currently live in boarding homes alone.

As a result of a lack of affordable housing options, many persons have become homeless, and 20% to 30% of the homeless population is estimated to be mentally ill. Numerous institutionalized patients remain in the hospital much longer than necessary, because appropriate housing options cannot be found for them in the community.

We believe the time has come to address this crisis situation. Specifically, the MHANJ believes that the following services/measures should be undertaken to improve the lives of residents of boarding homes and extend housing options:

1) State SSI rates for boarding homes and residential health care facilities should be increased by $3.3 million as a supplemental appropriation to the Governor's budget. The State SSI rate has not been increased in 10 years. Many boarding homes, financed solely by SSI payments from low-income, disabled clients, have been forced to close due to increased costs associated with fire- and life-safety regulation.

2) Outreach services should be provided to boarding homes, including case management, support and follow-up, pre-crisis intervention and crisis stabilization, in-home operator training, vocational training, and transportation. This service continuum would improve the quality of life for the residents and help maintain them successfully outside of institutions.

3) In-home rehabilitation, support, follow-up, respite, and educational services should be developed for clients and their families, since 50% of the clients live at home.

4) A coordinated system should be provided that affords homeowners a positive means to address violations and communicate with licensing agencies, as well as create a mechanism to upgrade facilities.

5) Housing options should be expanded to reduce dependence on boarding homes. Small family-style homes that house up to three clients need to be developed with the full array of support services.

Historically, a boarding home package, sponsored by Senator Pallone and Assemblyman Otlowski, was developed in conjunction with the Department of Human Services, to upgrade the care, conditions, and services of boarding homes. This legislation was not signed into law by the Governor.

A subsequent boarding home reform package was submitted to the Governor for review. The Governor has not taken action on the package, and most of the bills that have been introduced into the Legislature have not moved out of committee. Many of our suggestions today are included in both of these efforts. We strongly recommend that the Legislature review and support these reforms.

My remarks today have focused on recommended improvements in the conditions of boarding homes and services available to New Jersey's chronically mentally ill, which would significantly enhance the quality of life for this population. The Rooming and Boarding House Act of 1979 was a beginning. The MHANJ urges this Committee to continue to initiate actions that would upgrade these facilities and bring about much needed reform.

Thank you.

SENATOR CODEY: Thank you very much, Ms. Puder. Our next witness will be Mr. Jeffrey Goldstein, the owner of the Lexington Rest Home in Lakewood.

J E F F R E Y G O L D S T E I N: Senator, I have a paper I would like to pass out.

SENATOR CODEY: Sure, go right ahead. Do you also have a copy of your statement, sir?

MR. GOLDSTEIN: Excuse me?

SENATOR CODEY: Do you have a copy of your statement?

MR. GOLDSTEIN: No, I don't.

SENATOR CODEY: Okay, that's all right.

MR. GOLDSTEIN: Mr. Chairman, my name is Jeff Goldstein. I am one of the owner/operators of the Lexington Rest Home, a licensed residential health care facility which is located in Lakewood, Ocean County, New Jersey. Established in 1970, it has a present licensure of 256, with a present population of 190 residents, of which over 90% are supported by Supplemental Security Income.

Given its considerable size, both in its physical dimension and population, one should be able to gain beneficial insight into the multitude of problems, issues, and circumstances that confront, on a daily basis, individuals who are associated with the maintenance and operation of a residential health care facility.

Now, the State manual standards define a residential health care facility as a vital community service and a substitute for the actual home of a person, offering essential personal care and other services. However, this description is general in nature, and certainly oversimplifies what is a highly complex and involved area of health care.

If I might reflect and expand a bit on the services, although there has been mention made, I would like to state that the services offered the residents include, but are in no way limited to, the following: a furnished room, three meals a day, daily housekeeping, utilities included, personal laundry; there are social activities available; assistance in the management of personal funds; supervision of medication; supervision of hygiene; nursing maintenance and monitoring; monthly health assessments; the scheduling of various appointments for medical doctors and psychiatric counseling; certain specialized diets, on occasion; staff personal service instruction and orientation; and assistance in occupational therapy programs. These are part of the "limited" services that are offered in a responsible residential health care facility.

Now, in order to guarantee these services, every RHCF, and boarding home, for that matter, has to coordinate its efforts with many governmental departments and agencies. In these are included: the Department of Health, the County Board of Social Services, municipal welfare, health, and building inspectors and personnel, Division of Mental Health and Hospitals, county mental health clinics, State mental

hospitals, medical centers, various physicians, certain support programs that are outgrowths from the mental health programs -- such as programs called Interact, DARE, and Double Trouble -- volunteer groups such as AA, the Division of Developmental Disabilities, the VA, and county occupational centers. Also, we should be responsible in responding to certain programs which are available to the facility and the residential population; programs for life-safety improvements, which requires a cooperative effort among DCA, the Department of Health, and HFA. Sometimes that is very, very difficult to work. Department of Energy home weatherization projects, home energy assistance funding-- We have dealt with the Ombudsman on many occasions, and the Public Advocate. There is the Pharmaceutical Assistance Program, there is Medicaid eligibility, and there is Social Security eligibility. We have been involved in applications, denials, and appeals on behalf of our residents.

All of these aforementioned services come at the rate of approximately $14.70 per day per resident. I say that is a bargain at any price. What I passed among you, sir, is a schedule of the rates, reflecting the SSI increases over the last 11 years. I know many have referred to it, but as you can see, if you briefly look at the first column -- the New Jersey column -- New Jersey averaged approximately 1.3% per year over the last 11 years in increases. This offers the facility overall a rate -- if you take the New Jersey share in conjunction with the Federal share -- a total of 4-1/2% per year.

Also, in mentioning the fact that nursing presence exists in a RHCF, it was not mandated by law until 1983. In 1983-- If you will refer to the New Jersey share column, you will see that zero dollars were contributed by the State. We have always had a differential, because the services were different. We were mandated to do; other homes had a

discretionary approach. Those were the boarding homes. That has been improved over the years. But, it isn't as if we are being given a windfall of $119 more a month per resident, because we have nursing presence at the facility. I wanted to make that clear.

I fail to see where, in the State of New Jersey, which often boasts one of the highest per capita incomes in the country, and has often, in recent years, talked about its budgetary surplus-- I fail to see why we do not see fit to raise these percentage increases. General assistance seems to get funding; Aid to Families with Dependent Children gets funding. They receive reasonable increases annually, and those who are deemed disabled by definition and/or the aged are ignored, those being the residents of RHCFs.

Additionally, and this is something that has not been emphasized enough here today, the residents themselves receive a monthly allowance of only $53. If you think about what $53 breaks down to-- A vast majority of the residents smoke cigarettes -- and this I am simplifying -- at $1.50 a day. You can't begin to appreciate the behavioral management problems that confront the administrative staff in dealing with this problem. They are woefully underpaid as well. But, to have to stretch $53 for 30 days-- I think you could find $53 in the street if you looked hard enough for 30 days.

So, I ask you to pause and reflect on the numbers I have submitted to you, because compared to the spiraling costs and expenses and wages and taxes and insurance, repairs, maintenance, and improvements, added nursing care, and food-- They have all gone up, but SSI has not gone up. Who suffers? Well, all of us suffer; all of us must share in the responsibility. But it has impacted directly on the resident -- on the recipient. They are called second-class citizens, societal lepers, or whatever you want to call them, whatever you want to say, however you want to label them. But, at one

point in time, they were all productive members of society. I am not talking about people who have been committed for their entire lives. There are probably a thousand reasons for their present situations, but a typical profile would reveal a person between the ages of, let's say, 25 and 95, with a dual diagnosis of a chronic mental disorder and possible physical impairment, with a significant history of institutionalized care, depressed, on phychotropic medication, with a history of drug abuse, alcoholism, perhaps a criminal past, with a family offering little, if any, support, for they do not have the ability or the capacity to care, and I well understand that situation. And, oh, yes, very important, they are without any political conscience and no viable political voice.

Nevertheless, we are expected to provide for and care for these people, and sometimes the expectations are unrealistic. Believe me when I tell you, there is no such thing as self care any more. They may call it independent. You were talking before and referring to a blending -- moving ICF patients down into a residential health care setting. I can tell you right now that I am running an ICF facility labeled a RHCF. I have bath lists miles long. While these people are healthy and vital, they choose not to take direction, so it is difficult to guarantee and assure the overall health, safety, and welfare of the entire residential population.

We can sit here and we can convene countless committees and we can legislate, and we can mandate, and we can flood the public with reports and press releases, but, as far as I am concerned -- and I think as far as many operators are concerned -- the bottom line seems to rest with the almighty dollar. These needed services, at every level, will suffer if the present trend continues. It is time to appropriate. Let's worry about the legislative end of it, but appropriation is essential. We have long passed the point of crisis; we are at the precipice.

I wonder about the future of the industry. Certainly one must work equally with his heart, as well as with his head to make a successful business, but without adequate funding, no facility can survive. I am not saying to reward those who fail to abide by the regulations and standards which govern health care operations. Penalize them heavily; get rid of them. Because of their abhorrent practices, I am dragged down into their dirt. But, certainly, at the very least, compensate those facilities deserving of the title "health care."

Thank you.

SENATOR CODEY: Thank you for your testimony, Mr. Goldstein. Our next witness will be Mr. Harold Katz, owner of the Eden House Boarding Home in East Orange.

H A R O L D K A T Z: Senator, whenever attention is directed to the poor conditions in boarding homes in New Jersey, there is a knee-jerk reaction -- more inspections, more enforcement, more penalties. The idea behind this approach seems to be that the problem stems from unsavory and unscrupulous money-oriented boarding home operators. If we could only get them in line, we could solve the problem. The owner becomes the scapegoat for a problem not entirely of his own making, when, in fact, the problem was created because of lack of planning when deinstitutionalization became a matter of public policy. The operator is as much a victim of this system as are his residents. There is no time now to go into the actions and lack of actions by the State of New Jersey, by the operators, and, yes, even the part the residents have played that created the conditions, for better or worse, which exist in boarding homes today. We have to stop looking back to blame, but look at the total picture, at what part each party has played, and look forward to constructive ways to improve the system.

For example, let's take a quick look at some of the residents at my home, Eden House. Let's call her Martha, to start with. She has been with us for seven years. She has

been labeled schizophrenic, but she is now in the late stages of syphilis. She is not contagious, but she has severe brain damage as a result of her condition. Because of her condition, she is prone to emotional outbursts. Last week, she broke three windows. My wife, in concern, confronted me about Martha. "What are we to do?" "Well, first of all," I said, "let's get the broken windows fixed before we get penalized." As far as Martha is concerned, she needs our support. Eden House is her home, and we are her family. Hopefully, we will be able to provide conditions for her in which she will be able to function for the rest of her life, until her ultimate death resulting from her condition. Then we will give her a dignified service and burial, with her friends from Eden House to mourn for her. This has happened many times before, I can tell you.

Now let's take a look at another resident. Let's call her Lillian. Little old Lillian is in her 80s. She is somewhat senile and she is an alcoholic. But she is very streetwise and attempts to manipulate the system. She raises a ruckus every once in a while. She will accuse us of taking her money. She says she does work for us, and that we do not pay her. Fortunately for us, she pulls the same antics with other support services in the community. Otherwise, we would be subject to intensive investigation by a swarm of agencies. When she brings liquor into Eden House, we try to apprehend it. We are not always successful. We could go through the process of evicting her, but where is she to go? If we can't provide a home for her, who can?

Now let me give you another example. Let's call her Karen. Karen does not live in Eden House, but she comes to visit Mrs. Katz and myself at Eden House about five or six times a year. She has been doing this for the past several years. Four years ago, she was a catatonic schizophrenic who also used hard drugs. For the past two years, she has been

living independently and working full-time as a teller in a bank. She still has to take her medication, but she is fully functioning. She comes to say hello to us and thank us for all we have done for her. She is one of those very, very few whom I have known who have been able to make it back into society.

I could go on and tell you about the other residents, about the cigarette burns in the furniture and carpeting, the dirty clothing, the mess and the trash. I could tell you about people whose sickness is so debilitating and whose self-image is so low that they do not give a damn about themselves or their surroundings. The truth of the matter is, residents don't really care. I have seen residents move from better conditions to worse, just to try to get away to something, without knowing what they were trying to get away from, or to. There is an element of self-destructiveness in all of this.

But, gentlemen and ladies, that is not my point. My point is, there is more to know and understand about this environment -- the operators, the residents, and the facilities in which they live. There is more here than meets the eye or can be understood by a quick perusal of the situation. The reality is, there is no quick fix in more regulations, more inspections, more penalties.

I have the unique distinction of being both an owner/operator of a boarding home and a psychologist. My expertise lies in residential therapeutic communities. I like to think of myself as a social engineer as I look at, not only the person's personal problems, but the whole person in his or her entire environment. In 1970, I founded Damon House in Paterson, a therapeutic community for drug addicts. I have been a boarding home operator for 14 years. During those years, I have tried to interest various government people and agencies in my ideas on restructuring this environment to better meet the needs of this population. I have only met with frustration. My last effort was last year, when I presented my

proposal to the Department of Human Services. I was told that funds were available to work with the residents in the facilities, not just for external support programs. I think you heard someone mention that a lot of the residents will not go out to support programs in the community.

The answer was filtered down to me via letters from the county. "Sorry, Charlie. Good idea, but no funds. Good luck." I was looking for $90,000 a year for a comprehensive program for 125 residents in three facilities. This would have been less than it costs to keep two residents in a State or county psychiatric institution -- a bargain if there ever was one. I was turned down, not on the lack of merit of the program -- because no one is in a position to assess it -- but because of no money.

I have prepared a packet for you consisting of my program and a paper I wrote several years ago as an introduction to the identity of this industry. I hope you will find time to study these two papers to further enlighten you on the problem and proposals as seen through the eyes of both an owner of a facility and a psychologist.

But, specifically, what I am asking you to do is write a bill to provide funds for innovative programs in boarding homes, such as I have presented in writing to you. Professionals, as myself, need the State's financial support to provide the opportunity to explore these innovative program ideas, and you need us to create them. The benefactors will be this disenfranchised and debilitated population which needs this less restricting but supportive environment -- the boarding home. Oppressing the operators will not do the job; supporting them will.

Just for a moment, I would like to say a word about alternative living arrangements to boarding homes, such as group homes and independent living. They serve a definite place in the scheme of things, but cannot be a replacement for

boarding homes. I would like to explore my position on this matter with you, but, for the sake of time, I will let this statement stand on its own merit.

I would also like to make other recommendations for legislative action, but I realize my time is limited before this Committee. However, I would like, briefly, to present the following matters for legislative consideration:

First, we must increase the State's contribution to SSI. I was pleased to hear a lot on that matter today. The State's contribution to SSI is about $30 per month per resident in a Class C boarding home, and an additional $119 per month in a residential health care facility, when it costs more than $4000 per month to keep these same people in a State or county psychiatric institution. New Jersey's contribution to SSI is less than any other state I have visited -- Pennsylvania, New York, Virginia, North Carolina, Florida, and California.

Next, I would recommend that we make all Class C -- and this is another recommendation I have heard made widely today -- boarding homes become residential health care facilities. I have served on State task forces and other committees studying boarding homes, and every single report has drawn the same conclusion, that there is no real distinction between RHCFs and Class C boarding homes. In a recent doctoral dissertation by Professor Richard Blake of Rutgers, in which he compared Class C boarding homes with RHCFs on 35 different variables, he found no significant difference between the two types of environments. New Jersey is the only state where two types of boarding homes exist serving the same population in the same way. It is time for the Legislature to right this wrong.

Last, we must begin to license operators. This license should be predicated upon adequate and extensive training. There already exists an initial training program for operators which uses a didactic approach. This is a good

beginning, but not sufficient. My key staff at Eden House have gone through the program as I have, but it has not made them all I want them to be. We need an ongoing and experiential learning approach, so my staff can experience who they are and what effect who they are has on the residents they live with and relate to.

I want to thank you for allowing me to present my views to this Committee, and for your indulgence in what I have had to say. I only hope you will take to heart the recommendations I and others have made, and act upon them. Thank you very much.

SENATOR CODEY: Thank you very much, Mr. Katz. Our next witness will be Joan Ellison, Coordinator, Boarding Home Pilot Project, Essex County Department of Citizen Services, Division of Welfare.

J O A N E L L I S O N: Good afternoon. I would like to thank you also for this opportunity to present this afternoon. My name is Joan Ellison. I am the Coordinator of the Essex County Boarding Home Pilot Project sponsored by the New Jersey Department of Human Services and the Essex County Department of Citizen Services, through its Division of Welfare.

Through our efforts in the pilot project, we have strengthened services to boarding home residents and established a Boarding--

SENATOR McMANIMON: Excuse me. Could you speak a little louder, please?

MS. ELLISON: All right, I'm sorry. Through our efforts in the pilot project, we have strengthened services to boarding home residents and established a Boarding Home Reform Advisory Board. This Board has increased communication among State, county, and local agencies, as well as providing training and a forum for Essex County boarding home owners and operators who are represented on the Advisory Board.

Essex County is heavily impacted by all of the issues that we have heard about here today. Of the 10,000 residential health care facility beds statewide, Essex has 921. Of the 4000 boarding home beds, Essex has 880, and an additional 3156 rooming house beds. Essex, as a pilot county, has piloted several innovative programs, and I would like to just mention two of them.

In cooperation with one local community mental health center, we have developed a team concept in case management. We have three teams that consist of a mental health worker, a social service worker, and a nurse, who go out to the boarding homes and residential health care facilities and assess and case manage all residents.

Someone earlier mentioned the continuity of care issue. Essex has piloted, and has been attempting to gain statewide support for what we have developed and called an Admissions Form. This form would notify boarding home owners and residential health care facility owners of all residents coming into their homes, as well as county welfare agencies. This form would provide them with major information, such as problems, clinic appointments, their physician's and psychiatrist's name, their social worker, their medication, and any behavior problems the operator should be aware of.

In addition, some county welfare agencies have been involved with the Division of Youth and Family Services and the Division of Mental Health and Hospitals in sponsoring a training program for boarding home operators, which Mr. Katz just mentioned to you. To date, 510 owners and operators of Classes B, C, and D boarding homes and residential health care facilities have received training. One hundred and seventy owner/operators are scheduled to receive training in 1987. The training program will become a requirement for licensure for B, C, and D boarding home operators and residential health care facilities beginning July 1 of this year.

The training modules include, but are not limited to, information regarding regulations, medications, first aid, crisis intervention and behavior management, community resources, recreation, and financial management.

My testimony is based on interactions with providers at the county and State levels, and is supported by an extensive study of housing options and related services for the seriously mentally ill, sponsored by the Division of Mental Health and Hospitals, which was recently completed in Essex County. This study confirms what most already suspected, that boarding homes and residential health care facilities are one of the two major sources of community placements for seriously mentally ill individuals. The family is the second major source. Essex has approximately 1000 beds that are willing to accept the seriously mentally ill individuals. Eighty-four percent of these beds are in boarding homes and residential health care facilities.

Most significantly, the study concludes that Essex County has a current shortfall of 600 beds. This deficit of available beds is growing.

Statistics gathered by the case management team in Essex shows that Essex has a high population of psychiatric patients in its boarding homes and residential health care facilities who also receive SSI benefits. Countywide, Essex board and care facilities show 66% of their population with a history of psychiatric hospitalization and 43% who receive SSI benefits. These percentages are higher for the cities of East Orange and Newark.

The needs are great and, as I indicated, Essex has taken some innovative steps, with positive results. But, the service delivery system for the seriously mentally ill population continues to be fragmented and unresponsive to the growing needs of this population.

As the population ages, as deinstitutionalization proceeds, and as the newly identified population of "dually diagnosed" young adult chronic substance abusers who are also mentally ill, come on the scene, the need for more and diverse community support services and housing will continue to put pressure on an overburdened mental health and social service system.

The boarding home industry continues to labor under a heavy responsibility. Owners who have agreed to accept seriously mentally ill residents who are also SSI recipients, are expected to provide adequate housing that meets State fire and safety standards, provide three nutritional meals and snacks every day, and provide a homelike atmosphere throughout the facility -- all for $315.25 per month per SSI resident.

I daresay this would defy even the most astute accountant. Even if we were to assume that services for this population were adequately provided, the amount of public resources allocated for this population's needs is inadequate. The average cost of patient care in a board and care setting in New Jersey has been established, through a Department of Community Affairs study, at $420 per month per SSI resident. As we heard earlier, this is a shortfall of $104.75 a month for each SSI recipient.

Boarding home owners and residential health care facility owners have become the parent in many instances. In reality, they are the 24-hour caretakers of this population. We can examine the costs of food, shelter, and clothing; we cannot factor in the social costs to the serious mentally ill persons who are seeking life support in community settings.

Essex has lost 35 beds over the last year due directly to high operating costs and low reimbursement rates. Several more homes are in various stages of sale on the open market, a potential loss of some 40 additional beds. Again, the owners indicate it is impossible to maintain a facility under the current reimbursement rates and associated costs.

Not only are beds being lost due to sales, but we are experiencing greater and greater difficulty in placing SSI recipients into existing homes. Fewer and fewer owners will accept SSI recipients, for they can no longer afford to absorb financial losses year after year.

If we intend to continue to use the boarding home industry as a major source of community placement for the seriously mentally ill, we must provide adequate financial support. Operators must be able to provide a fundamental quality of life, to which this population is entitled, and without which appropriate and satisfactory adjustment in the community cannot be realized.

Coupled with our recommendation for greater financial support for the boarding home industry is the need for adequate monitoring by appropriate State and local agencies. This is essential if the overall goals of the State for adequate and affordable housing for the deinstitutionalized are to be realized, and the rights and needs of residents are to be assured.

We firmly believe that the policy of giving community-based care to the mentally ill is basically sound. However, in the two decades plus since the inception of deinstitutionalization, the State Division of Menatl Health and Hospitals has not provided the community care essential to make this policy effective. Instead, the deinstitutionalized mentally ill have simply been thrown into the community to be caught by an ill-prepared and ill-equipped boarding home industry which is expected to meet the needs of an extremely vulnerable population.

In our view, continued inaction will result in an increase in the mentally ill in institutions and shelters, will add to the homeless population, and will exacerbate the revolving door syndrome between hospital and community.

If individuals are to be maintained in a community setting, an array of social, mental health, and health services must be provided in a manner most beneficial to the client population. A policy to provide a full range of community-based care to include off-site services to the mentally disabled is sorely lacking. Only recently has there been a swing toward recognizing a broader responsibility in treatment and follow-up community care by mental health professionals. Mental health workers must be reassigned into the community, for they are needed. But, equally important, the funds freed up through consolidation and refocusing of the State's psychiatric hospital system, as promised years ago, must be used to open more community residences and to provide off-site service support programs to residents.

Community-based care must include off-site services, which means breaking the traditional medical model, and providing services in boarding homes, residential health care facilities, and other residential settings. We see this as pre-crisis intervention for the individual who is often inaccessible, fearful, and resistant to traditional intervention techniques. Portals of entry into the treatment system must be easily accessible and cannot always depend on the patient finding the way alone.

Social service staff should not be told that a woman who has stopped taking her psychotropic medication refuses to leave her room, and sometimes her bed, should be brought into the local community mental health center and then they would be more than happy to provide services.

In light of these observations, our specific recommendation is to: Provide mental health off-site services for pre-crisis, crisis, and post-crisis intervention, along with in-house socialization and recreation programs, and specialized housing services. We feel these services will help to provide a comprehensive service network for the seriously mentally ill.

We cannot continue to deceive ourselves that we have deinstitutionalized these patients, for without adequate and appropriate mental health services, we have created new institutions without walls and condemned the seriously mentally ill to the freedom of the community.

We recognize that there is no single answer to the problems of deinstitutionalization, but paramount to its success are appropriate services geared to the identified needs of this population, and a housing policy which considers the needs of the SSI population.

I thank you.

SENATOR McMANIMON: Thank you very much, Ms. Ellison. Our next witness will be Barbara Meredith, please.

B A R B A R A M E R E D I T H: Mr. Chairman and members of the Committee: I would like to thank you for the opportunity to speak with you.

I represent the Garden State Home -- residential health care facility -- in Burlington County, with 33 beds; the Burlington County Mental Health Board; the Residential Advisory Board to the State; and other homes located in Burlington County.

I would like to talk about the care we give in boarding homes and residential health care facilities and the amount of reimbursement for the care.

We receive $490 a month per resident, of which $53 is returned directly to the resident, allowing a total of $5232 per year, compared to $50,000 for institutional living, and $20,000 for a group home. This figure amounts to $14.57 per day for 24-hour coverage, a R.N. on duty 12 minutes per resident per week, supervision, daily living skills, monitoring medications, bathing, shaving, reordering and picking up medications, transportation to medical doctors and other professional help, meals, laundry, recreation, and I must stress, most important, the care and comfort to residents when there is no one else there who cares.

All increases have come from the Federal government. There has been no increase on the State side for 10 years. It is hard to understand the State wishes us to maintain a resident at the same level, or we feel a better level of care, for the reimbursement we receive. This industry is very dedicated to the care of the residents. We know and read about the bad homes. We feel these homes should be put out of business.

At the rate of reimbursement, we are losing homes drastically. In Burlington County, five homes have closed -- not transferred to other owners, but closed -- in the last year. These homes were 100% mental health clients. Mercer County has had a large amount of beds lost also.

The cost of boarding your pet is greater than boarding your loved one. It costs $10 a day for room and board for your pet. If the pet needs a bath, it is $15 more; medications given would be $1 and up. Now, that is $26 a day for your pet, compared to $14.57 a day for your loved one. It leaves an empty feeling in my heart that we need to make this comparison, but it is important for us to understand the reimbursement, and how totally it is off line.

The other thing is services. There are a few pilot recreation programs which are very good and need to be expanded. Programs offer stimulation to clients in the home. The clients have something to look forward to. There is a fear that these programs will not be continued due to the lack of funding.

I serve on the Burlington County Mental Health Board. At our last meeting, we did work-ups on the priorities for the money coming into the county. Housing was the number one priority for funding, because of the loss of housing in the county. This is becoming a problem all over the State. If the homes continue to close, housing will grow worse, but without fair reimbursement, we have no choice but to close our doors.

In summary, the homes out there are providing good care to mental health clients and the elderly, and they should have a fair rate to provide the best quality of care to the clients, who have a right to live in the community and function to the highest degree of their ability.

We must not take a few homes and judge all homes by these. But, we do need to look at reality. Without more funds, the homes cannot survive, and if they do, the quality of care is being sacrificed.

We have helped to reduce the cost of institutions by providing for these clients in the community, but now to maintain these same clients we need a fair rate of reimbursement. These moneys were suppoed to follow the clients from the institution into the community. I would like to know, what happened to these funds?

Chairman Codey and members of the Committee, I would like to invite you to visit our facility, to see for yourself what a residential health care facility is like, and to see what we offer.

Thank you.

SENATOR McMANIMON: Thank you very much, Ms. Meredith. Our next witness will be Christine Anderson.

C H R I S T I N E A N D E R S O N: Good afternoon. Thank you for the opportunity to address the Committee today. My name is Christine Anderson. I am the Director of Mental Health Administrative Services, representing East Orange General Hospital.

East Orange General Hospital has been providing community-based mental health services since 1973. We established the first clinical case management program for deinstitutionalized mental health patients -- Project Portals -- in 1976.

During our 14 years of serving the mentally ill in our general hospital setting and in the community, we have worked

extensively with boarding homes and residential health care facilities. From our perspective as a primary health care provider, we have seen drastic changes since 1976 in how the mentally ill are faring in the community and what their special needs are. Overall, what we have seen is that the need for supervised community housing has increased drastically, while the availability of such housing has decreased dramatically.

The result is a crisis, which perpetuates overutilization of emergency services, drains scarce community resources, and contributes to the lack of stability in the lives of the chronic mentally ill.

The problem did not appear overnight. Rather, it is a problem that has been with us since 1976, when deinstitutionalization from State and county psychiatric hospitals began in New Jersey. At that time, boarding homes, as private enterprises, presented a welcome solution to the housing shortage, and were also the first homelike atmosphere available to many deinstitutionalized persons in 10 to 20 years. With the exception of alleged abuses and violations in a small percentage of these homes, boarding homes and residential health care facilities were more of a solution than a problem in 1976.

In the past 11 years, however, the number of people needing community housing has increased, along with the intensity of services they require. For example, today's typical boarding home or RHCF resident is between the ages of 18 and 35. He has had multiple short-term psychiatric hospitalizations this year for psychiatric problems, which began at age 16. He has been referred many times to outpatient mental health programs, but has never had regular attendance at any program. He has had the experience of living in many boarding homes and residential health care facilities, and has probably had difficulty following the rules in these homes. He is likely to be involved with alcohol and/or drugs, but is

unwilling to be treated for these problems. He is unable to reliably take his own prescribed medication, which controls his major psychiatric symptoms, such as hallucinations, and he is, therefore, repeatedly hospitalized in local, State, or county facilities. He frequently makes use of emergency mental health services, and is frequently brought there by the police for bizarre behavior or for creating a disturbance.

In our opinion, this person has little chance of being mainstreamed into normal community life because:

1) He has few choices in where he can live, and none of his choices provide him with a therapeutic residential environment to help him improve. And, because there are few choices, even if he does improve, he has nowhere else to go.

2) Because of his mental illness, he is unwilling to go to treatment programs in the community, and because community outreach services which can come to him are very limited, he probably will not receive the mental health services he needs.

3) If he does agree to become involved in community mental health programs, few of them will be equipped to offer him the specialized, intensive services he needs to help to keep him involved in the programs.

4) Because he is disabled and dependent upon public assistance, such as SSI and municipal welfare moneys, he has even less choice about where he can live. This is because his public assistance dollars cannot compete with private dollars for the same short supply of housing. He will rarely have a chance to live with other people who are not on public assistance. What can make the situation even more difficult, is that there are many homes where all residents are on public assistance. In these cases, the boarding homes and residential health care facility operators will have a hard time making ends meet, and will probably go out of business.

Our typical resident, then, for all of these reasons, does not receive the housing and mental health services which could help break the costly cycle of deterioration, hospitalization, housing placement, and deterioration once again. Based on our experience, we know it is possible to break this cycle and help the chronic mentally ill person to become a more productive member of the community. But our ability to build on our success is now threatened by the lack of adequate housing available in the community for this group of people. The housing shortage, which was a problem back in 1976, has reached crisis proportions in 1987.

We do not think it is too late to bring a halt to the immediate crisis. We have four recommendations we propose to this Committee:

First, we recommend the expansion and development of a continuum of supervised living arrangements available in the community, specifically for the chronic mentally ill. This continuum would include, but would not be limited to, supervised shelters, supervised rooming houses, supervised boarding homes, supervised RHCFs, supervised group homes, apartments, and other independent living arrangements. They should all be staffed with mental health professionals. On-site mental health services should be available for hard-to-treat clients for a short period of time, until they can become involved in community programs.

Second, we recommend the expansion and development of off-site mental health services. This would allow mental health professionals the opportunity to engage and treat reluctant clients where they live, until they are willing and able to attend treatment programs in the community.

We recommend that consideration be given to allow for reimbursement of off-site mental health services. This would enable existing programs to be delivered to anyone who needs them in any location.

Third, we recommend the expansion and development of specialized mental health services in the community geared specifically to the hard-to-treat client, who needs treatment, but who typically rejects it. This would include programs for the mentally ill chemical abuser, who comprises a large segment of this hard-to-treat group.

Fourth, we recommend that boarding homes and residential health care facilities be encouraged to accept more residents who are dependent on municipal welfare and SSI. We also recommend that these facilities increase their staffing, so that they can provide more intensive supervision to the mentally ill residents who reside there, and to be able to coordinate their efforts with health, mental health, and social service agencies working with their residents. This would require that additional funding be allocated to boarding home operators and residential health care facility operators.

We respectfully urge you to consider our four recommendations. We believe that New Jersey has an opportunity to maintain its leadership role in caring for the chronic mentally ill. We strongly encourage this Committee to focus on both the short- and long-term solutions to the crisis now facing us.

Thank you very much.

SENATOR McMANIMON: Thank you very much. Our last and final witness will be Patricia Love, please.

P A T R I C I A L O V E: Good afternoon. My name is Patricia Love. I am the Director of Park Place, which is the community care component of Jersey Shore Medical Center.

Park Place is the name of a psychiatric day program servicing boarding home residents of Asbury Park. This program, originally known as Project Outreach, was the first such program and, to my knowledge, continues to be the most extensive boarding home outreach program in the State. I have been the Director of this program almost from its inception in

1978. I base my comments on my direct experience within boarding homes, and that of my colleagues, who have daily access to those boarding homes. I have come to the conclusion that:

Privately owned and operated boarding homes and residential health care facilities should not be used as the primary housing option for the psychiatrically disabled. The following is my rationale:

Within the boarding home industry, there exists a built-in disincentive for providing quality care. It is not in the best interest of the boarding home proprietor to provide the type of services and/or environment that would encourage residents to achieve a higher level of functioning. To do so would invite the possibility of the resident seeking a more independent living environment. The resulting vacancy leaves the boarding home operator with far less palatable options, such as accepting a more difficult-to-manage, maybe recently discharged from a State psychiatric hospital, individual. Additionally, within the larger homes, it is common practice to have the more skilled residents work within these facilities. These are highly valued residents whom operators do not enjoy losing, even if it were in the interest of the residents to move to to less supervised facilities.

Additionally, the size of these boarding homes and residential health care facilities can have a negative impact on the psychiatrically disabled. The larger facilities can be deleterious on the residents, regardless of the quality of the care provided. Housing large numbers of these individuals in boarding homes increases their sense of isolation and desperation. Their sense of identity, already questionable, becomes even more fragile. The State hospital system recognized this, and stopped the warehousing of clients, deciding it was counter-therapeutic, and attempted to limit the amount of patients residing in the cottages within the State

hospital system many years ago. Why, then, do we discharge patients into facilities which are sometimes larger than those cottages within the State hospital system?

Clients adopt the dysfunctional "norm" to which they are exposed. When abnormal behavior is commonplace, any normal coping skill or social skill which may have been present could easily be lost. Additionally, in the larger facilities, there is a smaller percentage of individuals whose appropriate behavior can be modeled.

Often, boarding homes inadvertently reinforce abnormal behavior. Apathy, lack of volition, and psychomotor retardation, which often accompany mental illness, are desirable behaviors to many operators. The "good" resident is the one who quietly spends all day watching television. Residents who attempt to assert themselves by complaining about conditions, are considered "troublemakers" and are quickly rebuked.

During their day treatment, clients are encouraged to reengage with the world. However, in the boarding homes, they are criticized for doing so. In most cases, you treat the client during a day program, and you expect certain behavior from them, and you encourage certain skills. The living environment is crucial for the practice of these skills. Without that living environment, the therapy that goes on during the day for the chronic mentally ill can be totally undone.

Most boarding homes are incapable of creating the type of environment, or of providing the extensive services necessary for the majority of the psychiatrically disabled. The boarding home industry cannot be blamed for the current state of affairs. They, inadvertently, became part of the mental health system and were ill-prepared for it. The assumption by the Division of Mental Health and Hospitals that merely providing food and shelter would adequately meet the

needs of the deinstitutionalized population, was at best naive, and at worst, unconscionable.

The low reimbursement rate for boarding homes and residential health care facilities contributes significantly to the situation. The low salaries offered by operators attracts poorly educated, unskilled employees. The result is personnel who themselves may lack even marginal coping skills, and are, in all probability, unequipped to even begin to address the unique problems of a unique population. It is not uncommon to find a boarding home staff who are current recipients of extensive mental health services, or who are known substance abusers.

Also, the boarding home environment increases the risk of many health problems. There are boarding homes where as many as 90 individuals congregate in one room. That 85% of those individuals are heavy smokers is a realistic estimate. I have personally found it intolerable to remain within that room for any extended period of time. Yet, this is the only available lounge area and many residents spend eight to twelve hours there.

Although physicians sign statements verifying prospective residents are free of contagious disease, there is no mandatory laboratory testing required to verify this. Additionally, the guidelines requiring mandatory yearly physicals do not specify the nature nor the extent of the physical, so very marginal physicals can take place. Therefore, tests for contagious diseases and blood sampling, which is generally considered a requirement for individuals on psychotropic medications, are rarely performed.

Only through our advocacy are periodic tuberculin tests performed. These tests have, over the years, identified several residents in need of treatment. These are not done regularly within the boarding homes.

The final conclusion is: Reliance on boarding homes leaves mental health clients susceptible to the whims of the

private sector. Nowhere is this more evident than in the Asbury Park area, where more than 500 boarding home beds will soon be lost due to the redevelopment plans.

I would be remiss if I did not mention that there are some small boarding homes to be emulated. There is one such small, 12-resident home in Asbury Park, where residents are provided with a warm, supportive, enriching environment. The staff are excellent role models for their residents. They encourage residents to become actively involved in the activities of daily living. The pride that this involvement evokes helps to motivate the residents to achieve their maximum level of functioning. The staff work closely with the mental health providers. They encourage the independence of their residents, even if that may mean losing them to a less supervised setting.

A few of the recommendations I have are:

1) Begin the development of a full range of housing options for the psychiatrically disabled.

2) Provide financial incentives to support the continuation and expansion of the smaller room and board facilities. Again, across-the-board increases in funding will only serve to go into the pockets of the larger facilities, and will never be seen as far as increased services for the majority of the individuals is concerned.

3) Revise the rules and regulations governing boarding homes to more specifically define quality of life issues.

4) Allocate funding for the provision of mental health case management services to boarding home residents.

5) Provide seed money for the development of not-for-profit boarding homes. These homes would be designed and supervised by skilled professionals. By eliminating the profit, these homes could be self-sufficient and could be a model on which to base a whole new standard of care.

I also agree with the immediate consolidation of the regulatory function of boarding homes and residential health care facilities under one department.

The things I have outlined here are just a few examples of problems that the psychiatrically disabled face in the boarding homes. We have also seen the horror stories -- the rape of the elderly resident in the boarding home, the financial exploitation, the suicides within the boarding homes. But, what I wanted to do was highlight that even under the best situations, even with boarding homes that provide good quality of care, they are not an acceptable alternative for the psychiatrically disabled who need professionally maintained homes, and can be given specialized environments which will encourage them to meet their maximum level of functioning.

Finally, I would just like to say, I think what scares me the most about the current situation is that I have heard several times questions being asked, such as, should these people be discharged from the State hospitals? Perhaps we should look at keeping them within the hospital situation. I think what's happening is, the psychiatrically disabled are being blamed for the failure of deinstitutionalization, where it is truly the lack of services to address their unique needs, and the problems with the over-reliance on the boarding homes, that have caused this problem. I would hate to see the focus being on the need to return any individuals to the hospitals.

From my experience in working with these individuals, they can achieve a significant changes in behavior and become actively involved in the community, if given the proper support.

Thank you very much.

SENATOR McMANIMON: Thank you very much.

This concludes our public hearing for today. I would like to take this opportunity, on behalf of Senator Codey and myself, to thank everyone for appearing here. You can rest

assured that you have given us some very enlightening information, and we will really look into it.

Thank you very much.

(HEARING CONCLUDED)