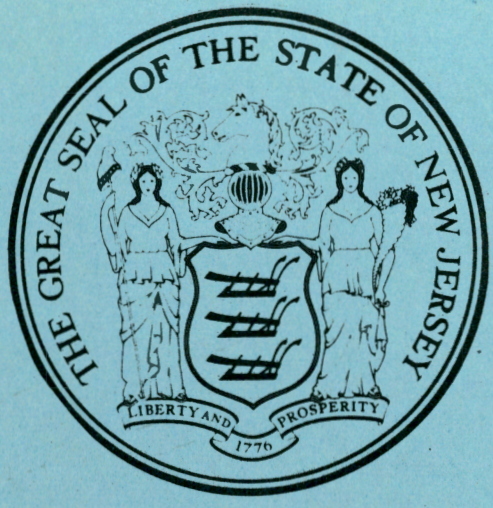
STATE OF NEW JERSEY. Legislature.
" Joint Mental Health Subcommittee.



FINAL REPORT

TO THE

LEGISLATURE

(PURSUANT TO SCR 89 OF 1974).

THE JOINT MENTAL HEALTH SUBCOMMITTEE OF THE SENATE AND ASSEMBLY INSTITUTIONS, HEALTH AND WELFARE COMMITTEES, CONSTITUTED TO INVESTIGATE AND REVIEW NEW JERSEY'S MENTAL HEALTH CARE SYSTEM.

NOVEMBER 1975

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JOINT MENTAL HEALTH SUBCOMMITTEE OF THE SENATE AND ASSEMBLY INSTITUTIONS HEALTH AND WELFARE COMMITTEE, CONSTITUTED PURSUANT TO SENATE CONCURRENT RESOLUTION 89, OF 1974, TO INVESTIGATE AND REVIEW NEW JERSEY'S MENTAL HEALTH CARE SYSTEM.

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DISTRICT 22 (Parts of Union and Morris Counties)

You cannot see my scars,
But they are there, and real,
Cut as deeply as the gorges
Sliced by a raging river
Rushing toward a hostile sea.

I drift in this bottomless ocean,
Searching for a friendly shore
Upon which I might find pause
From my lonely and constant fear
Of slipping away from life.

You pass like a ship at night
Seeing no distress, hearing nothing,
While my often whispered scream
Rises and signals as a silent flare
Casting its light as darkness.

I feel the waters closing now,
Covering all there ever was.
I feel the numbness coming now,
Blanking whatever will be.
I feel the waters closing now.

But wait,
I see a light!
A figure on the land
Throwing a hope out to sea
Offering a helping hand.

Bill Perry, Jr.
Mental Hygiene Vol. 58, #4, Fall, 1974

Introduction

The Joint Mental Health Subcommittee was created pursuant to Senate Concurrent Resolution 89 of 1974 (filed May 14, 1974), with a broad mandate to study and evaluate the State's program and the public's needs for new mental health institutions, agencies and programs.

The Subcommittee interpreted this mandate to include, among others, the following broad objectives:

1. To study the present mental health care system to determine how the system is operating and how it might operate more effectively;

2. To enlist the viewpoints of persons having first-hand experience in delivering mental health care. This meant that patients, relatives of patients, nurses, attendants, psychologists, psychiatrists, administrators and selected staff of the Division of Mental Health and Hospitals would be asked to share their knowledge with the Subcommittee;

3. To hold hearings as needed on the psychiatric hospitals and on subjects which require investigation;

4. To issue periodic reports on Subcommittee hearings, so that the public and the Legislature remain informed on important issues in mental health; and,

5. To make recommendations on changes and improvements which appear to be needed on the basis of hearings, investigations and inspections of facilities.

All of these objectives are incorporated in the two major objectives which served as operating principles for the Subcommittee:

1. To act as ombudsmen for mental patients, mental health care providers, and an interested and concerned public; and,

2. To act as catalysts for change toward an improved mental health care system.

In pursuit of these objectives, the Subcommittee held six hearings, visited four facilities, took testimony from approximately sixty people, spoke informally to many others, and held many work sessions to evaluate the information obtained and prepare recommendations for improving mental health care.

Legislation was introduced when necessary to implement such recommendations for improvement. Furthermore, existing legislation was evaluated, amended if needed, and released to the full membership of the Senate and Assembly Institutions, Health and Welfare Committees for consideration. When mental health bills were released from committee for consideration by the Senate or General Assembly, Subcommittee members actively supported passage of these mental health proposals by interpreting provisions of the proposals to the Legislature and explaining why the legislation was needed.

The Subcommittee also worked closely with the Department of Institutions and Agencies in pursuit of its objective of effectuating change in the mental health care system. The Departments of Institutions and Agencies and Health established a Mental Health Planning Committee to develop a comprehensive

mental health plan for the State at approximately the same time that the Legislature created the Joint Subcommittee. It seemed natural, therefore, for the two groups with similar objectives to work cooperatively. While the Mental Health Planning Committee studied the mental health care system to devise a plan to implement an improved care delivery system, the Joint Subcommittee's role was to emphasize the need for such improvement.

This final report to the Legislature attempts to outline the efforts of the Joint Mental Health Subcommittee over the past two years. The report is divided into four major sections.

The first section provides an historical perspective to mental health care in New Jersey. By knowing what has been attempted in the past -- what was successful and what failed -- the Subcommittee felt that its conclusions and recommendations would be more meaningful.

The second section summarizes the reports issued throughout the two-year period on various mental health facilities. It contains an overview of findings and recommendations on Greystone Park Psychiatric Hospital, the New Jersey Neuro-Psychiatric Institute, the Woodbridge Emergency and Child Diagnostic Center, Trenton Psychiatric Hospital, Marlboro Psychiatric Hospital and the Menlo Park Diagnostic Center.

The third section contains summaries of staff reports on special issue areas, prepared at the Subcommittee's request as a result of a public hearing or investigation of a particular problem.

The last section contains a summary of the work of the Subcommittee, and some conclusions and recommendations.

Acknowledgements

The Subcommittee would like to thank Irene Salayi and Michael Bruinooge of Legislative Services for their extensive contribution. Gratitude is also extended to Linda Magno, an intern from the Woodrow Wilson School of International Affairs at Princeton University and to all others who testified at the hearings and provided analysis solicited by our staff. Lastly, we wish to thank the Citizens Conference on State Legislatures, who, through their Model Committee Staff Project in Health, have made a full-time staff person, Nancy Daley, available to assist us in our hearings and research.

HISTORICAL PERSPECTIVE

At one time, New Jersey was a leader in mental health reform. Almost 130 years ago, construction was started on our first institution for the mentally ill: Trenton Psychiatric Hospital was built as a model for humane and progressive care and treatment of the insane. The New Jersey Legislature and the public supported the building of this first insane asylum, as they were then called, to reflect the State's sense of responsibility and concern for its mentally ill citizens. Legislators were aroused by the efforts of Miss Dorothea Dix, who told horror stories of "lunatics chained fast to their cells" in local jails and almshouses, when she appeared before them in 1845. In response, they moved swiftly to eliminate the abusive situations by providing funds for an asylum which could treat and cure the insane.

The first asylum was small -- only 200 beds -- for it was believed that small institutions would allow each patient to "receive thorough medical and 'moral' treatment based upon careful study of each patient, taking into account his social, civic, and family history."[1]

[1] Psychiatric Progress in New Jersey, 1844-1944, William J. Ellis, Ll. Phil. D. Commissioner, N. J. Department of Institutions and Agencies.

Furthermore, the first medical director of Trenton Psychiatric Hospital desired to make State institutions a place for the cure of mental patients in the early stages of their illness. He urged "friends of the insane to appreciate the danger of delaying an early resort to the appropriate curative means." He also supported alternatives to institutionalization: "The patient ought never to be sent to an asylum when the means of treatment and the probabilities of relief are equally great at home. Persons of advanced age who are insane from the irregular decay of the faculties... may be treated as well at home as at an asylum."

This asylum was carefully designed and built with the highest hopes that, at last, after ages of neglect, apathy and misunderstanding, insanity could be treated and cured. The setting for the asylum was chosen with the patient in mind: an isolated community, with quiet, peaceful surroundings and plenty of room was the ideal place for settling deranged minds. The buildings were handsome and imposing, as well as clean, safe, bright and efficient. Every detail of the building, from the windows to the furniture, was chosen with the patient's needs in mind. The best intentions inspired, planned and built New Jersey's first hospital.

Today--one hundred and thirty years later--the very institutions which were built to eliminate the abuses and horrors described by Miss Dix are the settings for "intolerable conditions" and "dehumanizing indignities."

Why have these hospitals, built with such high hopes and good intentions, become "horror chambers?" Why does New Jersey still seem so far from the goal of providing humane and adequate care for the mentally ill?

There are many answers to these questions -- far too many to be adequately considered here -- but some answers of a general nature can be found through an appraisal of the rise and fall of the psychiatric hospital.

The reform movement of the 19th century, which spurred the construction of State hospitals, came as an alternative to former practices, that had included imprisoning those whose behavior was unseemly or potentially dangerous or embarrassing. Lunatics, as they were then called (and are still called in current statutes), were not seen as evil, but as helpless victims of disease, who needed secure and safe surroundings where they would be protected and where the community would be protected from them.

As is often the case, the solution or reform soon became a problem.

One of the earliest commissions of the Legislature established in the 1830's to investigate the need for a State asylum, reported that there were only 695 lunatics and idiots known to New Jersey authorities. This estimate was soon proven to be very inaccurate. Furthermore, the original concept of the asylum as a center for the treatment of "newly afflicted" patients soon had to be abandoned as the authorities in charge of the asylums realized that the public viewed the role

of the asylum differently. Many citizens had supported the creation of the asylum so that chronic patients, formerly housed in jails, almshouses and the attics and cellars of private homes, could be served in more humane surroundings. By 1870, Trenton's population had risen from the original 200 in 1848, to an "intolerable" number: 648. One of the results of this rapid growth was the erection of the State's second asylum in 1876, Greystone Park Psychiatric Hospital, with a capacity of 800 patients. A second result of increased demand for the State to assume responsibility for its mentally disabled residents was authorization of the payment of State subsidies to counties for the care of patients in county facilities. Even with these two developments, the State soon conceded that additional construction was needed, as populations in the State asylums grew steadily.

At the same time, it was determined that feeble-minded persons, or retardates, and epileptics had different care and treatment needs and should be in separate facilities. Therefore, the first training school for the retarded was built in the 1880's and an epileptic village was established in 1898.

In time, the number of patients grew and the character of the asylums changed. As the definition of mental illness broadened, almost anyone could be defined as insane in one framework or another. When

families and governments could find no other solution for misfits, the asylum became the place of last resort. The old, the unwanted, the unmanageable filled the asylums beyond capacity. Before long, the typical mental hospital became indistinguishable in most respects from a prison.

The lovely rural settings, chosen to soothe and calm troubled minds, kept the unwanted out of the public eye. Abuses could flourish, overcrowding could be ignored and scandals could be hidden. Hospitals changed from places of therapy, hope and cure to places of disappointment, alienation and custodial care. The policies of the originators of the hospitals could not be continued; the public expected the State to assume responsibility for <u>all</u> insane, not just the curable.

The policy question which remained unresolved for years -- whether the State should provide asylums for custody or hospitals for cures -- was resolved by default. The State tried to do both, and as a result, little progress was made in the treatment and cure of mental illness and custodial care was unsatisfactory and expensive in State institutions. The State could not decide on a specific role for the institutions, and instead, gave the patient minimal treatment and custodial care.

In 1918, an investigation of conditions of mental hospitals and other charitable institutions was under-

taken by the Legislature. The celebrated "Earle" commission reported:

"At the State institutions for the insane, patients are admitted regardless of the overcrowded conditions which always prevail. In some cases even ordinary sanitary conditions are lacking...buildings old, unsanitary and unsafe, and veritable fire-traps are housing hundreds of old and infirm people."[2]

As a result of the legislative investigation, and other developments, an attempt was made to "modernize" the two hospitals. Greystone Park, in particular, was found to need extensive repair. New buildings were erected at both hospitals and new equipment was installed. The old asylums were to become modern hospitals, with laboratories, therapy rooms, expanded professional staff and other indicators of innovation. A third hospital was also built as the populations of State and county facilities continued to increase.

Marlboro State Hospital differed in design from the existing hospitals: "Here is an institution that looks more like a college than a place for the care of mentally sick," a visitor reported in 1933. "The old, gloomy fortress-like 'asylum' is gone. In its place are numerous smaller

[2]Report of the N. J. Commission to Investigate State Charitable Institutions. 1918.

buildings...a hospital, a dining hall, nurses' home and a series of cottages...pleasant, light and airy."

On the whole, the period between 1918 and 1945 was a period of optimism. New therapies, such as shock and drug therapy, were instituted with notable success. In-service training programs for staff were developed. "Home visiting" or "parole" programs for patients were established and became part of the hospital's regular service. Mental hygiene clinics were established so that mental examinations could be conducted in the community, and individuals could be treated on an outpatient basis. Attempts were made to work with children who had behavior problems, so that preventive measures could be taken to avert or forestall the development of future mental problems. These clinics also attempted to educate the public on the nature of mental illness and the role of the institution. Several clinics were located in general hospitals in hope that, as the clinics proved their worth, general hospital authorities would recognize the need for psychiatric wards or in-patient services and establish them in the general hospital.

Despite the gains which were made, several key policy questions remained unresolved and certain indicators appeared to belie the general optimism of the period. The State hospitals were still asked to perform dual functions: treat and attempt to cure acute mental illness and care for chronic "hopeless" cases. This dual function was reflected in the dual management which developed in two of the State

hospitals. The Business Manager, on the one hand, was required to run the hospital as economically as possible; his goal was maintaining a self-sufficient institution. The Medical Director, on the other hand, was responsible for medical care and treatment of the patients; his goal was to cure or alleviate a patient's mental illness. As you can understand, these goals were often in conflict.

While the Commissioner of the newly formed Department of Institutions and Agencies stated that the "policy of treatment and prevention" was a basic goal of the Department, administrative decisions and policy directives from the central office actually stressed economy of operation as a central goal. Particularly during the Depression years, saving taxpayers money and keeping the staff and patients busy were of prime importance. Running a self-sufficient institution required extensive patient labor, which was called therapy. Because there was little emphasis on genuine treatment and therapy, and because little was known about what kind of treatment and therapy was effective, cure or improvement was the exception rather than the rule in State mental hospitals. Therefore, as chronicity and the rates of new admissions increased, overcrowding again became a problem and staff was forced to concern itself with providing a minimal level of care for an ever-increasing number of patients.

A second policy question which was not resolved during this time concerned the community's role in the prevention and treatment of mental illness. The promising start toward

establishing alliances between outpatient clinics, child guidance centers, general hospitals and State hospitals never really developed to a satisfactory level. No "carrots or sticks" were proposed by the State to insure continuation and expansion of these promising alliances in an orderly and purposeful manner. In some cases, successful integration of community services and State hospital programs were accomplished, but this often happened as a result of the efforts of interested and determined community leaders, not as a result of State efforts. If a community was fortunate enough to have a few knowledgeable and active people working to develop the tenuous alliances into permanent services, the services flourished. As could be expected, this haphazard approach resulted in the development of good community-State hospital relations in some regions, and no development in other areas.

The question of how the State and counties should divide responsibility for the care of the mentally was also left unresolved. Standards at county hospitals were not controlled by the State, and, on the whole, care and treatment standards at such county facilities were below the standards of the State facilities. The State allowed the existence of such dual standards of care by not requiring the counties to meet higher standards as a condition of receiving State subsidies.

As a second alternative, the State could have taken over the county hospitals and brought them up to State standards. However, this alternative would have been more costly than

continuing to subsidize the substandard county hospitals, so no other action was taken by the State.

Many of these unresolved issues were carried over into the post-war years. By 1940, half of the State's wards were in mental hospitals, which constituted the Department's largest investment in plant and professional staff.[3] Overcrowding and understaffing had reached epidemic proportions: in 1945, Marlboro State Hospital had 25 attendants and 175 open attendant positions and 13 graduate nurses, and 50 open nursing positions; in 1946, vacant Navy barracks at Mercer Airport were converted into temporary housing for senile patients because of the severe overcrowding at Trenton Psychiatric Hospital.

A special Mental Hygiene Committee of the State Board of Control was convened to suggest ways of meeting the crisis in the State hospitals. They proposed that increased shock therapy and aftercare, the provision of some kind of special care for the increasing number of senile cases, and the construction of a new State hospital would resolve the crisis. There was also continued hope that psychiatric wards would be developed in general hospitals and that more mental hygiene clinics, as extensions of the State hospitals, would be created.

[3]James Leiby, Charity and Correction in New Jersey, (Rutgers University Press, 1967), p. 331.

In an attempt to insure that some of the aforementioned would become realities, the position of deputy commissioner for mental hygiene and hospitals was created. As liaison between the commissioner and the mental hospitals, the deputy commissioner was given the following duties: "to encourage high standards of treatment, service and staff training; attend to psychiatric service in all institutions; develop the mental hygiene clinics; oversee the inspection of county and private hospitals, and advise parole from mental hospitals," as well as administer programs under the National Mental Health Act and oversee the distribution of Federal aid for hospital construction. However, he was given no direct authority or professional staff to assist him in these duties.

From this inauspicious start in the 1940's, the Division of Mental Hygiene and Hospitals grew and provided leadership for new programs. The Division and its programs were supported because a number of outside forces coalesced at this time to put pressure on the State to develop practical plans to implement "new" thinking. One force was the public's increasingly sympathetic view of mental illness, which occured partly as psychiatry gained general acceptance and as large numbers of veterans returned from the war as psychiatric casualties. At the same time, Federal veterans hospitals were created with high standards of treatment and service which made State facilities and programs suffer

by comparison.

Another federal development was the passage of the National Mental Health Act of 1946, which authorized funds for research, staff training and community programs. Lastly, the Council of State Governments studied various State mental health service programs and made extensive recommendations for improvement. With the new public interest and support, the example of the veterans hospitals, the stimulus of Federal money, and the recommendation of the Council of State Governments, New Jersey was pressured into moving in several areas. Some of this movement represented new thinking; other responses were clearly a continuation of traditional thinking.

When Ancora State Hospital was started in 1953, the public was divided in opinion on the creation of a fourth large State hospital. Some felt that it was a symbol of progress in mental health care, particularly since the buildings were more attractive and modern than the old asylums. Others felt discouraged that still another hospital was built when the existing hospitals seemed to be so unsatisfactory.

In dedicating Ancora, Governor Meyner characterized it as "a monument to mankind's failure to find the answers to the problems of mental illness in our complex modern society." [4]

[4] Ibid, p. 342.

He indicated that bricks and mortar were not the answer. He said that a new approach was needed to break the cycle of overcrowding and new building, even if it proved more costly.

One new approach, which had some roots in the past, was the establishment of community services for the mentally ill.

In most States, new community service programs were administered by departments of public health; the National Mental Health Act of 1946 purposely bypassed the traditional State mental hospitals in favor of a public health emphasis, attempting to insure that new services would be a product of new thinking. In New Jersey, however, the Department of Institutions and Agencies was the administrative agency, since mental hygiene clinics, first established in 1918 as extensions of State hospitals, were already operating.

As mentioned earlier, there was little Statewide uniformity in the operation of these clinics. The locations, services rendered, and populations served were often dictated by chance. Of a similar chancy nature was the hope that State-supported mental hygiene clinics would foster workable community services. It is not surprising, therefore, that these services developed slowly and sporadically in the post-war years. One of the first concrete signs of progress was the passage of legislation which allowed local officials to subsidize quasi-public clinics.

Under this law, several child guidance clinics were established with both public and private financial support. One of the prime movers behind this legislation was the newly formed (1948) State mental hygiene association, later renamed the New Jersey Association for Mental Health.

This group of informed and interested citizens demanded improved community services, and in time, came to criticize the omnibus structure of the Department of Institutions and Agencies as unresponsive and lacking in planning capability and leadership needed to implement the community services approach.

No departmental reorganization resulted, although the criticism was recognized to have some justification, for it was directed at what the Department had failed to accomplish rather than what it had accomplished. In fact, many of the accomplishments of the late forties and early fifties could be characterized as attempting to catch up, not move ahead. The Commissioner and the State Board were unable to concentrate on directing the Department toward new programs when old programs needed remedies. For example, the State hospitals had physically deteriorated to such an extent that major repairs were required to make them minimally safe and livable. Much time and effort was expended in building legislative and public support for two bond issues for needed renovations. This time-consuming public relations campaign was successful, but it did not result in new community services. Once again, time, effort and money was spent on "bricks and mortar."

Not until 1957 and the passage of the Community Mental Health Act, was the Department able to provide incentives to communities to move in new directions. This act encouraged local sponsors to plan community projects by providing a grant-in-aid for one half the cost of the project up to a maximum for each county of twenty cents multiplied by the population of the county. By the end of the first year, seventeen clinics were receiving aid; in the next two years a total of thirty-seven clinics were in operation. These clinics were not mental health centers, as we know them today, but provided out-patient services for persons with less severe disturbances. When Congress passed the "Community Mental Health Centers Act" in 1963, New Jersey passed similar legislation in 1967, allowing many existing clinics to expand into full-fledged mental health centers meeting Federal requirements for funds.

As in the past, hopes were high: community mental health centers were to replace the "human warehouses" and "horror chambers" the State institutions had become. However, as you well know, the centers did <u>not</u> replace the institutions which still operate today. And, although the institutions now have fewer residents, it appears that the centers are not responsible for the diminished role of the State hospitals.

A number of factors seem to indicate that the new centers were not a meaningful force in the reduced resident populations of the State hospitals. In the first place, the decline in such hospital populations on a national

level started in 1956, at least ten years before the centers became operational in New Jersey. Second, the increased use of tranquilizing drugs made possible the release of many patients who were previously considered hopeless. Another factor was the policy of summarily releasing patients to stem the rising cost of hospitalization, with little regard for continuation of care in community centers. Some of these released patients were placed in nursing homes, sheltered boarding homes or foster care homes. Others were institutionalized in hospitals for the retarded and a few were treated in the community. On the whole, though, it appears that the new community mental health centers were treating the nonchronic, less severely disturbed patients, characterized as having "personality disorders," "behavioral disorders of childhood," or "transient situational disorders."

It is not surprising that the new centers were not supplanting the State hospitals: the legislation which established these centers did not require treatment of the "tough" cases; in fact, there is no mention of services for State hospital patients in this law. Therefore, the aged, the alcoholic and drug dependent, and the psychotic were, on the whole, selectively ignored by the centers in favor of more "treatable" patients. No incentives were provided by the State or the Federal government for the centers to tackle these more difficult type patients, so most centers avoided these patients. In all fairness to the new centers,

it may be that they realized they could not treat these kinds of challenging patients with the treatment resources at their disposal.

Furthermore, there is increasing recognition that a whole network of supportive community services is needed to enable persons who have been institutionalized for long periods of time to function in the community. The chronically impaired individuals who leave the back wards need halfway houses, sheltered workshops, job training, homemaker services, day care programs and other social supports to live productive lives in the community. Some of the facilities and services were included in the Federal definition of a "comprehensive" community mental health center, but most centers did not provide such services, since they were optional rather than required services under the Federal regulations.

Changes which were made this year in the Federal law may alter the way centers operate and force them to provide services which are more in tune with the needs of the chronic, back ward kind of patient.

It appears that special programs will be required for the elderly, who had previously been ignored by the centers. Programs for the prevention and treatment of alcoholism and alcohol abuse and drug addiction and abuse must be provided, if the need for such programs exists in the community. Follow-up care, as well as transitional halfway house services,

must be provided for former hospital patients. Of equal importance, centers are required to coordinate with health and social service agencies to insure that mental health care is integrated with other needed services. Hopefully, these changes will make centers more responsive to the needs of former State hospital patients.

Other developments, on a national and State level, seem to indicate that attitudes toward the mentally ill and traditional methods of caring for mental patients may be changing.

One development concerns the role of the courts. Up to about ten years ago, mental health was a relatively ignored area of the law. Then, in 1966, Charles Rouse, an 18-year-old who was committed to an enormous Federal hospital for the mentally ill after being acquitted on a misdemeanor charge by reason of insanity, petitioned the court for his release. He claimed that he was no longer insane, and that he was not receiving treatment. Furthermore, the maximum sentence for the misdemeanor would have been a year and he had already spent four years in the hospital.

Chief Judge David L. Bazelon of the U.S. Circuit Court of Appeals in Washington, D.C., who is an expert in the field of law and psychiatry, ruled that Rouse had a "right to treatment" on the basis of a D.C. statute. He suggested further that the prohibition against cruel and unusual punishment, or the due process or equal protection clauses

of the Constitution, might be used to challenge mandatory commitment when a statutory guarantee to treatment was lacking.[5]

The ruling was important for two reasons: first, it established that the court had the right to follow committed persons into a mental institution, rather than abandoning them to mental health professionals and the vagaries of legislative funding practices. Second, it established the principle that if the State confines someone to give him treatment, then the State is obliged to provide treatment.

In 1971 another important case built on Judge Bazelon's decision. Federal District Judge Frank Johnson,Jr., ruled that involuntarily committed patients have a constitutional right to treatment under the due process provisions of the 14th Amendment. This decision was a result of a class-action suit on behalf of Ricky Wyatt, an involuntarily confined patient at Bryce State Hospital in Alabama, and others like him. Judge Johnson found that Bryce Hospital was clearly not providing satisfactory treatment and gave the State six months to remedy deficiencies and come up with satisfactory treatment plans.

[5] Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966).

When the State failed to meet the Judge's order, Johnson issued two detailed and comprehensive sets of orders, defining what constituted acceptable treatment, and covering everything from staff-patient ratios to the number of showers required.[6]

One of these rules concerned patient labor and resulted in a subsequent decision by U.S. District Judge Aubrey Robinson who rejected the notion that work need not be compensated if it is therapeutic: "Economic reality is the test of employment...so long as the institution derives any consequential benefit, the economic reality test would indicate an employment relationship rather than therapeutic exercise."[7]

The court ruled that work could not be labeled "therapy" any longer, and that patients who were performing jobs which were primarily of economic benefit to the institution would have to be reimbursed according to the Fair Labor Standards Act.

[6]Wyatt v. Stickney, 344 F. Supp. 373, 344 F. Supp. 387 (M.D. Ala. 1972).

[7]Souder v. Brennan, 367 F. Supp. 808 (D.C. Cir. 1973).

While the abovementioned decisions on right to treatment and peonage are concerned with mental patients who are already confined, other decisions have been concerned with how the patient was committed.

Courts have found that the State can legitimately limit a person's liberty in certain instances, but that a variety of placement and treatment alternatives must be explored before hospitalization to insure that the "least restrictive alternative" is employed. This decision, hopefully, will force States to provide facilities which are less restrictive than State hospitals, such as foster care, home-health care, transitional residences or shelters, and community mental health centers.[8]

A very crucial U.S. Supreme Court decision of this year dealt with three issues: whether a right to treatment exists for mentally ill persons who are found to be dangerous to themselves or others and involuntarily committed; whether involuntary commitment for purposes of treatment is allowed for non-dangerous mentally ill persons; and, whether damages are due non-dangerous mentally ill persons who have been confined without treatment.

While all of these issues were not decided, the court clearly stated "that mental illness alone cannot justify a

[8]Lake v. Cameron, 364 F. 2d 657 (D.C. Cir. 1966); Lessard v. Schmidt, 347 F. Supp. 1078 (1972).

State's locking up of a person against his will and keeping him indefinitely in simple custodial confinement."[9]

New Jersey courts have also demonstrated concern over inadequate mental health laws and procedures. Court rules concerning involuntary commitment have been revised to provide persons facing involuntary civil commitment with additional legal rights and protections.[10] Furthermore, certain sections of New Jersey law, concerned with automatic involuntary commitment to a mental institution of persons acquitted by reason of insanity in a criminal case, were declared unconstitutional in a court decision. This decision also established interim procedures for the disposition of persons acquitted by reason of insanity, until new laws could be enacted.[11]

[9] O'Connor V. Donaldson, 43 U.S.L.W. 4929 (1975).

[10] Court Rule, 4:74-7

[11] State v. Krol, Docket No. A-102, 68 N.J. 236 (1975)

Other State-level developments indicate that a major change in the delivery of mental health services is overdue.

In 1973, a coalition was formed to challenge the withholding of Federal funds from community mental health centers. In early 1974, the New Jersey Association for Mental Health formed a Statewide citizens committee to promote the concept of community leadership in the delivery of mental health services. The Legislature created the Joint Mental Health Subcommittee in early 1974 to examine all phases of mental health, review pending mental health legislation and recommend ways to improve the State's mental health programs. The Executive branch created a Mental Health Planning Committee to design a new comprehensive State mental health care system.

In addition, the Division of Mental Health Advocacy in the Department of the Public Advocate filed a suit against the State seeking to bar new admissions to Greystone Park Psychiatric Hospital on the grounds that patients have a right to adequate professional care and that such care is not provided at Greystone. A grand jury investigation of Greystone resulted in a number of indictments and a 40-page presentment which stated that patients were subject to "intolerable conditions" and "dehumanizing indignities" and concluded: "In the final analysis Greystone Park Psychiatric Hospital, inaugurated 100 years ago, is the

product of a century of ignoble indifference. It is a public failure not by virtue of conscious decision, but by a general unwillingness on the part of our society to properly recognize and efficiently correct the problems it presents."

In light of this it is not surprising that Greystone and other State hospitals were disaccredited by the Joint Commission on Accreditation of Hospitals, which reported that these facilities fell far short of professionally accepted standards.

All of the aforementioned developments can be viewed optimistically as indications of new and unprecedented concern over New Jersey's mental health care delivery system. However, an honest appraisal of the past reveals previous periods of optimism which were similarly heralded as "new eras in mental health care."

Reviewing the history of mental health care in New Jersey is not encouraging. Certain characteristic repetitive patterns in our treatment of the mentally ill can be noted. The patterns appear to be fixed, for little variation in theme is recorded in events of the past.

The pattern starts when we admit that certain conditions have become intolerable (what will be tolerated from year to year varies); next, we recommend ways to change the conditions; then, we hail these recommendations as solutions to the problem; and finally, we provide only enough resources to alleviate the "intolerables" and adopt and implement only those

recommendations which will temporarily keep the problem from recurring. In other words, we react to crisis situations with solutions which resolve the crisis, but fail to take actions to avert the same crisis in the future.

Our history is full of examples of this kind of step-by-step progression; we do achieve a measure of progress in this incremental fashion. However, our history is short on examples of bold, innovative actions.

We do react when scandals surface and investigations tell of abuses. Our conscience is stirred periodically by detailed and graphic reports of cruelty, neglect and indifference. When surplus people are put in the spotlight, held in front of our disbelieving eyes, displayed in their misery, we do react. We have built new buildings, replaced old ones, thought up new kinds of buildings, and built again.

We have reacted, but we have rarely acted on our own initiative. Our motto appears to have been "minimal services for maximum numbers."

What will our future motto be?

GREYSTONE PARK PSYCHIATRIC HOSPITAL

Greystone Park Psychiatric Hospital has become a symbol of deficiency in the State's system of mental health care. Although other State hospitals have similar problems, Greystone has had the unfortunate distinction of being labeled the worst in an inadequate State hospital system. The very word "Greystone" conjures up words like "horror" "abuses" and "neglect." Whether it deserves to overshadow the other State hospitals with its poor reputation has often been debated. Many say that Trenton Psychiatric is equally bad, if not worse. Others cite the number of suicides at Marlboro to give it consideration in competition for the "worst in the State."

Since problems at Greystone have been repeatedly brought to the attention of the Legislature and a number of former employees at Greystone wanted to testify before the Subcommittee, a closed hearing on conditions at Greystone was held on November 8, 1974.

Upon reviewing testimony given by eight former Greystone employees, six volunteers and one former patient, the Subcommittee stated that it was convinced that conditions at the hospital were intolerable. They recommended that a number of immediate steps be taken to improve living conditions

and that certain future changes were necessary to prevent recurrence of the terrible conditions. They expressed hope that this might be the last time that a legislative body need recommend improvements at Greystone. They hoped "that soon others will agree that Greystone has outlived its usefulness; that patients could be better served in smaller community-based facilities; that Greystone should shut many of its doors, permanently."

The Subcommittee recognized that interim measures were needed to make patients' lives more bearable on a day-to-day basis until a future shutdown of the institution was possible or until the number of patients was reduced. Twenty specific recommendations were submitted to the Legislature by the Subcommittee concerning, among other things, patient classification procedures; patients' rights; sanitary conditions; employee screening, training and salaries; employee-patient relationships; public accessibility; post-release services and deinstitutionalization.

The Subcommittee emphasized Commissioner Klein's commitment to improve the State hospitals and stressed that her testimony was supportive of many Subcommittee recommendations. In its conclusion the Subcommittee stated that "much of the testimony that was given by persons who

lived and worked daily at Greystone described things that go beyond recommended changes of a concrete nature. While every person who spoke said that there were employees who cared about patients at Greystone, that considerate and selfless people worked there for little monetary reward, and that positive steps had been taken in some hospital units to improve patient care; while each person spoke briefly about humane treatment, the overwhelming impression which the Subcommittee got at the conclusion of the hearing was an impression of neglect, apathy, brutality, indifference, weak or absent leadership, and perhaps most frightening of all, a lack of recognition of mental patients as human beings."

"It appeared from the testimony that patients are no longer considered to be people when they are locked behind doors -- people with the right and capability to make decisions, with the ability to feel and hurt, and with the capacity to get well and resume their lives outside the hospital. This pervasive disregard for the basic rights of patients as fellow human beings was the most disheartening aspect of the testimony."

"It is, therefore, obvious that any recommendations for improvement must start with a change of attitude and spirit at Greystone, so that people who are brought there for help can receive help."

The following recommendations were submitted to the Legislature for improving patient care at Greystone Park:

1. Patients be properly classified, and housed and treated within such classifications:

a. Geriatric patients with other geriatrics;

b. Retardees separate from mentally ill patients;

c. Children with children, not adults; and

d. Alcoholics, addicts, and patients charged with criminal offenses be segregated.

2. Therapeutic relationships and settings be given high priority:

a. Therapy programs be conducted in privacy away from toilets and other unpleasant or distracting settings;

b. Attendants be encouraged to participate in therapeutic programs and decisions regarding patient therapy whenever possible; and,

c. Inter-disciplinary or milieu therapy be encouraged, when possible.

3. Patients have sufficient toilet articles to maintain personal hygiene (soap, wash cloth, towels, tooth brushes, toothpaste, toilet paper, etc.). Whenever possible, patients

should have such articles in their own possession and not have to request attendants to distribute them daily. Individual lockers should be provided for each patient's personal possessions.

4. Patients wear their own clothing; hospital gowns only be used for the most severely-ill patients.

5. Patients have a right to privacy in showers and toilets.

6. All employees having direct contact with patients, from attendants to psychiatrists, be screened to insure psychological suitability for the job before being employed:

a. Appropriate psychological tests be developed to provide needed pre-employment screening;

b. Oral interviewing be incorporated into the screening process; and,

c. Careful review and screening be instituted during probationary periods.

7. In-service training programs be developed for attendants to:

a. Provide attendants with paraprofessional skills to become active and useful co-therapists;

b. Give attendants opportunities to discuss

negative feelings which may arise in working with difficult patients;

c. Teach patient-attendant inter-actional skills; and,

d. Prepare attendants for positions of greater responsibility.

8. Continuing education programs be offered on the Hospital grounds to all interested employees, involving both course work and on-the-job training, and providing high-school equivalency diplomas or appropriate college credits for job enrichment and advancement.

9. Attendants be designated "care persons" (or another humanizing term) and wear easily identifiable nameplates to distinquish them from other employees and patients.

10. Complete and realistic job descriptions be provided for every hospital position involving patient contact. Annual reviews and recommendations for raises and promotions be judged in accordance with performance standards specified in the job description.

11. Career-ladders be developed for employees, so that attendants and other employees do not find themselves in "dead-end" jobs.

12. Attendants have designated times to relieve stresses of working under difficult conditions and separate lounges for such rest periods. However, during working periods, attendants be required to perform, under supervision, all of the duties of their jobs to the best of their abilities.

13. Salaries for attendants be increased so that qualified persons are attracted to these positions and the administration can, therefore, be more selective in its hiring practices.

14. Every effort be made to open up Greystone to the public. Such "open door" policies be publicized regularly through local media. Recruitment of volunteers, both on an individual and group basis, be given high priority through regular appeals to:

Boy Scouts, Girl Scouts, 4-H Groups

Business and Industry

Service Organizations

Elementary and High Schools, College and Universities

Churches

Theater and Entertainment Groups

Other Interested Community Groups.

Maximum cooperation be given to volunteer workers in their work with and for patients by the administration and all staff members.

15. Children under 12 years of age be permitted and encouraged to visit patients, especially geriatrics.

16. Administrators and supervisors be held responsible for the actions of those persons working under them:

a. To insure that employees who are still learning their jobs are properly supervised and not assigned duties which they are, as yet, unqualified to perform alone;

b. To insure that supervisors do not abuse their supervisory status by requiring persons under their jurisdiction to perform tasks which are not job-related; and,

c. To insure that attendants and professionals are performing the work for which they were hired and are paid.

17. Administrative procedures and operating policies of the Hospital be more closely integrated with the Division of Mental Health and Hospital's central administrative office in Trenton, so that all State Psychiatric Hospitals shall operate under uniform guidelines and with similar objectives and goals.

18. Services be offered to patients to insure successful reintegration into the community through:

a. Job placement and counseling;

b. Counseling for parents, children and other relatives of patients;

c. Increased liaison between the Hospital and community mental health centers and other community services; and,

d. Improved follow-up on post-release medication needs.

19. Sanitary conditions and basic cleanliness be given higher priority through increased personnel, if necessary, and improved supervision.

20. Greater emphasis be placed on deinstitutionalization through:

a. Movement of geriatric patients to approved nursing homes;

b. Identification and transfer of retardees to more suitable facilities;

c. Transfer of patients with less serious illness to "least restrictive alternatives" such as, half-way or group homes, day residences or day care centers; and,

d. Where possible, return of patients to their own homes, with the supplemental assistance of home health services.

NEW JERSEY NEURO-PSYCHIATRIC INSTITUTE

The New Jersey Neuro-Psychiatric Institute (NPI) was the second facility to receive the Subcommittee's attention. At a closed hearing on December 13, 1974, relatives of former patients and Institute staff testified on the children's treatment program and other programs at the Institute. On January 3, 1975, the Subcommittee went to NPI, inspected the buildings and spoke to patients and staff.

The on-site visit was prompted by the Department of Institutions and Agencies' decision to change NPI from a mental health hospital to a mental retardation facility. Since this decision would disrupt many Institute programs, particularly the educational program for autistic children and the inpatient alcoholism program, the Subcommittee wished to evaluate these programs and determine what plans had been made for their continuation.

On the whole, the Subcommittee was favorably impressed by the morale of the staff and the quality of the programs at the Institute. In particular, the education program for autistic children impressed the Subcommittee. Furthermore, they concluded that institutions of smaller size, like NPI, had many advantages.

There were, however, certain features of the Institute which caused concern. The isolated rural setting was not conducive to the development of sound hospital/community relationships. Furthermore, maintaining extensive grounds appeared to unnecessarily add to the cost of patient care. For example, the Subcommittee learned that only 15.5 of the 79 buildings were used for patient care. The remaining buildings were for employee housing and other support services. Many buildings were vacant, but had to be maintained to prevent deterioration. Moreover, the facilities for autistic children appeared to be inadequate. Living areas were drab and cheerless. Both the school and the children's residence had more than one story. Since many of the children had severe physical handicaps, negotiating stairways was particularly difficult. The Subcommittee concluded that the staff deserved much credit for making the children's program as successful as it was, despite the physical setting.

In addition to the concerns expressed above, the Subcommittee recommended that the following improvements and new programs be considered:

1. The development of special adolescent programs, similar to the children's program;

2. The use of one-story buildings for physically handicapped persons;

3. Elimination of the "quiet room" for children;

4. General improvement of living conditions for patients, to insure more privacy and easier access to bathroom facilities;

5. Improved cooperation between the Departments of Health and Institutions and Agencies in the supervision of institutional sanitarians and their reporting of sanitary conditions.

Because the Subcommittee felt that the Institute had several positive features, often lacking in State psychiatric hospitals, such as a small in-patient population, a number of unique treatment programs, and recent accreditation by the Joint Commission on the Accreditation of Hospitals, they questioned the Department's decision to change NPI from a psychiatric hospital to a retardation facility.

Therefore, a meeting was held with Commissioner Klein and the Directors of the Divisions of Mental Retardation and Mental Health and Hospitals. This meeting was intended to give the Commissioner and her staff an opportunity to explain the decision and, also, to allow the Subcommittee to express its concern for the preservation of certain Institute programs, the well-being of patients displaced by the transfer, and the future of employees whose jobs might be discontinued.

Commissioner Klein cited the following reasons for her decision: (1) the Institute's location in central New Jersey; (2) the make-up of the present population (one half of the patients at NPI were classified as retarded); (3) the present employee's experience in working with the retarded; (4) the availability of physicians and superior medical-surgical facilities at NPI for multiply-handicapped retardates who

would be transferred to the facility; and, (5) the need to close a psychiatric hospital as part of the Department's deinstitutionalization program.

As a result of this meeting, and upon receiving assurances that concerns over patient's needs, the continuation of certain programs, and employee's rights were being considered in the transition, the Subcommittee concluded that the change in the function of NPI was justified. This endorsement of the Department's decision did not alter recommendations for improving the physical conditions of many buildings at NPI. In fact, since many of the retarded persons to be transferred to the Institute were severely physically handicapped, the need was increased for accessible one-story buildings in place of antiquated three and four story buildings.

WOODBRIDGE EMERGENCY RECEPTION AND CHILD DIAGNOSTIC CENTER

Introduction

The Joint Subcommittee on Mental Health became aware of the problems at the Woodbridge Center as a result of newspaper reports in November, 1974, charging that the Center had been empty for over a year while a sizeable staff sat idle and children were denied needed services. Because of its concern with all State institutions, the Subcommittee launched an inquiry into the causes of the delays and the present status of the Center. After a four-hour hearing held at the Woodbridge Center with representatives from the Department of Institutions and Agencies and its Division of Youth and Family Services (DYFS) and the Department of Treasury and its Division of Building and Construction (DBC), the Subcommittee issued its findings in a report to the Legislature on February 27, 1975. The Subcommittee attempted to reconstruct the events which led to the Center's problems as accurately as possible to determine what had caused the extensive delays, who was responsible, and what could be done to avoid the recurrence of such problems.

Before summarizing these findings, it may be helpful to describe the Center, its functions and the funding authority for its construction. The Division of Youth and Family Services is responsible for many of New Jersey's children who suffer from serious behavioral, educational and emotional problems.

The Emergency Reception and Child Diagnostic Center in Woodbridge was designed as a residential facility where children could be thoroughly evaluated by a trained staff and plans developed for further treatment and services. The Center is a short-term residential facility with a projected diagnostic capacity for 450 children per year.

A 1968 bond issue provided funds for the Center. All contracts were awarded and contractors directed to begin construction of the $886,000 facility by April 12, 1972. However, final completion and authorization for provisional occupancy was delayed until January, 1975.

Throughout its investigation, the Subcommittee was primarily concerned about the children under the State's care who were denied essential services as a result of the extensive delays in the completion of the Center. In its conclusion the Subcommittee agreed that the children who were not served were the real losers in the bureaucratic tangle at Woodbridge.

Causes of the Extensive Delays

In its report to the Legislature, the Subcommittee described in detail the numerous problems and "foul-ups" which caused repeated delays in the opening of the Center. Some of the most plaguing problems developed as construction proceeded, and included a faulty steamline running through the Center property; an incorrectly installed fire alarm system; design errors causing access and storage problems; and Standard Building Code violations concerning "fire-stopping". The Subcommittee also expressed concern over the lack of adequate construction supervision due to staffing limitations in the Division of Building and Construction and the use of multi-contractors.

Other delay-producing problems concerned the access road to the Center, the provision of food services, and the procurement of furniture, all of which resulted from bureaucratic miscommunication and delay.

The newspaper reports in November, 1974, emphasized the fact that a sizeable staff had been employed by the Center, but was not working. After reviewing the delays, the Subcommittee found two major explanations for the existence of this situation. The first was the lack of communication and cooperation between DBC and DYFS. Lists of "important dates" given to the Subcommittee by both divisions emphasize the discrepancies in the importance assigned the various developments. The second

explanation was offered by DYFS representatives. The Director of DYFS cited, in his testimony, problems in recruiting and hiring staff in accord with Civil Service regulations. In order to recruit and train personnel, sufficient lead time is needed. If the hiring process had been delayed until the Center was ready to open, the newspaper headlines might have read, "Center stands ready but unused for lack of staff."

Conclusions and Recommendations

As a result of its investigation, the Subcommittee concluded that there were five major areas in which improvement could and should be made in order to avoid a repetition of the problems at Woodbridge.

1. We concluded that in situations where two or more departments or divisions share responsibility for the completion of a facility, the intervention of a third party, or arbitrator, may be needed to review the situation and determine when the building is ready to be turned over to the operating agency.

2. With regard to hiring practices the Subcommittee recommends, in the future, hiring decisions should be made by a Division Director or a Deputy Commissioner upon careful consideration of the facility's condition.

3. The Subcommittee feels that the State's role in construction oversight must be strengthened. In addition, the current practice of using multi-contractors needs to be reviewed so that accountability may rest in one central authority.

4. Further, the Subcommittee feels that contract deadlines must be realistic and firm. Penalty clauses in contracts must be enforced when the deadline is not met. In the case of Woodbridge, the electrical contractor could have been fined $28,800 had such penalties been enforced.

5. Finally, the Subcommittee is concerned with the numerous examples of lack of communication or miscommunication which took place between the two divisions. The Subcommittee recommends that communication links between departments and divisions within departments be reexamined and improved.

Minority Report

In a separate report to the Legislature, Assemblyman George Otlowski expressed general agreement with the investigative sections of the Subcommittee report. He stated, however, that he believed the recommendations were incomplete and should be reconsidered and made more specific by the Subcommittee.

Assemblyman Otlowski expressed particular concern with "the waste in State building and construction" which is not unique to the Woodbridge situation. He offered two approaches, both requiring legislation, which could reduce such waste:

1. The creation of a Building Authority, appointed by the Governor, and comprised of an engineer, an architect, and a person experienced in public service. The Authority would employ additional supportive staff, and would be responsible for authorizing construction and controlling both capital and operating funds.

2. Creation of a Commissioner of Buildings and Construction whose authority and staffing would be similar to that of the Authority in the first proposal. Again, final authority and accountability would rest in the one office.*

*Legislation (Senate Bill Number 3147) was introduced on April 10, 1975, by Senator Raymond Garramone, to address many of the problems highlighted by this report. This proposal establishes a Department of State Planning, responsible for the planning, design and supervision of construction of the State's capital program.

TRENTON PSYCHIATRIC HOSPITAL

The format of the Joint Subcommittee's fourth hearing was changed in order to hear from community-based service personnel within the Trenton Psychiatric Hospital catchment area. Those who were present to testify were asked to offer specific proposals to solve problems encountered in the mental health system as it is presently constituted.

Those present to testify included county mental administrators, directors of community mental health center programs, county psychiatric hospital representatives, a former patient, the Director of the Division of Mental Health Advocacy and others who represented consumer and planning groups.

The proposals offered primarily spoke to unifying the fragmented and often duplicated services which are now available throughout the system. Cooperation and expanded financial assistance appeared to be the overwhelming theme of the testimony.

Proposals offered to rectify inadequate funding included: institution of a new funding scheme for county mental health services based on a block grant approach; or as an alternative, raising the $1 per capita funding ceiling for community mental health service grants; elimination of dual medicaid payment standards which discriminate against outpatient services; inclusion of partial hospitalization coverage by insurance and other third party payment mechanisms; provision of funds for food and transportation for patients utilizing community mental health services; and provision of free medication to the poor.

Other recommendations which would make the mental health system more responsive included: development of pre-screening in the community prior to inpatient treatment in mental health hospitals; development of pre-discharge planning for psychiatric hospital patients; emphasis on the phase-out of large inpatient State hospitals and substitution of limited inpatient and expanded partial-hospitalization schemes; development of community residency programs for mental health personnel; development of comprehensive community geriatric programs; development of emergency care capacity, lacking in some communities; and review of the ability of administratively inexperienced psychiatrists to administer State psychiatric hospitals.

Furthermore, it was stated that the designation of the Trenton Psychiatric Hospital to serve patients from Hudson County and Newark worked a hardship on the patients, their families and community agencies who were involved with the hospital because of the distance from these areas to the hospital.

Lastly, it was felt that the State must share more of the responsibility for community services, not only in funding but also in coordinating services with the State hospitals and lending technical assistance to the counties.

MARLBORO PSYCHIATRIC HOSPITAL

The Subcommittee hearing held at Marlboro Psychiatric Hospital on May 9, 1975, consisted of two separate parts: a closed session in the morning during which staff of Marlboro spoke concerning the quality of patient care and the number and causes of suicides at the hospital, and an open session in the afternoon concerning aftercare services available to patients discharged from the hospital.

During the confidential morning session, the Subcommittee heard testimony from hospital staff on the possible lack of patient supervision, the number of accidental deaths and suicides which occured in the past few years, and the circumstances surrounding such deaths. The Subcommittee has reserved comment on these matters for the time being, since charges made during testimony were of a serious nature and required further investigation. However, Dr. Michail Rotov, Director of the Division of Mental Health and Hospitals, indicated to the Subcommittee that steps have been taken to rectify the situation at Marlboro which may have been responsible for inadequate patient supervision.

The open afternoon session concentrated on existing problems and possible future improvements in providing needed aftercare services to released patients. Those testifying provided the Subcommittee with information on social services, the adequacy of boarding homes and sheltered care homes,

health services and expanded community mental health after-care. Numerous recommendations were offered to improve the delivery of existing services and to make a wider range of services available in the future to patients released from Marlboro.

Specific recommendations were made on improving the hospital's pre-discharge planning efforts. Many felt that such planning should begin when a patient was first admitted to the hospital, through an assessment of the patient's home environment. Testimony stressed that a released patient's mental health often deteriorated when he returned to a home situation which may have been a causative factor in his illness.

Testimony indicated that addressing the problems of the home environment would require cooperative hospital/community efforts. For example, the loss of income which may result from a hospitalization might require income assistance from a county welfare board; a local homemaker service might be required if the hospitalization deprived the family of its homemaker or child care provider; and, finally, a family services agency could provide professional counseling for a patient's family to help the family understand the special needs of a discharged patient.

Patients who have no family and who may be discharged into boarding homes, nursing homes or their own homes also have special pre-discharge planning needs which differ from the needs of patients released into their family's care. Testimony indicated that there is little follow-up on the

fate of such patients when they are placed in a community facility. Because needed supportive services are lacking for successful reintegration into community life, these isolated patients either become permanent residents of a boarding home or sheltered care home or becomes part of the "revolving door" syndrome. That is, they are in and out of the community for short periods of time, returning periodically to the hospital for needed support, care and treatment.

While such recycling through the system is not productive, the alternative -- permanent placement in a boarding home or sheltered care home -- may be equally unsatisfactory. Since these partial care facilities receive a per diem rate of only $7.30 from the State, the quality of care provided is often inadequate.

Recommendations for improving the care provided to former patients in such boarding or sheltered care homes were also included in the testimony: closer State supervision of boarding homes; the development of guidelines for State hospitals when using unlicensed or unapproved placements; increases in the $7.30 per diem reimbursement rate; provision of training programs for staff and owners of such homes; and improved coordination between State and local providers of support and rehabilitation services.

MENLO PARK DIAGNOSTIC CENTER

The Menlo Park Diagnostic Center was the subject of a Subcommittee tour on August 19, 1975. This Center, which provided diagnostic evaluations on juveniles for the courts, was scheduled to cease operation as a result of a drastic budget reduction of $1.4 million, necessitated by the State's fiscal crisis. The Subcommittee spoke with Center staff in the course of the tour and consulted with representatives of the Department of Institutions and Agencies in an effort to determine: 1) whether the Center should remain in operation with a special appropriation from the Legislature; 2) how the juvenile diagnostic services provided by the Center might be continued by community agencies, in the event that the Center should close; and, 3) how the buildings might be utilized in the future if they were no longer used as a juvenile diagnostic service center.

With regard to the first concern, the Subcommittee could not reach a unanimous decision on closing the Center. Two members supported the enactment of Assembly Bill Number 3624, providing funds for the Center's continued operation until December 31, 1975. One member concluded that A3624, which had already passed both houses of the Legislature and was awaiting the Governor's action, should be vetoed, since many children had already been transferred to other facilities in anticipation of the Center's closing. This Subcommittee member felt that re-establishing these children at the

Center for an indefinite period (funding was only provided to the end of this year) would cause them unnecessary emotional turmoil and would also be fiscally irresponsible. The remaining three members could not decide from the available data whether or not the Center should remain open as called for in A3624 and felt that an in-depth study by the Department of Institutions and Agencies was necessary to provide sound data on the availability of alternative services, the costs of such alternative services, and possible future plans for the facility if it were not to continue as a diagnostic center for juveniles.

The Subcommittee was not provided with a satisfactory answer to their second concern, that is, how communities or other agencies would provide the juvenile diagnostic services formerly provided at Menlo Park. Therefore, the Department of Institutions and Agencies was requested to prepare a report for the Subcommittee on the status of alternative diagnostic services utilized in place of Menlo Park. This report has not as yet been forwarded to the Subcommittee.

Lastly, the Subcommittee recommended that Menlo Park be adapted for other purposes, if it is not continued as a diagnostic facility for juveniles. It was felt that the newer sections of the Center, which had a swimming pool, gymnasium/auditorium, canteen and library, should not remain unused. The Subcommittee suggested that consideration be given to the possibility of using the Center as a community service center for retarded, deaf or physically handicapped children.

Since the time of the Subcommittee's inquiry, the Menlo Park Diagnostic Center has closed. No action has been taken on A3624 by the Governor and no additional information has been received from the Department of Institutions and Agencies on the future use of the vacant facility.

Staff Reports on Specific Mental Health Issues

In addition to holding hearings on mental health facilities, the Subcommittee studied certain critical issues which appeared to affect the delivery of mental health services. Three issue reports were prepared for the Subcommittee to provide information on certain policy concerns brought to the Subcommittee's attention through the course of their public hearings and tours of State institutions.

Summaries of these reports, entitled "Sectionalization," "Dollars Following Patients Through the Mental Health System," and "Budget Review of Greystone Park Psychiatric Hospital," follow.

I. Sectionalization

"Sectionalization," "unitization," or the "Clarinda Plan" is a hospital management scheme whereby large psychiatric hospitals are divided into smaller, semi-autonomous units, supervised by assistant medical directors. Within each section, a group of mental health professionals is responsible for the continuing needs of a specific group of patients, both during and following hospitalization. Ideally, this would allow each patient to develop stable therapeutic relationships with a team of care-providers who were responsible for that patient's progress during different phases of treatment and aftercare. This system was considered to be preferable to other patient management schemes which moved the patient from one team of professionals to another as he progressed toward re-entry into the community.

The following sections have evolved in our State hospitals under this philosophy:

1. Adult Psychiatric Sections - The care of the residential programs, the adult sections provide services to patients between 17 and 65. Separate adult psychiatric sections are maintained for each county within a hospital's catchment area. Generally, the practice has been to maintain separate buildings for each county the hospital serves.

2. Geriatric Sections - Provide services to senior patients usually 65 years of age and older. The trend has been to maintain a single section for all geriatrics, regardless of county of residence. The emerging terminology is geriatric hospital.

3. Children's Sections - Ideally, these are 75 bed units for children under 17 requiring residential treatment. However, the actual bed capacity varies among the hospitals. As with geriatrics, children from the entire catchment area are admitted to the children's unit.

4. Medical-Surgical Sections - Infirmary and general hospital services for all patients of the hospital. The forensic program at Trenton Psychiatric Hospital is attached to the hospital's medical-surgical section.

Implementation of the concept of sectionalization in New Jersey has been less than ideal. While sectionalization is a sound managerial concept, intended to promote close and continuing patient-therapist relationships, other factors have distorted this initial intent. Sectionalization has often meant one building for each section, regardless of the building's capacity or physical condition. As a result, patients in one section were crowded into one building which was inadequate for the number of patients in that section. Although there is nothing in the concept of sectionalization which mandates one building per section, this rigid application of sectionalization evolved in some of New Jersey's psychiatric hospitals and caused many problems.

In addition, a second problem in the implementation of sectionalization must be noted.

The success of sectionalization depends on the availability of a full range of services and personnel for select categories of patients. Without adequate funds, staff, facilities and personnel to provide services at the critical stages of pre-admission screening, hospitalization, and post-release aftercare, the concept behind sectionalization can not work. Given the acknowledged deficits in all of these areas in all of our hospitals, there is little wonder that sectionalization has not worked as intended.

Fortunately, Commissioner Klein recognized the deficiencies of sectionalization, and announced in October that all four major State hospitals "will be reorganized from sectional units, where patients have been grouped according to their home counties, to level-of-function units, where they will be treated according to their specific needs" following the principals of normalization. Normalization means "an approach to the treatment of the mentally ill that emphasizes an environment, treatment and staff attitudes as near to normal life as possible and staff is taught to look for and eliminate signs of and practices characteristic of total institutionalization."

II. Dollars Following Patients Through the Mental Health System

This report was prepared for the Joint Subcommittee by Linda Mango, an intern at the Woodrow Wilson School of International Affairs at Princeton University.

The report discusses the effects of current budget decisions on the flow of patients through the mental health system in New Jersey and examines the concept of "dollars following patients" through the mental health system as a viable means of achieving the community care approach to treating the mentally ill. With a shift in policy emphasis from traditional state hospital programs to alternative community programs, a reorganization of departmental financing patterns must occur to reflect decreased in-patient loads in the hospitals and to reassign resources to community programs in a unified and coordinated manner.

Such re-deployment of resources must occur within a unified system of mental health services. The current approach in New Jersey is to provide budget allocations on a project-by-project basis for each type of available care, with various providers competing for limited resources at each level of government. This piece-meal approach has been characterized by fragmentation and discontinuity of care. For example, three service areas in Bergen County contain four federally-funded community mental health centers, while Atlantic, Burlington, Camden, Cape May and Salem counties have no such centers. Furthermore, it is estimated that approximately

half of the in-patient population of Ancora Psychiatric Hospital, which serves these counties, would be better served in local community facilities, rather than in the intensive therapeutic environment of a State hospital.

Even where new programs do exist locally, the problem of fragmentation of services still exists. Many community mental health services have ignored the needs of the institutionalized mentally ill while attracting new types of patients who need mental health services. Although centers have been critcized for failing to treat deinstitutionalized patients, there has been no leadership from the State to provide centers with incentives to treat this group of patients. Furthermore, it is unrealistic to expect such centers to treat both patient populations without increasing their resources and authority.

An examination of current mental health expenditures reveals that less than 20 percent of public funds from all sources are used for local facilities, community mental health centers, social services, and out-patient programs operated by the State hospitals (1975 appropriations). Furthermore, fewer than half of the State's 49 mental health service areas, concentrated in 11 of the 21 counties, have developed programs under federal staffing and construction grants.

It appears, therefore, that there has been no substantial shift in the flow of funds and other resources from the institutions to the communities. As budgets for community based services have increased, so have those for the State hospitals, despite the fact that the institutional population in 1972 was less than half of its 1959 level.

If deinstitutionalization in a major policy thrust for New Jersey, the failure to shift funds and resources from the institutions to the communities must be questioned. Persons who have been confined for long periods of time in institutions cannot function in society independently upon release without the provision of supportive community services. A variety of living and working arrangements must be offered to allow such persons who have attained varying levels of functional independence to pursue activities within the community tailored to their social and therapeutic needs. For this reason, a policy of deinstitutionalization cannot be implemented without the reallocation of resources necessary not only to establish new supportive services but also to integrate them with existing facilities. In other words, these alternative community programs must be coordinated to assure the availability of resources and support staff needed to make the transition from hospital care to community-based care.

This coordination requires flexible funding mechanisms so that resources -- mental health professionals, social service personnel and dollars -- can follow patients into the community as this becomes the locus of their care. In contrast to a program of unified flexible funding and reallocation of re-

sources, the budget process in New Jersey can be said to have created a mental health system in which patients follow dollars. That is, many persons in the State hospitals would not be there if the community programs available to them offered the same range of services they are currently receiving. Of these, continuity of care and of therapeutic relationships are perhaps the most important. As long as public financing of mental health services continues to place the bulk of resources into large institutional facilities, these will remain the dominant component in the delivery of mental health care. Even community-oriented treatment centers will be forced to depend on the State institutions for the provision of long-term care for the acute mentally ill until a flow of resources from the State hospitals filters downward into the community care projects, affording them the opportunity to develop a broader range of ongoing intensive services.

A number of alternatives, based on the assumption that State government will continue to play a significant role in providing therapeutic and related services to the mentally ill, are offered to implement the concept of dollars following patients. One is a Statewide insurance plan, whereby the State would pay for all or a portion of all mental health services rendered to State residents. The exact level of support would be decided on a case-by-case or formula basis, depending on demonstration of financial need. The other alternative is the development of a system of vouchers, whereby persons who would otherwise receive treatment in a State hospital

would be given vouchers in an amount equal to the cost of the average length of stay in a State hospital.

Both of these alternative financing proposals have positive and negative features, and are simply offered herein as possible policy directions for the future. Neither alternative addresses the problem of fragmentation of services which now exists, nor do these proposals insure that administrative supervision and coordination of the various services would be developed. Finally, by permitting full use of private as well as public facilities for mental health services, both the voucher system and the mental health insurance proposal forego a degree of cost control which can be exercised over public and quasi-public facilities.

Several European countries have developed comprehensive mental health care systems which ought to be considered as possible models for promoting the concept of community-oriented care. Employing an approach known as "sectorization," these countries have achieved a network of in-patient, out-patient, partial hospitalization and public welfare services in which continuous contact was maintained between patients and the professional personnel who had worked with him/her during hospitalization. Mental health teams from the hospital were assigned to geographic areas and were responsible for both

hospital and community care for their patients and other residents of their sector.

Such arrangements allow the incorporation of funding and staffing and administrative responsibilities into one level of government, preferably the local unit. Moreover, whatever the cost-sharing arrangements to be worked out between the State and local communities, responsibility for program development would be located in the community, while professional personnel working in and out of the State institutions and the community facilities, would be responsible for patient care. This division of accountability into two clear-cut quarters eliminates a good part of the confusion which currently pervades the mental health system when a patient is moved from one facility, or locus of responsibility, to another.

The additional advantage to be gained from such an administrative and service arrangement is that it would free personnel currently working in the institutions full-time from the pressures of working in that setting and would allow them to gain expertise in alternative means of treating the mentally ill. This would derive from their ongoing contact with released in-patients and with community-based facilities.

The integration of institutionally based personnel into the provision of community services is likely to assure the development of those services needed most by former patients. In addition, such an arrangement would facilitate the smooth transition from hospital to aftercare to home, and is thus

likely to reduce the rate of readmissions to institutional facilities.

Above and beyond the organizational administrative changes outlined above, this form of dollars following patients would require changes in civil service regulations to permit movement between community and State facilities. While the actual details of planning for such a program present some difficulties, this system makes the least artificial distinction between the types of resources being allocated and mobilized for the most effective use in treating the mentally ill. To move dollars without personnel or facilities would be, at best, wasteful; at worst, tragic.

III. Budget Review of Greystone Park

Subsequent to the Subcommittee's hearing on Greystone Psychiatric Hospital, staff was asked to make an effort to decipher the budget requests for the next fiscal year from this hospital, in order to obtain a perspective on where funds were being spent. In reviewing this budget it was found that the budgeting practices of the hospital, and the State generally, perpetuate shortages of staff and basic necessities while over-budgeting in other areas, creating a "juggle the budget" situation whereby the hospital must borrow from one account to cover others.

The Subcommittee concluded that many of these budgetary practices are counter-productive to proper management of a health care facility, and recommended scrunity by management and fiscal experts as a reasonable first step in altering practices which perpetuate short staffing, shortages in basic necessities (e.g. towels, fuel and utilities), and create hardships on present staff and the patients.

Summary

"So what else is new?" the editorial asked, commenting that once again Greystone Park Psychiatric Hospital was the subject of sensational reports of cruelty and misconduct toward patients by ward attendants.

The editorial continued the "What else is new?" refrain: "Cruelty and abuse at Greystone Park have been the staple of legislative inquiries for years. Some legislators built their political careers on such investigations. Usually these inquiries take place just before Election Day. Inevitably, once the fiery oratory they produce runs its course, the furor dies out and it's back to business as usual at Greystone Park."

The Joint Mental Health Subcommittee knew that many others agreed with the premise of this editorial. They were aware when they agreed to serve on the Subcommittee that they were tackling an enormous job, and that public opinion was as pessimistic as the editorial.

What is more, the Subcommittee members knew when they toured an institution that they were seeing the same depressing sights that other legislators had seen before, and hearing testimony in closed hearings which had been heard before.

Nevertheless, when a former employee of a State hospital broke down in tears, describing the misshappen head of a chronic patient who was the special target of abusive attendants, the impact of his testimony was not diminished because it

described recurrent abuses. The Subcommittee members were similarly moved by the testimony of a former patient who spoke of beatings she endured at a State hospital, even though they knew that such beatings had occured before.

Knowing that their task was enormous -- examining New Jersey's mental health care system, reviewing pending legislation, and recommending ways to improve the system -- and that the problems which they were trying to address had existed for a long time, largely because of public and legislative apathy, the Subcommittee was determined to operate in an effective manner. Therefore, when first organizing, the Subcommittee determined that their objectives could best be accomplished by their becoming ombudsmen for interested and concerned mental health care providers and consumers and by becoming catalysts for action.

In order to further their role of ombudsmen, hearings were purposely conducted in a manner which would encourage people who had previously been reluctant to speak up about their own experiences as patients, employees or relatives of patients, to share their insights and contribute their unique viewpoints. Furthermore, the Subcommittee was determined to have their efforts reflect their concern for the welfare of patients in the State's care, rather than reflect interest in publicity for themselves. Information gathered through closed hearings, therefore, was treated with confidence. In addition, the Department of Institutions and Agencies was

invited to participate in such hearings, and cooperative working relationships were established between the Subcommittee and the Department's Mental Health Planning Committee.

As a result, a number of encouraging developments occured. First, the testimony at hearings was worthwhile; people who had first-hand knowledge of the mental health care system volunteered testimony which proved invaluable. Second, the Subcommittee learned that they were not alone in seeking their objectives; the Commissioner of the Department of Institutions and Agencies also provided worthwhile testimony concerning problems encountered when implementing new policies and the frustrations which accompany attempts to change and improve the system.

The Subcommittee's determination to conduct its hearings and investigations in a responsible manner, without the "circus-like atmosphere" which had on occasion characterized past legislative investigations of mental hospitals, allowed them to fulfill their ombudsman role.

The hearing on Greystone Park Psychiatric Hospital was a prime example of the Subcommittee acting as ombudsmen. A number of former hospital employees, who felt that their charges of existing abuses had not been given sufficient attention by the administration, brought their problem to the attention of the Subcommittee, which, in turn, made the

administration and the public aware of the alarming situation at Greystone. Members of the Morris County Prosecutor's Office were observers at this closed hearing, and as a result, the Morris County Grand Jury was impaneled to investigate the allegations of abuses.

The investigation of the New Jersey Neuro-Psychiatric Institute (NPI) was another example of the Subcommittee acting as an ombudsman. Relatives of former patients at NPI were given an opportunity to speak of their experiences. In addition, staff members were able to present their viewpoints on conditions at the hospital to the Subcommittee. Finally, the Subcommittee toured the facility and spoke at length with employees responsible for various levels of patient care, in order to make a determination concerning the future role of the hospital as a mental retardation facility.

In a similar manner, the investigations of the Woodbridge Emergency Reception and Child Diagnostic Center and the Menlo Park Diagnostic Center were conducted with the Subcommittee acting as an ombudsman. The public had great interest in learning why the Woodbridge facility failed to open for a year while staff was being paid and children were being turned away. Similarly, the closing of Menlo Park after the budget was slashed caused concern. Many Center staff members felt that the kind of specialized services provided by the Center to the courts would not be adequately provided by other

agencies once the Center was closed. The Subcommittee brought these concerns to the attention of the Department and the public.

In furtherance of the Subcommittee's second objective -- acting as a catalyst for change -- the Subcommittee published reports of findings and recommendations after each investigation, so that the Legislature could be better informed of special problems which had come to the Subcommittee's attention. These reports and recommendations were also intended to stimulate the Department into taking action to remedy the problems.

The hearing on Trenton Psychiatric Hospital was purposely designed to highlight problems of a non-institutional nature. Although it was certain that an investigation of Trenton would reveal the same kinds of abuses and poor conditions discovered at other State hospitals, the Subcommittee felt that duplicating that sort of hearing would not be productive. Therefore, the Trenton hearing emphasized ways in which alternative, community-based care for the mentally ill could be strengthened and expanded. The Subcommittee realized that it could fulfill its role as a change agent by examining problems encountered in the implementation of a new system, as well as by bringing the horrors of the old system to the public's attention. Furthermore, the Subcommittee was aware that many States, upon deciding that the system of State hospitals was no longer satisfactory, rushed into closing down such hospitals without developing alternative community care. As catalysts for change,

the Subcommittee wished to pressure for change in two areas: first, change in the way State hospitals were operated; and second, change in the way communities assumed responsibility for the mentally ill.

The hearing at Marlboro State hospital illustrated these dual change objectives; the first half of the hearing was closed, and testimony was concerned with inadequate patient supervision and resultant suicides; the second half was an open session concerning the inadequacy of aftercare services provided to patients discharged from Marlboro. The Subcommittee continued to stress the need for change in the institutions and in the communities through this public hearing.

Much of the legislation introduced and supported by the Subcommittee also stressed institutional change and change in the role of the community. Two major proposals for change in the operation of State hospitals and the care and treatment of patients in such hospitals are S-1117 (now P.L. 1975, c. 85) and S-1032, which outline the civil rights of mental patients and establish mechanisms for setting standards for patient treatment and for reviewing patient care.

Another bill requires the Department of Institutions and Agencies to adequately screen prospective hospital employees and provide training programs for employees (S-3365). The possible detrimental effects of deinstitutionalization programs on present employees of State institutions is the concern of another proposal, S-3366, which attempts to see that employees with valuable experience in caring for the mentally ill are not lost to the system.

Other proposals attempt to strengthen the concept of community-based mental health care. For example, S-3155, 3156, and 3157 all expand insurance coverage for outpatient treatment of the mentally ill. Senate Bill Number 1517 would require every county to have a mental health administrator. Assembly Bill Number 3362 prohibits local authorities from denying the use of single family dwellings as community residences for the mentally ill or retarded. Three proposals, S-644, A-2159 and A-2308, provide for additional funds for community mental health services.

Conclusions

After working for nearly two years, hearing a countless number of complaints, seeing building after building, talking with nurses, doctors, patients, administrators, students, volunteers and relatives of patients -- after two years of trying to determine what is right and what is wrong with the State's mental health care system -- the Joint Mental Health Subcommittee concludes:

1. New Jersey's mental health care system is not adequately meeting the needs of its citizens. All of the testimony presented to the Subcommittee supports this conclusion. Patients, professionals, the press and the general public unanimously agree that there are many dedicated workers in the State hospital system who are doing a tremendous job under difficult conditions, but the size of the hospitals, depressing physical settings, and shortage of trained treatment personnel can result in the provision of little more than custodial care for some patients. Furthermore, alternative community services are not integrated with the State hospital system and are not responsive to the needs of former State hospital patients and the severaly mentally ill.

2. State psychiatric hospitals, in their present form, are obsolete. In the 1800's the idea of establishing mammoth self-sufficient institutions in isolated rural settings seemed plausible; today such institutions are economically and therapeutically unsound. It cost about $10,000.00 per year to treat a patient in a State hospital. There is little evidence that such expenditures are justified by results.

3. A fundamental reorganization of the mental health care system is overdue. All components of the system -- from the Division of Mental Health and Hospitals which determines State policy, to the hospital ward attendant who cares for a patient, to the community which refuses to accept responsibility for follow-up care -- must be re-examined and redefined to provide an integrated, responsible care system which works in a mutally supportive and effective manner to provide restorative therapy to the mentally ill and necessary aftercare services to maintain mental health.

4. An improved mental health system will require additional resources. The State must be willing to provide additional funds for additional services. While some of the resources now channeled into State hospitals could be diverted into community services, it is nevertheless unrealistic to assume that an improved system will not require more money. Since New Jersey is unwilling to summarily close its psychiatric hospitals before adequate alternatives can be developed, there will, of necessity, be an interim period when an institutional system will have to be continued while an alternative community system is created.

Recommendations

No recommendations shall be issued by this Joint Subcommittee. History has demonstrated that it is a futile effort, easily ignored or forgotten.

This Subcommittee has one central goal: change New Jersey's mental health care system so that people who need help will receive it. If a list of recommendations would produce a mental health care system that worked, then recommendations would follow.

But, no.

Recommendations have been issued and ignored too often. It has become a conditioned reflex. The Legislature asks a group to study a problem, the group studies it, issues a report of findings and recommendations, the recommendations are ignored, and that takes care of that problem until the next time.

What will possibly work, then, if recommendations are consistently ignored?

One thing will work. There is no loss in suggesting it; the worst that can happen is that it, too, will be ignored.

The Joint Mental Health Subcommittee invites all legislators and the public to an "open hospital," to be held any day, any hour, at any one of our four State psychiatric hospitals or any six county hospitals.

If you choose to visit a State hospital, you will need a map to find your way around the extensive grounds. At least half of the buildings are empty, but maintained with tax dollars.

Be prepared for sights and odors and sounds which will stay in your memory long after you wish to erase them.

The patients will either eagerly greet you as a miraculous change in the unrelentingly monotonous routine or look past you with vacant, dull eyes.

The staff will either be nervous about having visitors without warning, if they are not doing their job as they should, or pleased to have you, if they are doing the best they can.

Don't ask the attendants how they were hired, how long they worked there, what their salaries are, or what kind of training they received for the job.

You will not like the answers.

Don't just visit the front wards. Walk around at random. Ask questions about the meals ... about prices at the commissary ... about privacy ... access to a telephone ... ground privileges ... beatings ... homosexuality ... suicides.

Ask when they last saw a doctor ... how their treatment is progressing ... when they expect to go home.

Look at the toilets and showers and imagine having to use them daily. Imagine your own daughter or son sleeping in that dreary dormitory, playing in that water-stained cellar, locked in that tiny "quiet room." After your visit, you will not need this Subcommittee's recommendations.

You will know what needs to be done.

SUPPLEMENTAL COMMENTARY

The Joint Mental Health Subcommittee has consciously brought the short-comings and deficits of New Jersey's mental health care system to the attention of the Legislature and the public in attempting to fulfill its role of a change agent. All evidence gathered in the two years of the Subcommittee's operation indicates that change is needed in many areas. However, the Subcommittee would be acting irresponsibly if it did not also attempt to relate some of the positive features noted in the course of its investigations. One of the most heartening and encouraging features of the care system is the dedication of many people working at our State hospitals. The work is not easy and the conditions are far from ideal, and yet, there are many sensitive and caring people working to help the mentally ill return to their homes and resume their normal lives. Unfortunately, they often work at low paying positions with few rewards other than a sense of self-satisfaction in knowing that they are helping another person.

This report is not intended to be a blanket indictment of an entire system and of all the people working within that system. It is intended to assist those dedicated and caring people who have spent a good part of their lives in service to the mentally ill, by calling for changes which will provide them with better working conditions, more resources and improved facilities to deliver superior patient care.

Lastly, the Subcommittee is concerned about the prospects for change. Almost everyone agrees that change is needed. There is unprecedented agreement on and support for the concept of community-based care for the mentally ill. A Mental Health Planning Committee has been studying the system in depth and will soon present a comprehensive operational plan for overhauling the State's mental health care delivery structure. Antiquated laws have been reviewed and found to be inadequate; new proposals have been prepared to replace them. Courts have challenged the existing laws. Mental patients have new advocates to stand up for their rights. All in all, the signs of change are numerous.

Despite all of these encouraging signs, the Joint Subcommittee is concerned about the prospects for change for several reasons. First, the history of mental health care in New Jersey is not encouraging. Secondly, change only occurs when there is total commitment to change as a number one priority. In allocating scarce resources for needed State services, mental health care must be a priority concern for any major change to occur. Finally, the need for change must be continually restated. Other issues compete with mental health, distracting decision-makers and diverting resources.

For these reasons, it is suggested that a permanent Legislative "watch-dog" committee or commission may be needed to monitor implementation of the new comprehensive mental health plan, to insure that critical budget decisions and

funding patterns reflect new policy directions, to give mental health care consumers an "ombudsman-like" group to hear their problems and concerns and take actions, to review existing legislation and propose new measures, and to periodically review the operations and conditions of State mental health facilities.

A P P E N D I X

APPENDIX I: RECENT COURT ACTIONS AFFECTING MENTAL HEALTH

Federal

O'Connor v. Donaldson, _____U.S._____,43 U.S.L.W. 4929 (1975). United States Supreme Court decision which stated that mental patients cannot be confined in the institutions against their will and without treatment if they are not dangerous and are capable of surviving on their own or with assistance outside of the institution.

Wyatt v. Stickney, 344F. Supp. 373, 344F Supp. 387 (M.D.Ala. 1972). Federal District Court decision which found a federal right to treatment based on the U.S. Constitution. The U.S. Court of Appeals for the Fifth Circuit upheld the district court decision in November of 1974, however, this decision is now on appeal to the United States Supreme Court.

Coll v. Kugler, Civil Action No. 1525-73, Federal District Court, Newark, September 3, 1975. New Jersey case in which the plaintiff is seeking to have New Jersey's involuntary commitment law declared unconstitutional. A three judge panel has reserved its decision. Any appeal of the decision in this case would be to the U.S. Supreme Court.

New Jersey

In re Geraghty, Docket No. A139, July 22, 1975. This case was an appeal of a Somerset County Court ruling which set forth a right to counsel for persons being involuntarily committed to psychiatric institutions. The New Jersey Supreme Court's decision found this case moot in light of recently promulgated Court ?Rule, 4:74-7, which provides for counsel to persons subject to involuntary commitment.

In re Minehan, 130 New Jersey supra. 298 (Co. Ct. 1974). Ruling by Superior Court Judge Cuddie Davidson which gives persons appealing an order of commitment a constitutional right to a transcript.

In re Alford, Docket No. L-10591-74, Law Division, January 10, 1975. Docket No. A1429-74, Law Division, September 30, 1975. Mercer County Superior Court Judge George Y. Schoch granted a motion to have an independent psychiatrist examine the petitioner, at county expense, prior to a commitment hearing. (Unreported decision). Court Rule, 4:74-7, effective September 8, 1975, upholds this decision.

In re Bohuk, Docket No. L36210-66, April 21, 1975. Unreported. Letter Memorandum filed with court. Mercer County decision in which it was found that treatment rights (of court patients) are paramount to penal interests giving the courts the right to transfer such patients to a less restrictive setting for treatment purposes.

Marin v. Yaskin, Docket No. L-20055-73, Superior Court, Law Division, Camden County, March 24, 1975. This case is seeking to establish a constitutional right to counsel at commitment hearings.

Doe v. Klein, Docket No. L12088-74, Law Division, December 4, 1974. Class action suit filed in Morris County on behalf of Greystone Psychiatric Hospital patients seeking a ruling that conditions at the hospital violate the patients' rights to treatment, to freedom from harm and cruel and unusual punishment, to the least restrictive alternative setting for treatment, to a durational limitation on periodic review of commitment, and to practice their civil rights while institutionalized.

Carrol v. Cobb, Docket No. A669 - 74, A 1044-74, Consolidated Appeal, Appellate Division. Decision concerning 34 residents of the New Lisbon School who were denied their right to vote. The decision held that the Burlington County Elections Commissioner was without authority to blanketly deny residents of the school the right to vote.

APPENDIX II: MENTAL HEALTH LEGISLATION IN THE NEW JERSEY LEGISLATURE (AS OF NOVEMBER 1, 1975)

S-644 (Hagedorn) and A-2308 (Berman)

These bills seek to increase State aid to Community Mental Health Projects from $1.00 to $2.00 per capita. S-644 is pending in the Revenue, Finance and Appropriations Committee while A-2308 is in the Assembly Institutions, Health and Welfare Committee.

A-1268 (Otlowski)

This bill increases the State's participation in funding Community Mental Health Projects from 60% to 90%. A-1268 is pending in the Assembly Institutions, Health and Welfare Committee.

A-2159 (Otlowski)

Provides for unapportioned State aid for Community Mental Health Projects to be used for those projects which have demonstrated a need for additional funding. A-2159 is pending in the Assembly Institutions, Health and Welfare Committee.

S-3155 (Menza)

Permits health insurance coverage (other than group and blanket) for outpatient mental health treatment. S-3155 is pending in the Senate Labor, Industries and Professions Committee.

S-3156 (Menza)

Permits group and blanket health insurance coverage for outpatient treatment of the mentally ill. S-3156 is pending in the Senate Labor, Industries and Professions Committee.

S-3157 (Menza)

Requires hospital service corporations to make available coverage for outpatient treatment for mental illness and emotional disorders. S-3157 is pending in the Senate Labor, Industries and Professions Committee.

S-1032 (Menza)

Establishes a Mental Treatment Standards Committee to set standards of treatment for State and County psychiatric hospitals and establishes a Patient Treatment Review Board to hear patient complaints concerning treatment. The Committee and Board would be in the Department of Institutions and Agencies. S-1032 is on second reading in the Assembly.

S-1407 (Menza)

Proposes major changes in the State's involuntary commitment statutes. S-1407 is on second reading in the Senate.

A-3109 (Wilson)

Emphasizes within State policy the intent to encourage the development of community mental health programs to reduce the need for State hospital commitments and gives funding priority to those projects which fulfill this intent. A-3109 is on second reading in the Assembly.

S-1517 (Menza)

Requires all county mental health boards to create the position of mental health administrator. S-1517 is on second reading in the Senate.

S-3256 (Menza)

Permits persons, other than the criminally insane or incompetent to stand trial, who have been discharged from institutions or facilities providing mental health services as recovered, to apply to the court for expungement of commitment records. S-3256 is pending in the Senate Institutions, Health and Welfare Committee.

A-3362 (Wilson)

Prohibits municipalities or local boards to deny the use of facilities zoned as single family-dwellings for "community based residences" for the mentally retarded or mentally ill. A-3362 is pending in the Assembly Institutions, Health and Welfare Committee.

S-1074 (Hagedorn)

Establishes a Department of Mental Health as a principal State governmental department; appropriates $100,000. S-1074 is pending in the Senate State Government, Federal and Interstate Relations Committee.

A-3093 (Otlowski)

Establishes a Department of Mental Hygiene; appropriates $100,000. A-3093 is pending in the Assembly State Government, Federal and Interstate Relations Committee.

S-3365 (Menza)

Establishes a personnel screening program at the State and County Psychiatric Hospitals.

S-3366 (Menza)

Requires the Department of Institutions and Agencies to establish a manpower redeployment program for workers whose jobs are threatened by deinstitutionalization programs.

P. L. 1975, CHAPTER 85, *approved May 7, 1975*

1974 Senate No. 1117 (*Third Official Copy Reprint*)

AN ACT concerning the civil rights of the mentally ill **[and the mentally retarded,]** and amending sections 9 and 10 of P. L. 1965, c. 59.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 9 of P. L. 1965, c. 59 (C. 30:4–24.1) is amended to read as follows:

9. Every individual who is mentally ill **[or mentally retarded]** shall be entitled to ***[humane care and treatment]*** ****fundamental civil rights**** and*[, to the extent that facilities, equipment and personnel are available,]* to medical care and other professional services in accordance with ***[the highest]*** accepted standards****, provided however that this shall not be construed to require capital construction****. Every individual between the ages of 5 and 20 years shall be entitled to education and training suited to his age and attainments.

Every patient shall have the right to participate in planning for his own treatment to the extent that his condition permits.

[Mechanical restraints, including isolation, shall not be applied in the care or treatment of any mentally ill or mentally retarded individual unless required by his medical needs; every use of a restraint and the reasons therefor shall be made a part of the clinical record.

Nothing in this act shall preclude the application of measures in emergency situations for the control of violent, disturbed or depressed behavior. The emergency nature of the measures shall be fully recorded in the clinical record.]

2. Section 10 of P. L. 1965, c. 59 (C. 30:4–24.2) is amended to read as follows:

10. [Subject to the general rules and regulations of the facility

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

and except to the extent that the head of the facility determines that it is necessary for the medical care and treatment of the particular individual to impose restrictions, every patient shall be entitled:

(1) To exercise all civil and religious rights provided for under the Constitutions and the laws of the State of New Jersey and the United States, unless he has been adjudicated incompetent and has not been restored to legal capacity;

(2) To communicate by sealed mail or otherwise with persons, including official agencies, inside or outside the facility; and

(3) To receive visitors.

Any limitations imposed by the head of the facility on the exercise of these rights by the individual and the reasons for such limitations shall be made a part of the clinical record of the individual.]

[Notwithstanding any limitations authorized under this section on the right of communication, every individual shall be entitled to communicate by sealed mail with the commissioner and with the court, if any, which ordered his commitment and with his attorney, and on his request shall be provided with the necessary means for doing so.

For the purpose of a patient's exercising his civil rights there shall be no presumption of his incompetency or unsoundness of mind merely because of his admission to a mental hospital.]

a. **[*Notwithstanding*]** ***Subject to*** *any other provisions of law* ***and the Constitution of New Jersey and the United States***, no patient shall be deprived of any civil right solely by reason of his receiving treatment under the provisions of this Title nor shall such treatment modify or vary any legal or civil right of any such patient including but not limited to the right to register for and to vote at elections, or rights relating to the granting, forfeiture, or denial of a license, permit, privilege, or benefit pursuant to any law.*

*b. Every patient in treatment shall be entitled to all rights set forth in this act and shall retain all rights not specifically denied him under this Title. *A notice of the rights set forth in this act shall be given to every patient within 5 days of his admission to treatment. Such notice shall be in writing and in simple understandable language. It shall be in a language the patient understands and if the patient cannot read it shall be read to him. In the case of an adjudicated incompetent patient, such procedure shall be followed for the patient's guardian. Receipt of this notice shall be acknowledged in writing with a copy placed in the patient's file. If the patient or guardian refuses to acknowledge receipt of the notice,*

*the person delivering the notice shall state this in writing with a copy placed in the patient's file.**

c. No patient may be presumed to be incompetent because he has been examined or treated for mental illness, regardless of whether such evaluation or treatment was voluntarily or involuntarily received. Any patient who leaves a mental health program following evaluation or treatment for mental illness, regardless of whether that evaluation or treatment was voluntarily or involuntarily received, shall be given a written statement of the substance of this act.

d. Each patient in treatment shall have the following rights, a list of which shall be prominently posted in all facilities providing such services and otherwise brought to his attention by such additional means as the department may designate:

*(1) To be free from unnecessary or excessive medication. No medication shall be administered unless at the written order of a physician. **[The use of medication shall not exceed standards or use that are established by the United States Food and Drug Administration.]** Notation of each patient's medication shall be kept in his treatment records. At least weekly, the attending physician shall review the drug regimen of each patient under his care. All **physician's orders or** prescriptions shall be written with a termination date, which shall not exceed 30 days. Medication shall not be used as punishment, for the convenience of staff, as a substitute for a treatment program, or in quantities that interfere with the patient's treatment program. **Voluntarily committed patients shall have the right to refuse medication.**

*(2) Not to be subjected to experimental research, shock treatment, **[lobotomy, or surgery, other than emergency surgery,]** **psychosurgery or sterilization,** without the express and informed consent of the patient *[or his parent or guardian]* after consultation with counsel or interested party of the patient's choice. *Such consent shall be made in writing, a copy of which shall be placed in the patient's treatment record. If the patient has been adjudicated incompetent a court of competent jurisdiction shall hold a hearing to determine the necessity of such procedure at which the client is physically present, represented by counsel, and provided the right and opportunity to be confronted with and to cross-examine all witnesses alleging the necessity of such procedures. In such proceedings, the burden of proof shall be on the party alleging the necessity of such procedures. In the event that a patient cannot afford counsel, the court shall appoint an attorney not less than 10 days before the hearing. An attorney so*

appointed shall be entitled to a reasonable fee to be determined by the court and paid by the county from which the patient was admitted. Under no circumstances may a patient in treatment be subjected to experimental research which is not directly related to the specific goals of his treatment program.*

*(3) To be free from physical restraint and isolation. Except for emergency situations, in which *[it is substantially likely that a patient could harm]* *a patient has caused substantial property damage or **[harmed]* ** **has attempted to harm** himself or others and in which less restrictive means of restraint are not feasible, a patient may be physically restrained or placed in isolation only on a medical director's written order **or that of his physician designee** which explains the rationale for such action. The written order may be entered only after the medical director **or his physician designee** has personally seen the patient concerned, and evaluated whatever episode or situation is said to require restraint or isolation. Emergency use of restraints or isolation shall be for no more than 1 hour, by which time the medical director **or his physician designee** shall have been consulted and shall have entered an appropriate order in writing. Such written order shall be effective for no more than 24 hours and shall be renewed if restraint and isolation are continued. While in restraint or isolation, the patient must be bathed every 12 hours *and checked by an attendant every 2 hours with a notation in writing of such checks placed in the patient's treatment record along with the order for restraint or isolation*.*

(4) To be free from corporal punishment.

e. Each patient receiving treatment pursuant to this Title, shall have the following rights, a list of which shall be prominently posted in all facilities providing such services and otherwise brought to his attention by such additional means as the commissioner may designate:

(1) To privacy and dignity.

(2) To the least restrictive conditions necessary to achieve the purposes of treatment.

(3) To wear his own clothes; to keep and use his personal possessions including his toilet articles; and to keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases.

(4) To have access to individual storage space for his private use.

(5) To see visitors each day.

(6) To have reasonable access to and use of telephones, both to make and receive confidential calls.

(7) To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.

(8) To regular physical exercise several times a week. It shall be the duty of the hospital to provide facilities and equipment for such exercise.

(9) To be outdoors at regular and frequent intervals, in the absence of medical considerations.

(10) To suitable opportunities for interaction with members of the opposite sex, with adequate supervision.

(11) To practice the religion of his choice or abstain from religious practices. Provisions for such worship shall be made available to each person on a nondiscriminatory basis.

(12) To receive prompt and adequate medical treatment for any physical ailment.

f. Rights designated under subsection d. of this section may not be denied under any circumstances.

g. (1) A patient's rights designated under subsection e. of this section may be denied for good cause in any instance in which the director of the program in which the patient is receiving treatment feels it is imperative to deny any of these rights; provided, however, under no circumstances shall a patient's right to communicate with his attorney, physician or the courts be restricted*. Any such denial of a patient's rights shall take effect only after a written notice of the denial has been filed in the patient's treatment record and shall include an explanation of the reason for the denial.*

(2) A denial of rights shall be effective for a period not to exceed 30 days and shall be renewed for additional 30-day periods only by a written statement entered by the director of the program in the patient's treatment record which indicates the detailed reason for such renewal of the denial.

*(3) In each instance of a denial or a renewal, the patient, his attorney, *[or]* *and* his guardian*, if the patient has been adjudicated incompetent,* and the department shall be given written notice of the denial or renewal and the reason therefor.*

h. Any individual **[detained pursuant]** ***subject*** to this [act] *Title* shall be entitled to a writ of habeas corpus upon proper petition by himself, by a relative, or a friend to any court of competent jurisdiction in the county in which he is detained ***and shall further be entitled to enforce any of the rights herein stated by civil action or other remedies otherwise available by common law or statute***.

3. This act shall take effect immediately.

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SENATE CONCURRENT RESOLUTION No. 89

STATE OF NEW JERSEY

INTRODUCED JANUARY 28, 1974

By Senators MENZA, HIRKALA, SCARDINO and HAGEDORN

Referred to Committee on Institutions, Health and Welfare

A CONCURRENT RESOLUTION *[directing]* *_constituting_* the Senate *_and General Assembly_* Standing *[Committee]* *_Committees_* on Institutions, Health and Welfare to study and evaluate the State's institutions, agencies and services for the mentally ill.

WHEREAS, State and Federal courts in recent years have ruled that to confine the mentally ill but not treat them is a denial of people's constitutional rights; and

WHEREAS, New Jersey remains heavily reliant upon its four psychiatric hospitals which provide residential care that is primarily custodial and affords patients minimal programs of care and rehabilitation; and

WHEREAS, One of every three persons now in some of these State psychiatric hospitals is there only because neither his family, his community nor the State have made any alternative provisions for his care; and

WHEREAS, The 1966 State Plan to develop 50 community mental health treatment centers throughout New Jersey to provide a wide range of mental health services has been implemented thus far only to the extent of opening 12 such centers; and

WHEREAS, The modest Federal aid support of the existing centers expires after a maximum of 8 years and the President has terminated all programs for Federal aid to new mental health centers; now; therefore

BE IT RESOLVED *by the Senate of the State of New Jersey (the General Assembly concurring):*

1. The Senate *_and General Assembly_* Standing *[Committee]* *_Committees_* on Institutions, Health and Welfare *[is hereby directed]* *_are hereby constituted a joint committee and directed_*

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

to study and evaluate the State's program and the public's needs for new mental health institutions, agencies, and programs.

2. It shall be the duty of the *[Senate Standing Committee on Institutions, Health and Welfare]* **joint committee* to make an inventory of all existing mental health services in the State to reevaluate the 1966 State plan recommendations, to review the adequacy of existing State budget review mechanisms as they apply to providing appropriations for mental health services, and to make such studies and inspections of mental health services, programs and facilities in this and in other States as it deems necessary for preparing its evaluation and report.

3. The *[commission]* **joint committee* shall be entitled to call to its assistance and avail itself of the services of any head of any department of the State of New Jersey, and of such employees of any State, county or municipal department, board, bureau, commission or agency as it may require and as may be available to it for said purposes, and to employ such stenographic and clerical assistants and incur such traveling and other miscellaneous expenses as it may deem necessary, in order to perform its duties, and as may be within the limits of funds appropriated or otherwise made available to it for said purposes.

4. The **joint** committee may meet and hold hearings at such place or places as it shall designate during the sessions or recesses of the Legislature and shall report its findings and recommendations to the Legislature, accompanying the same with any legislative bills which it may desire to recommend for adoption by the Legislature.