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

before

SENATE INSTITUTIONS HEALTH AND WELFARE COMMITTEE

on

CONDITIONS IN STATE MENTAL INSTITUTIONS

Held:
December 1, 1972
Assembly Chamber
State House
Trenton, New Jersey

MEMBER OF COMMITTEE PRESENT:

Senator Garrett W. Hagedorn (Chairman)

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health care program in New Jersey. Certainly a state that in seven years can increase its expenditures for education three and one-half times - in 1966, $265 million to, in 1972, $914 million - or in the case of welfare, increase its expenditures by 650% - from $50 million to $381 million - must recognize its responsibility to the unfortunate residents of our institutions and provide adequate funding.

I trust that today we may have the beginning of that effort to generate and focus attention upon the people of this State on the need to improve mental health care.

The first gentleman to testify will be Dr. Simon of Marlboro State Hospital. I would like to call upon him at this time.

D R. M I C H A E L R. S I M O N: Senator, I think one has to make a difference between the care and treatment of patients within a mental hospital, specifically a state mental hospital, and the problem of suicide. I think if we're talking about care and treatment of patients in a general sense, we can, in fact, see a specific correlation between our imput, in terms of manpower, in terms of providing for the care and treatment of mental patients, and the result that we can hope to achieve. I think in that sense we can have almost a simple correlation. When we get into the problem of suicide, I think we get into a much more complex issue.

Suicide and the causes of suicide are not yet known to be so specific that we can actually build programs around the prevention of suicide. Surely we can take the measures that we do take with respect to the prevention of suicide. However, the problem itself is of such a complex nature that to try to find simple answers by simply changing an environment or adding a few more personnel, in my opinion, will not particularly solve the problem.

Within the area of suicide, we're dealing with individuals who are so alienated from being able to accept

help that the question of providing more help is not always the answer to the question of suicide.

I would like to point out, for example, one specific case of suicide that we had at Marlboro. This individual was a young girl. Now if we talk about help, in her particular case I don't think any more help could have been given in the sense that a doctor, the family, social worker, psychologists, all were making efforts with respect to trying to reach this girl and at times it seems that the efforts were paying off, it seemed as if her mood had changed, it seemed as if she had been reached, and at the time that we felt that she had actually been reached, where we felt we were making real progress with her, at that time, secretively she was storing up pills which she had bought in an ordinary pharmacy outside the hospital and then killed herself with them.

So, I think we must make a separation between the fact that there is - very specifically there's a need for improvement within the State Hospital system in terms of more personnel, in terms of improved programs. But when we're talking about suicide, I think we must in fact look at this issue from a different point of view. We must have more study in terms of having a study around the causes and the preventions of suicide.

Again, if I can come back to Marlboro in terms of the picture of suicides that we've had. We went through 1971 without a suicide. We went through 1972 with 4 suicides. We felt that in 1972 the care and treatment that we were providing with respect to our patients was equivalent to what we were providing in 1971. However, there were these four suicides that we had during this year.

If we analyze the situations, we cannot in point of fact say - I cannot in all honesty say that if I had this particular program or that particular program we might have been able to prevent any of the suicides. Suicide is an unfortunate situation, it's a tragic situation. It's a tragic situation from the point of view of the individual who acts

out suicide, it's an unfortunate situation for the family. It is a very difficult problem. What seems to be on the surface is not always going on as far as the depth of the individual is concerned. We find individuals who commit suicide will try again and again in spite of the care and concern that we find people extending toward them.

I repeat, from my observation it seems to be a situation where the alienation of the individual is so strong in terms of his connection with people around him, that all our efforts at times seem to be in vain.

Thank you.

SENATOR HAGEDORN: We appreciate your testimony, Dr. Simon, and we do recognize that you run a rather fine institution at Marlboro.

DR. SIMON: Thank you very much.

SENATOR HAGEDORN: I have no questions.

I understand that Dr. Fenimore from Greystone is present and I would like to ask if he would be willing to testify at this time.

D R. F R A N K D. F E N I M O R E: Yes. I am Frank D. Fenimore, M.D.

SENATOR HAGEDORN: Dr. Fenimore, inasmuch as there has been a lot of attention focused upon Greystone, I was wondering if you would be willing to tell us about the circumstances surrounding the three suicides that took place in Greystone.

DR. FENIMORE: Yes, I will.

The first one was a young man who escaped from the Hospital and proceeded to go to a bridge over the Harlem River. This young man had made three or four previous attempts and on each occasion we were fortunate in catching him before he jumped from the bridge. He always seemed to head for the George Washington Bridge and we, as soon as we learned he was missing, alerted the police in that area and they immediately searched the area, as they had done on

previous occasions, but this time he went on to the Washington Bridge which went over the Harlem River and, unfortunately, succeeded in his suicidal attempt.

This young man had been showing progress in his treatment program and at the time of his escape he was attending an occupational therapy program. The occupational therapy area was not in a locked area and, unfortunately, when the Occupational Therapist turned to take care of someone else the patient was able to slip out unnoticed.

The second one was a young man who, ever since he came to the Hospital, kept hitting himself in the face saying that God was telling him to do this because he was bad. He also had begun to show signs of improvement. During a period when he was allowed into a linen room to pick up his clothing for the night - the linen room was open daily for a period of 45 minutes or so so that patients could get themselves ready for bed. Unfortunately, he was in there alone for a brief period and the one attendant on the ward was not at the door because he was alone on the ward and he had other things to do. Within a matter of say 15 minutes this boy had succeeded in tying a shirt over a clothes pole and allowed himself to slump down so that he could hang by his neck.

The third case was one that was really upsetting to us because we had put in so much effort and we were getting a wonderful response after a period of two years. This young man was granted ground privileges so that he was able to live on an open ward and gained the use of the entire grounds. He went to an area which was not a patient-occupied area, it was an employees' bathroom on the second floor, and he pushed out the window screen, stood up on - we assume he stood up on the windowsill and dove, head first, on to the pavement below. He had to clear a garbage collector, a Dempsy Dumpster, which meant that he really had to spring from the windowledge to accomplish his purpose.

He was dead immediately.

Now whenever patients are brought to the Hospital with suicidal tendencies, they are kept in an area right outside the nurse's station so that they can be observed continuously. But when they get over this immediate period of suicidal tendencies and then we get into the treatment programs this is when, unfortunately, these things do occur. I don't know of any way that I could honestly tell you how we could prevent suicide. I wish there was a simple answer to it. Giving us a thousand more people to work isn't going to guarantee us no suicides.

SENATOR HAGEDORN: Could I ask you a question at this time? Do you think it would help prevent them? additional staff?

DR. FENIMORE: I am sure we could reduce the number because we wouldn't have the incidence where there would be one person on a ward, we would have at least two or three.

SENATOR HAGEDORN: I have a few more questions, if I may.

DR. FENIMORE: Yes.

SENATOR HAGEDORN: Knowing that some of them have suicidal tendencies, do we have any extra precautions, exercise any extra precautions in those areas? For example, I'm thinking of the one boy you talked about who went to occupational therapy and I was wondering how many attendants we have. Do we have additional attendants knowing that we are faced with these problems?

DR. FENIMORE: No. Unfortunately we don't have that much help. I mean, if we had decided that because we didn't have the help this individual would be deprived of this program, that in order to safeguard against any suicidal tendencies we would leave him locked up on the ward, and we don't feel that this is good therapy.

SENATOR HAGEDORN: Has there been any effort to secure additional help for this type of problem?

DR. FENIMORE: Yes. I believe we submit in our annual budget requests for positions.

SENATOR HAGEDORN: Which apparently are not recognized?

DR. FENIMORE: Well, when I was on the other side of it, just the head of a section, I used to become annoyed because we would ask for something and didn't get it, but I am learning now that there is just so much to give out, everybody wants, somebody has to get less if we get more. So I don't want to say that we are the only ones that should have the more. Now, if there was enough for everybody, that would be the answer.

SENATOR HAGEDORN: Well, I can assume that you are dissatisfied with the response of the State in providing adequate staff for your institution.

DR. FENIMORE: Yes.

SENATOR HAGEDORN: Thank you. I have one other question and that is, do we have police reports on the three suicides at Greystone, in other words, have they been investigated and do we have filed reports?

DR. FENIMORE: Yes. Every incident that violates any criminal statute is thoroughly investigated by the police and reports are submitted to the County Prosecutor's Office.

SENATOR HAGEDORN: Very good. If you have other comments, we will be glad to listen, otherwise, we are very happy that you have come here and answered these questions and provided testimony.

I understand that Frances Dunham is in the audience who would like to testify.

In each case, we would ask the people who testify to give their names and address and what organization they represent.

F R A N C E S D U N H A M: My name is Frances Dunham. My address is 690 Whitehead Road, Trenton, New Jersey. I am Executive Director of the Health Care and Rehabilitation Unit of

Council 63, American Federation of State, County and Municipal Employees, AFL-CIO. Our organization is the certified bargaining agent for 8,000 non-professional institutional employees in mental hospitals, state schools for the retarded, and food service workers in state prisons.

Over the past year, our organization, while not having accurate figures as to the number of suicides that have taken place in these institutions because of a veil of secrecy by the Department of Institutions and Agencies, has been greatly concerned and has more than once gone on record that there is a desperate need for improvement in patient care to prevent suicides. It is our opinion that these suicides are the direct result of a "penny pinching" policy by the State of New Jersey resulting in antiquated facilities, unbelievable shortages in staff, and unqualified administrators.

The administrators we make reference to are the majority of doctors in these institutions who besides giving health care services, have the overall responsibility of overseeing, supervising, and running these institutions. In actual practice, these doctors show no concern for staffing patterns, no interest in the number of personnel on any given ward, and have a seemingly carelessness about the welfare of the patients.

It is no secret that many of these doctors are discontent with the monies they receive from the State of New Jersey as compared to their colleagues in private practice resulting in an indifferent

attitude towards the operation of the institution. Other doctors are foreign born who work under the head of the institutions' directors certificate with no understanding of the American workers and in many cases having a language barrier resulting in an inability to communicate with patient and employee alike.

Another component in the inability of these institutions to function properly are those who operate the institutions, namely the directors, who are not trained in personnel relationships and coping with physical facilities equal to the size of a small city. A doctor is not trained to deal with employee problems. A doctor is not trained to understand how to feed thousands, run laundries, oversee massive utilities, engineering, electricity, plumbing, and so on.

Flowing from this type of antiquated administration are under paid, under staffed, and demoralized employees, many of whom live in the ghettos of New Jersey and must travel at great personal expense and time to get to their jobs. These employees, hired as non-professionals, end up doing para-professional work which includes motivating patients, giving "shots", administering medication, giving occupational therapy, and giving recreational sessions. These same employees wash and clean wards; serve food; wash and iron clothing; scrub walls, windows and floors;and clean dishes.

If you can picture all these responsibilities being fulfilled with a large shortage of staff, you can then understand that meaningfully overseeing the patient and his needs becomes secondary. These employees just don't have time to talk to the unfortunate patients who are in these institutions,denying them a lifegiving feeling of concern which is so desperately needed by those who are mentally afflicted. Regretably, those who are the institutional professionals other than doctors, just are so few in numbers that they cannot give any kind of professional service to the patient. Without employees having time to talk to a patient, they have absolutely no contact with the outside world and, possibly, with reality.

Lastly, the facilities are antiquated. For example, there are no protective measures for windows within the facilities where patients are housed on the second or third floor wards. Exposed pipes are clearly visible in most of the institutions and patients have been known to use a sheet across the piping in attempted suicides. Toilet facilities in most of the institutions are insufficient and antiquated with built in hazards of self-destruction. They are also without privacy, debilitating patients into feeling like an animal rather than a human being.

In most of the facilities, there is no available drinking water for patients. They must use the sink inside of the toilet for their driking water which is another debasing factor which could lead to feelings of self-destruction.

On the wards themselves, there is not enough space between beds for nightstands so that a patient can keep his personal belongings. In many wards patients have been known to come down with pneumonia or other illness because of inadequate heating and improper ventilation. Factors like these obviously lead to severe depressions.

It is our conclusion that the only way to address suicides that have taken place in the institutions is to start working on improving staffing patterns, improving physical facilities, improving professional services, hiring trained hospital administrators, and putting a greater political and public emphasis on mental facilities; as opposed to what's happening in New Jersey where those who are able to riot get the monies and alterations over those who are unfortunate enough not to be able to fend for themselves.

SENATOR HAGEDORN: Have you finished, Mrs. Dunham?

MRS. DUNHAM: Yes, I am, Senator Hagedorn. I have two employees representing - one, the State Hospital at Ancora, and the other, the State Training School at Vineland, and they will be giving testimony from what they have seen on the job.

SENATOR HAGEDORN: We would like to listen to them at this time.

MRS. DUNHAM: I call Louis Cruz from Ancora State Hospital.

L O U I S C R U Z: My name is Louis Cruz, 430 South 30th Street, Hammonton, New Jersey.

I have been employed at Ancora State Hospital for six years now. I work on an Admission Ward. We had an incident about three or four months ago where a patient on the top floor where I work with only two attendants taking care of 46 patients, three patients on homicidal precautions, four patients on suicidal precautions. There were only two attendants on the floor who cannot watch that many patients. The patient got out of his bed, went into a linen closet, hung himself. The two attendants cannot be on the ward at the same place at all times. With so many patients in bed - this is a med-surgical unit where a third of your patients are bed patients. You have about 10 on critical conditions. We feel, at Ancora State Hospital, there have been other suicides because of the lack of help. We care for our patients but if we do not have the proper people to be with the patients we just can't do anything. Our hands are tied.

Where you have a ward with 60 or 70 patients and you have just two or three attendants around all shifts - we have attendants who have to go out for their supper and you send one at a time and you are always leaving two attendants taking care of 60 patients. We have not only suicidal but we also have homicidal patients. We

are placed on the ward by ourselves where the majority of patients - you might have two or three on homicidal and those we would have to keep a special eye on, the same as the suicidals.

I just took over a patient to the Vroom Building, yesterday, myself. He attacked one of our attendants on third shift, there were only two attendants on third shift. He hurt the attendant pretty bad. I took him this morning over to the Vroom Building.

But our main concern is our patients. If we don't have the staff to watch over them, we just cannot do our job. Our hands are tied. We cannot speak to the patients because we are watching the patients constantly, we are feeding the patients, we are mopping the walls, we are mopping all the wards, we are washing walls. This is required of us, to do all the housekeeping. How can we do housekeeping duties and keep an eye on a suicidal patient if we just don't have the adequate staff to do this.

I heard you speak to Dr. Fenimore saying if help would alleviate suicides. Yes, this would help because if we have enough staff you can put it on a one-on-one basis for a suicidal patient. But if you don't have the adequate staff, you cannot put them on a one-on-one basis. We are in bad shape as far as help is concerned. We have people who are sick and tired of what's going on who are just leaving their jobs and I don't blame them. I have stuck it out for six years and I don't know how much longer I can stick it out.

At this time I would like to call Mary Moore who will tell you the problems at Vineland State School.

SENATOR HAGEDORN: Thank you, Mr. Cruz.

M A R Y M O O R E: My name is Mary Moore. I'm a CTS at the Vineland State School, Vineland, New Jersey.

While the mental retardation schools do not have as many suicide potentials as the mentally ill, we do have patients who are self-destructive, who are self-abusive, and we do have - I know in the unit in which I work, she was there until approximately six months ago - one who was a potential suicide. She was the type of patient who used the bathing areas where the water could be let run and accumulate, or if we were running baths for children to be bathed, she was the type of child who would run and get into the bath tub and submerge herself under the water. Now the attendants had to observe her very carefully because she would even go to the hopper facilities and put her head under the water. Now she has since been taken out of the building. I do not know if this is a regular practice, taking suicidal patients from the unit and other areas. I don't know. But I do know she was removed.

However, because of the lack of help we have had instances where there have been interactions among the residents which resulted in the death of a resident. Now this happened in 1971, February. It was during the preparation for bedtime. They had gotten the children bathed and they were being readied for bed. They have at 8 o'clock what they call a snack time, they give them cookies and milk or cake and milk, some type of snack. This particular child - we have 102 residents in that building and at this particular time we have six attendants on duty. There are four areas, actually there are six areas but they closed off two, the day rooms, and the bath rooms and dormitories were open, which gave us four areas which had to be covered with six attendants. There was one attendant in the dormitory at this time. When this snack was being served one child, seeing the other one with cake, after she had eaten hers, tried to

take it away from her. To protect her cake, the resident jammed the whole piece into her mouth. This resident knocked her down, sat on top of her and proceeded to choke her to get the cake away from her. Now the one attendant hears the fracas - she's at the other end of the dormitory - and when she turns around the child is choking the other resident. She goes to her and attempts to get her off and in an attempt to get her off of her she cannot - she was a hyperactive child and it took two or three attendants to control her if necessary. So she had to go to another area to get help. By the time she got back and they were able to get the child off the resident, she was dead.

This incident was reported. I know there was a police investigation because that evening the people who were on duty were held past shift releaving time being that the police were there. So I am pretty sure it was reported.

We have had other incidents. Like I say, in the mentally retarded area there are not that many suicides. We have had interaction which has resulted in injuries to attendants, because of a lack of help. As I said, in our unit, - I can speak only for the unit I'm in - at the present time there are 105 in the building now. We have on each shift - there is a complement of 14 on the first shift and all the slots are never filled and in the last six months we never have more than nine in the morning, which is your fully active shift. This is the first shift where all the activity is going on, where a woman might have to go out to take a number of children to a clinic, there are children going back and forth to recreation. So this takes the women out of the building, leaving approximately one [illegible] on duty to supervise the 54 or better residents who are

left in the unit.

Also on the second shift they work a minimum of six in a building to cover 102 patients with six areas to be supervised. Also during that time there are children going back and forth, being shuttled to the hospital, the clinic, to the nurse, to recreation, to classes, which means each group that leaves must take an attendant with it. Therefore, they wind up with one woman being left in the dormitory with 55 children who are not leaving the building. As a result, the children cannot be potted because she cannot leave one area to go into another and leave them unsupervised. Therefore, she must wait for someone to come back so that both areas are covered and the bath rooms can be opened. This, of course, leads to accidents because of the urine, etc. that cannot be cleaned because she must go to the vestibule to get cleaning facilities to bring them to the area. She dares not leave the children unsupervised and, therefore, it has to be let go until someone comes on the floor.

It's a situation where we are losing employees because they are tired of doing the work of four people with two people on duty or coming on duty at the last minute and finding that they are the only ones to cover a dormitory. How in the world they expect us to give adequate care to 56 or 54 children in each dormitory, which adds up to 105 children, and two of us on duty at night -- I have worked two nights in the last two weeks with two people on duty, myself and one other attendant to cover 102 patients.

SENATOR HAGEDORN: Could you outline to us exactly what your responsibilities are?

MRS. MOORE: We were hired for resident care. Actually we are compelled - now I can give you the procedure on the third shift. We come in at 11 o'clock. There is a cottage check to be sure that the cottage is

secure, that the children are in bed and everyone is accounted for. After the shift is changed, it is our responsibility to check the children to be sure they're in bed and asleep. All right, we have hyperactive children which means that there is constantly somebody running on the floors that we are not allowed to restrain or keep them in bed in any way unless we have a doctor's order. At night we can call if they are destructive or abusive to get a temporary restraint order to tie them into bed to keep them there. We have children on this ward who will get up and beat another child, you know, next to her. The beds are crowded, you can barely get through the beds. They are close as these desks are here.

After we check the children and get them in bed - we're supposed to have an attendant on duty in each dormitory to constantly check because we do have children who will get up and attack other residents. However, we don't have the help so she is put in the hall so she can monitor both the bath rooms and the dormitories at the same time. Now if something happens in the dormitory then she has to leave the hall and go into the dormitory because there is no one to relieve her to go into that area. Therefore, we have one woman covering two areas, yet we are supposed to have supervision constantly in that area but this is impossible.

The children are gotten up at 11:30 for potty. They are potted and put back to bed. Of course you are going to have those that are not going back to sleep and there should be someone there to watch the activity. After the potting is done, we are responsible for getting together the children's clothing for the next day which is in another area of the building and we have to leave the floor completely to get the clothing together for the next day's use. We are responsible for housekeeping

procedures. In my particular building there is a medicine room, the hopper room which is the storage room for the cleaning facilities, there is a laundry room where we are responsible for getting the laundry done during the night, we are responsible for folding these clothes and putting them away. We are also responsible for cleaning and straightening the sewing rooms. We have floors to mop. And, of course, we have children to keep dry and clean. And it's really too much work for one woman with 102 residents.

SENATOR HAGEDORN: You mentioned you do the laundry.

MRS. MOORE: Yes.

SENATOR HAGEDORN: What part of the laundry do you do?

MRS. MOORE: In our building we have quite a few children who are on Social Security. Now the clothing that is purchased for them with Social Security money does not leave the building. Their total wardrobe must be washed, that they use each day. In my unit there are 33 Social Security children. Therefore, we must wash all the clothing that they use during the day. Some of them are changed five, six and seven times a day. Anything that is used is washed in the building, ironed, and put away in the cottage.

SENATOR HAGEDORN: By the attendants in the building.

MRS. MOORE: Yes, by the attendant.

SENATOR HAGEDORN: Thank you. We appreciate your testimony and your great interest in the care of these young children.

MRS. MOORE: Thank you.

SENATOR HAGEDORN: At this time I would like to call upon Monsignor Dooling of the Mount Carmel Guild.

M S G R. J O S E P H A. D O O L I N G: My name is Joseph A. Dooling. I am Administrative Director of the Mt. Carmel Guild Multi-Service Center which has a comprehensive mental health center as one of the services in addition to some satellite outpatient services.

I brought our Administrator with me, Mr. Fasulo; and also the Executive Medical Director of the Mental Health Division, Dr. Robert Dublis; and Mrs. Nancy Monti who is in charge of admissions to the Center.

I presume that our presence here today would be not so much along the lines of custodial care as it would be along the lines of treatment. So many of the things that have already been expressed here today that we have listened to that revolve around custodial care, we would of course be concerned about it because we have an emergency-crisis type of intervention service, but we would be concerned more about the modality of the treatment that would be given to patients that might show some evidence of self-destruction on homicidal tendencies.

I think that we could reasonably emphasize the importance of the community mental health center in this regard that the services of the center are immediately available to anyone on an off-the-street type of approach, as well as the various points of comprehensive mental health care, and these would include the inpatient area, the outpatient area, partial hospitalization - which is a hospitalization and day care type of approach - plus consultation and education, and then aftercare. These five elements of the comprehensive mental health center we feel are the more direct approach to mental health. We feel too that it gives the patient or the person who needs immediate care the opportunity to come immediately to a center and, therefore, the element of prevention is highly important here because

people who have a tendency toward self-destruction might never get to that serious stage if they have the opportunity for immediate care when they felt they had a need for it. The off-the-street type of approach for us is highly important because there isn't any reason for a person to be referred by a doctor or by someone in the family or by someone who would be locally interested in the person. But the patient could come in off the street and immediately see a professional who is assigned on a regular tour-of-duty basis to take care and see immediately patients that come to the center.

Mrs. Monti would be able to give you the statistics on this. She can also give you the crisis intervention statistical data that I think might be impressive. But our main reason in coming here is to emphasize the approach of the comprehensive mental health center, the community mental health center, which is a service that is immediately available to the person in his own locality.

I would like to present, Senator, if I may, Mr. Fasulo who would speak along the lines of what the Center is set up for.

SENATOR HAGEDORN: Before you do, Monsignor, I would like to make the observation that I have been privileged to make an inspection tour of the Mount Carmel Guild in Newark and I was really overwhelmed by what I saw, the dedication, the efficiency, the cleanliness. And, hopefully, this is the type of program that we want to generate for the public institutions of our State. And, again, may I say, thanks for your great dedication.

R O B E R T F A S U L O: My name is Robert Fasulo and I am the Administrator of the Mount Carmel Guild. I would like to just for a moment confirm or reemphasize what Monsignor was saying and that is that our purpose

in coming here, while not directly related to the problem that you are talking about, the suicides in the State Institutions, we felt that some imput from a community mental health center, in terms of what can the community health center do to relieve some of the burden on the state institutions, might be something good for you to know. As a matter of fact, our position is that the community mental health centers, which are relatively new, are not being fully taken advantage of by the state institutions. I am sure that that's not because the state institutions don't want to cooperate as much as the lack of liaison, perhaps, and communication between the two of us.

We have started to build a bridge with our state affiliate, the Trenton State Hospital, and in the past year we've made excellent progress, in the beginning, at least, to develop the kind of relationship that we hope some day will be a good working relationship.

For example, one of the things that we would like to see happen is for the patients in the State Hospitals to be unitized according to catchment area or service area. As you know, the State has been divided into service areas and hopefully some day each service area will house a community mental health center, making mental health services available to the community where it's needed. Now if in some way we can identify, when we visit the State Institution, with a team, a liaison team of clinicians, and know exactly who the people are that belong in our service area, then we can start working with those people while they are still in the State Hospital and develop a relationship such that when they leave the Hospital we will be able to pick up and provide the continuity of service that is required.

Now if this can't be done physically, at least the record could be so established that we would be able to easily identify the patients who are from our service area in the Hospital.

We would also like to recommend a pre-screening process whereby the patients who are being considered for admission into a State institution, who might be from our area, are brought to the Center or at least the case presented to the Center so that we can determine if we can handle that case. Then the person could receive the treatment they need in their own community.

On discharge for any of the patients - and this is extremely important and one of the things we've been working on with Trenton - we would like to be able to know in advance when a patient is being considered for discharge so that we can start the liaison and the communication and develop a relationship with that patient before he's released, because if that doesn't happen the chances are that, when the patient leaves the hospital, he is not going, of his own will, to move right into the Center and take advantage of the outpatient or day-hospital service that is available.

If you have no specific questions on this subject then I would turn to my colleague, Dr. Dublis, who is the Medical Director of the Clinic.

But one of the things I would like to say, before I turn this over to the medical aspects of the potential of the community mental health center, is that a community mental health center is not going to exist, and all the community mental health centers that are planned on are not going to come into being unless there is greater support. Now that support does not necessarily have to come in the form of financial assistance from the State. And let me

elaborate on that just briefly.

Right now there are two free-standing licensed psychiatric units in the State, at the Mount Carmel Guild and at Cumberland. Now these are licensed psychiatric inpatient facilities available in the service area, part of our mental health center. The concept of the free-standing unit in and immediately available to the community, we think, has great potential. But we are operating under a pretty severe handicap. Free-standing psychiatric hospitals being new - and that may not be the only reason, but we are being discriminated against by many insurance carriers, including Medicaid, because we are not operating as part of a general hospital. If we were operating as part of a general hospital, we would be eligible for full third-party payments in both inpatient and outpatient services. What that means to us is we have a tough time existing. For example, I think that the number of welfare patients that we see in our clinic is 40%. Now, if 40% of your patients can't pay anything and we cannot do anything with Medicaid, that tells you where we stand because we don't turn people down who come to us for psychiatric help. So we are in a position of operating in a low-income population. We serve patients, regardless of their income to pay, their ability to pay, and yet the insurance companies, Medicaid - Medicare we have slight hope of doing something with Medicare, but we are just not getting the money that we need to keep the place running. Our costs were five times our payments in this past year in our inpatient unit. And you know a hospital wouldn't operate on that basis.

We understand that there are programs under way to help the medically indigent. Again, those programs are being directed to the hospitals, to the general hospitals. I would say if we have 40% of our

people who are on welfare coming to us for assistance and help that a good 30 or 40% are medically indigent.

Now, if those monies - if there is a welfare and a Medicaid waiver kind of policy or program coming about, certainly the community mental health centers ought to be part of that program. Right now, as far as I know, only hospitals are.

Of course the financial aid that the State is already giving is a very helpful thing to us. Frankly, we think that should be at least doubled.

We hear a lot about revenue sharing. Right now we carry - as far as staffing is concerned, in order to get the community mental health concept going the Federal Government, through the State, pays for a large portion of our staffing. It started out with 90%, because we are in a poverty area, and we are now at a 75% level. That is the Federal Government puts up 75% of the staffing monies for the community mental health center. I might add that I don't want you to get the idea that this is 75% of all the salaries that is being picked up because the Guild has, for example, 400 employees. We're talking about the community mental health center and approximately 80 employees that we pick the 75% of the salaries up on.

Now we are in our fourth year. At the end of the eighth year there will be no support from the Federal Government.

Now you put all of these things together, the fact that we don't have Medicaid assistance in the inpatient unit and only minimal assistance from Medicaid in outpatient; that the third-party payment insurers are discriminating against us because we are not a hospital; and that we're on a declining scale in terms of Federal support; then I think it's

pretty obvious that if you want these community mental health centers to stay in existence - and there is a great potential there for really solving some of your very basic problems in mental health in the State - then we need greater financial support from the State, at least some assistance in trying to get the third-party payments that we should get.

I might add too that the State construction monies that were made available to us to put up our center were vital. If we had not received the 36% support that we did get then the center would not be in existence today. And if there is any thought of cutting out that construction money, you're not going to have many community mental health centers.

If you have any questions, I will be happy to answer them.

SENATOR HAGEDORN: No, I just have a comment, Mr. Fasulo. I would like to observe again that your presentation has been excellent, I think you've given us a lot that we've been dreaming about and hopefully that we can bring about for our State institutions. We are certainly going to research this Medicaid problem and see if we can't provide some assistance in that area.

MR. FASULO: It would be a great help.

I think I have spent time talking about some of these administrative problems and you've heard some of the medical problems from the institutions' point of view, I think it might be well if Dr. Dublis commented on the approach to solving mental health problems in the community mental health center.

SENATOR HAGEDORN: We will be delighted to listen to him.

D R. R O B E R T A. D U B L I S: I am Dr. Robert Dublis and I am Executive Medical Director at the Mount Carmel Guild.

I would like to first address Mr. Fasulo's remarks in terms of the context, and that is I think we can pretty much even begin to address ourselves, at least in some way, toward the problem which you seem to be wrestling with to some extent and that is the suicide problem.

I certainly don't think we have the answer in the community mental health center, not the total answer at this point in time, but I think we really are moving in a direction that can really be a solution, and I think this is the context in which I would like to address the issue.

First of all, let me just make a couple remarks purely as a psychiatrist, a professional opinion. I must to some extent - and I will say this initially - agree with what I believe was said by - I'm not sure whether it was Dr. Simon or Dr. Fenimore -- in terms of the preventability of suicide completely. I would have to say suicide is not completely preventable at this stage of our knowledge. We really have to accept that if someone is really totally bent on self-destruction, that it's just about impossible unless you are going to totally really incarcerate that person, keep him under total observation. There are certainly solutions in that regard but it means essentially depriving that individual completely of his rights for an indefinite period of time.

However, moving away from that because I think that's a relatively rare instance - we may have heard several of them this morning in listening to the individual testimony - in many cases it is preventable and I think the proper approach toward treatment can

make suicide preventable.

I think that is the area where the community mental health center can really begin to move toward a solution. I think some of the great advantages of a community mental health center are accessibility of care, its immediate accessibility. Monsignor was referring to an off-the-street type of approach, what we mean is a walk-in crisis intervention approach, and that is to really begin to bring care to the individual when the need originally arises. By the time this individual is assigned to a state institution he is often so far along the course of his illness that essentially the treatment approaches are difficult at best. You then run into the difficulty in a state institution that often even the type of staffing that could be considered is often at best making custodial staffing adequate rather than beginning to even approach what we think of in terms of staffing for treatment purposes. What we hear today in terms of inadequacy is really bringing staffing up from one or two persons per ward which is just barely enough to provide custodial care. And what we're interested in is treatment. And if the solution is anywhere it is really in bringing treatment to these patients.

The great advance of the community mental health center approach is really treating the person in his environment, in his community. When we see people from the Newark area, which is where we're located, these people are seen very initially in their problem and part of our treatment approach is to involve the individual in context of his community and his society, which means we don't remove him from the community, from his family, from the social contacts and supports that he has but we administer his treatment right there. Really the community is part of our treatment approach and it's really using all the resources that are available in terms of his social supports, in terms of other agencies,

in terms of his home life.

Again, to take the concept of treatment rather than custodial care, for the past, I would say, 100 years or so, in terms of the State institutions - I don't want to criticize them too greatly, they certainly have their own problems - the approach to mental health care has been primarily one to remove the individual from society, from the community, and place him in a relatively pastoral setting, and the concept was that that individual would then get better, that being away from the pressure of the city and being in a country-type setting this would in some way produce a cure. This has really not been the case at all. What we found, unfortunately, is that the custodial care of patients, long-term care, has essentially produced more deterioration in the patients, more aggravation of the primary problem than the illness itself. In fact, it had gotten to the extent that it has really been demonstrated that we have what develops called a social breakdown syndrome, as was described by Dr. Gruenberg, an international Epidemiologist and Psychiatrist, in terms of being a psychotic illness which is really much more serious than the original illness itself. And this is really a product of the social isolation and sensory deprivation of the patients which often occurs in the kind of setting in which they have been cared for.

Instead the approach at our center is really in terms of a very brief, short-term type of therapy, as I say, crisis oriented, available when the treatment is necessary and really a range of modalities which ranges, as Monsignor began to describe, from a crisis or emergency service through immediate hospitalization, if necessary. This can be full hospitalization or it can be just a partial hospitalization. The great advantage of partial hospitalization is that we can provide supports for the patient during the day or during the evening and then release him to his home or his job or his school, whatever

the case may be, so that the care itself, the hospitalization does not really remove him from that situation.

When we talk in terms of duration of care, the average duration of care for an inpatient, for instance, would be something like three weeks. Very, very often in State institutions we talk in terms of years rather than weeks. And you can begin to see what the result would be in terms of my earlier comments about social breakdown.

I would also say that another great advantage of this type of system of care is the continuity of the care.

What also happens and what you will see, if you trace the cases of many of these patients who finally may wind up in custodial care for life or a suicide, or whatever, is that the care is fragmented and that, even though an excellent program of care can be given, essentially this care is not continuously available to the patient. So we get into the concept of after-care. A hospital at a distance from the patient's home finally cares for him and at some point in time he is discharged. What this often results in is a subsequent readmission, a month later or a year later, or whatever. So we see a pattern of what's often called a revolving door, in and out of the hospital. What's really necessary is for care to be continuous, that after discharge continuing care be available and accessible to the patient.

Again, the great advantage of the Center, which is right in the community, the patient continues in outpatient care which is essentially administered by the same individuals who treated him while he was in the inpatient facility. The relationships which are so important to the patient are made and continued in the same institution.

I think that essentially is what I want to get across. I just want to return again to what Mr. Fasulo said, I said that I think is essential. I can speak to a great extent in terms of the professional aspect and advantage of

this type of approach. On the other hand, if it's not financially possible, we run into a difficult situation. I know this may not directly concern me, but it certainly concern me when it becomes a problem of staffing, the kind of professional staff we would like to make available for these patients, we do get into the financial aspects which become quite crucial.

SENATOR HAGEDORN: Thank you very much, Doctor. You have a young lady with you?

DR. DUBLIS: Yes. Mrs. Monti I think will address some more of the details of our approach.

N A N C Y M O N T I: My name is Nancy Monti, Mount Carmel Guild.

I don't want to minimize the need for staffing. We all struggle with large caseloads and a lot of people that we serve. We've heard here today how additional staffing certainly would be desirable in hospitals and in the various institutions. However, I would like to address myself in terms of the therapeutic approach where I would see one of the main advantages of a comprehensive mental health center in terms of keeping the person in the community. Someone said previously how the person becomes annihilated from various community members and from their family, and I think this may be true when you really distance that person from the community in which they live, not to speak of the readjustment that the person must make going back into the community and the fear the parents or the fear of the spouse or family of the patient when the person comes back and they have not been really helped to understand what the illness is all about.

I feel very privileged to work in a comprehensive mental health center because I think that we can handle both aspects of this problem, where we can work with an inpatient and we can work with the family in terms of getting them to understand the illness so that the patient going back into the home, for example, may not be rejected

by that home out of near fear for what this illness really meant, and perhaps have to return to a State Hospital or an institution which could have been prevented.

Also, I think we shouldn't overlook the fact of the potential suicide. We talked here about a number of suicides but let's not minimize the numbers of people that hospitals and community mental health centers have helped in terms of prevention of suicide. I direct a suicide program that we have at Mount Carmel. Last year we received over 1500 distressed calls. I don't want to call them suicidal calls - this has all been documented in the State record in terms of our statistics - but of the 1500 about 155 people will walk in, about 50 of those were hospitalized as people in need of inpatient services. This is a 24 hour service. I think that a comprehensive mental health center affords 24 hour service, meaning when the patient needs the help they come in, not when an agency is ready to provide the help.

Also, Dr. Dublis has been very instrumental in creating a walk-in service which - I have enough years in mental health to know that waiting lists become really the thing we hate to talk about, they grow, there are growing waiting lists - so a person or a parent may come in for a child and they are told, sure we'll be willing to help you but, you know, you have a 6 weeks, 6 months to a year waiting list. How realistic is that? Well, at the Mount Carmel you don't even need an appointment, you come in.

Now many agencies use this approach too but don't offer professional help in terms of an immediate appointment.

And, again, I'm not minimizing the effectiveness of what they are offering in terms of support to parents or to patients themselves, but I do think that what we have is an ability to come in and see a psychiatrist on the first call, a clinician, to maintain that continuity of care by

having that very same professional who sees that patient the first time continue their interest in that patient. We don't shuffle our patients around. We, therefore, do need staff to be on an on-call basis, as Monsignor said; we do need to have competent people who focus on the treatment, a short term treatment. Our current caseloads are such that we handle approximately 3,000 or better unduplicated patients during the course of the year. As of the end of the third quarter, we had 2156 patients in active status.

We are very concerned about active status meaning just that, you know, continuing to come in on a regular basis. This is in all five phases of our Center. But we find ourselves handicapped by what we feel are good - a good approach to mental health, and I would like to explain that.

If we were to be concerned with money, which is a concern of everyone, I'm sure, then we would have the same patient come back three to four times for the diagnostic workup that we do on the one-time basis, yet we find ourselves penalized by trying to give an immediate and comprehensive care to the patient upon the first visit. For example, if a patient came in for an in-take, and then came in to see a clinician, and then came in to see a psychiatrist, and then came in maybe for psychological, and then came in for an interpretation of results, we could build five visits. But what we do, we have the patient come in and we have an in-take, we have a clinical study, we have a psychiatric evaluation all on the same day. But we can't bill for that comprehensive service. Because we have really been concerned about what the patient's needs are and focus on trying to give him some response before he returns home as to what we can provide in terms of his treatment, we are penalized in terms of the operational costs of our facilities. And

I feel this really should be looked at because agencies realistically have to look at what their costs are. It would be foolish for us not to admit to that. So that you begin to think, well, what are you going to do? You know, all of these people that have to come in, should we have them return three times and collect three times or should we provide the service that we in fact can provide on a one visit basis and then penalize the agency, which is what we are doing at the present time.

The other thing that I think is also something that we should all seriously look at is the transportation problems for medically indigent people. We are in a position to offer all kinds of service regardless of whether the patients can afford it or not. We will not penalize indigent people. But they still need the carfare to get to our place. They still need the money to buy their medication. Now we find our patients, who are not on Medicaid, for example, where they can in fact get their money, you know, to pay for their medication, will divide their dosage in an attempt to really economize. This is a realistic problem. I am sure all agencies know of this. They will feel better so they will save that pill, they'll save those two pills. They have no idea of what it means medically, what it means in terms of their improvement, but they are so concerned with the very realistic problem of paying for medication that what they do is compromise the amount of medication that they are taking.

State Hospitals do help in terms of giving free medication but it's unreal to expect a person to travel sixty and seventy miles back to a State Hospital to get some free medication. So the patient finds himself in a bind. Does he continue with the comprehensive mental health center, when they won't give him this free medication, or does he go back.

So this has, in fact, become a real problem for

us in terms of good patient care. Also, we can have the best going program in terms of partial hospitalization, having a patient come in five days a week, but then they turn to me and they say, "Mrs. Monti, how can I possibly come in five days a week? Who is going to give me the carfare?"

We provide hot lunches. We realize some of our patients, for example, felt uncomfortable because they didn't have lunch money. So we've developed a program to provide lunch to all so that the medically indigent person doesn't feel as though he's inferior in that grouping. And, you know, we've noticed these kinds of problems, but there is help needed not only for the Center but for the patients so that patients - and I've talked with people on welfare - to provide them with transportation. Now, about two years ago, I believe, they cut these funds, not from the agencies but from the people who are on Medicaid, who are on Welfare, to get transportation money to get the mental health services that are available. But they cannot partake of these services because they don't have the means to go in on a regular basis. And I feel that is providing a good program with lack of availability, not because we're not in the community but because these people just cannot afford to come in. And I feel that this is a very serious problem.

Also I would like to say that we have been very busy working on liaison with State Hospitals and we've gotten some cooperation in terms of working through our communication problems. But we have been keeping track of the number of patients from our area, Area 5, that have been admitted to Trenton and we are very pleased to say that we're getting one to two people admitted to Trenton on a monthly basis, which is a very minimal number. We would like to prevent even those one

to two. We would really like to work it out so that these people would first come to us and see if there isn't something we could provide them. We have made no referrals to Trenton State Hospital.

Now, of the 96 patients last year that we had hospitalized in our inpatient unit, only two returned to any State Hospital for any kind of treatment. And we find that oftentimes a patient wanders back on his own and if there were, again, better communications developed whereby we could find out before the patient is admitted then perhaps we could have the patient come back into the community and deal with him on that level.

So, again, just to reiterate on the suicides, I think we would like to stress that we should look, while we're looking at the numbers who have in fact been self-destructive, - let's also look at the numbers of people that we have been able to really prevent from self-destruction and not minimize that factor.

Thank you.

SENATOR HAGEDORN: I want to say that we have been privileged to listen to a very knowledgeable and dedicated young lady and I know that we are going to scrutinize all the testimony you have given and I hope that we can come up with some answers to your problems. Thank you.

MRS. MONTI: Thank you.

SENATOR HAGEDORN: Again may I say, thank you, to the staff, Monsignor Dooling of the Mount Carmel Guild. You have made a great contribution.

SENATOR HAGEDORN: At this time I would like to call Mrs. Louise Sowdon.

L O U I S E S O W D O N: My name is Louise Sowdon of 15 Dolores Drive, Montvale.

I am not prepared with a written statement here, but I am a former mental patient and I was written up by Mark Stewart of the Bergen Record on November 10th, which article has stirred considerable interest.

I am very fortunate to have recovered from many, many breakdowns, dating back from 1945. I was in Greystone Hospital once in 1956 and I was recently there for 14 months from October 1, 1969, to December 25, 1970. On December 26, 1970, I was fortunately transferred to Cornell Medical Center in White Plains where I made a miraculous recovery.

My experience at Greystone was very, very painful. I have expressed myself in this newspaper article. Senator Hagedorn has mentioned a few of the unsavory conditions up there. I witnessed today some people trying to defend what the Attendants do. Well, I know firsthand that the Attendants in two wards that I was in were the cruelest people I have ever met. They did not scrub the floors, clean the toilets or anything. We did.

I was under the care of two doctors, but I rarely saw them in 14 months. I gained more by talking to the social worker, whom I presume was a psychologist. There were some good things I enjoyed in Greystone. I have a title for a book I hope to write comparing my experience in Greystone to going to a private, very expensive hospital. My title will be, "Journey from Darkness into Light." There is no comparison. But, of course, it is a matter of dollars and cents.

The meals at Greystone, I was told by the nurse when I asked, cost 75 cents a day for three meals. In 14 months I lost 50 pounds. I developed low blood pressure. I was put on 12 different medications, which I wrote down when I got in the other hospital. They did nothing for me.

I am very fortunate to have gone to a private hospital,

fortunate that my former husband had sufficient insurance coverage. He still paid plenty of money for those months I was there. In 4 months' time, I knew I was getting better because I was taking a marvelous new medication, which I believe was discovered in Australia. It is still under research. It is an element called lithium carbonate. It only cost me 4 cents a capsule and I am now taking 3 a day - that's 12 cents. Before my divorce I was down to taking one a day. It is a miracle drug and I just can't tell you how impressed I am.

My brother was in Veterans' Hospital a year ago. I called his doctor and pleaded with her, "Would you please put my brother on lithium." But, oh, no, these hospitals like the county, State and Veterans' Administration hospitals cannot take the time to watch for the side effects of some wonderful drug.

I am just lucky. I got well and I am very grateful and I am hoping to become active in this group here, the Brightstones, and I am most sympathetic to all the parents who lost their children through suicide. I have attempted suicide numerous times. If I had stayed in Greystone, I probably would have done so too.

The Attendants, I think, are the most shameful things they have in that place. The verbal abuse I took was unbelievable.

I am going to work for mental health and I believe that the county I come from, Bergen County, is one of the wealthiest counties in the United States; I believe, and I think there should be more people who are tuned in to wanting to do something.

So I will do the best I can and if you have any questions, I will be glad to answer them.

SENATOR HAGEDORN: I have no questions, but we do appreciate your testimony and we hope and pray that you will work very arduously for mental health and help us all.

MRS. SOWDON: That hospital is in the dark ages.

SENATOR HAGEDORN: Mrs. Helen Kardash.

H E L E N K A R D A S H: My name is Mrs. Helen Kardash, 179 McDonald Drive in Wayne.

Every word she has said is the gospel truth. I could break down and not even go on any further. It is not only the patients who suffer, but the mothers, and I am sure Mrs. Terrafranca and the other ladies back there will verify that this is so.

I just want to say to the young lady there, the doctor and Father that you all have the right idea, but the doctor was right on to what is wrong with Greystone. There has to be a patient-attendant-doctor relationship, which does not exist in Greystone. The patients are punished. They are not helped. They are actually punished and I think this will be verified.

Another thing I want to make clear is that whoever told you the patients get medication free is wrong. We pay for the medication that we get. When they even go home for weekends, we pay for that. My son fortunately was insured, but the insurance ran out. The insurance company used to give me a rebate on it, but the hospital didn't give it to me.

I would like to start by saying the mentally ill and retarded patients cannot be generalized. Each person is a distinct individual and must be trained and influenced to live in our society. Also direction, guidance and human compassion must be improved and maintained by personnel to assure the patients the respect and dignity they deserve as citizens. We must not allow anyone to deprive them of their legal rights and we must change the public attitude and stigma of mental illness and retardation. This is cruel and uncalled for, particularly in these days of riots, drug addiction, destruction of public and private property and the shameless burning and abuse of our American flag.

Governor Hughes in 1965 stressed the fact that a great deal of difficulty at Greystone was a result of the impossibility of recruiting enough qualified attendants.

Mrs. Shirley Davis quit her job at Greystone at this time because of frustration and inability to get things done. She was a supervisor. She suggested smaller buildings to improve patient care. Dr. Weinberg's goal as temporary director was to build small cottages on the grounds. The State Board of Control refused to consider the proposal because they had already approved the 50 million Master Plan to centralize institutional operations into a mammoth fan-shaped building. This plan is and will continue to be a disaster as is the county system. Their plans, I and many others agree, are the main reason for all Greystone's problems.

In the 1969 investigation, the Mental Health Unit of New Jersey called Greystone "an antiquated conglomeration" where "custodial care" rather than "active treatment" is still the rule.

The New Jersey Psychiatric Association called the Department of Institutions and Agencies "a conglomerate agency where those responsible for the mentally ill must vie with prisons and justify that they are worth as much state money as some serving a term for murder or a violation of our laws."

Dr. A. Jacobson said "patients' needs are treatment, not closed doors," and he would like a study conducted to improve mental health programs.

October 20, 1969, the Herald News reported, "a break for the mentally ill by the Psychiatric Association." This program would provide new hope, facilities and programs. The article went on to say, culture centers we had to have, but the mental hospital has to get by as usual and the treatment of the mentally ill is not a credit to New Jersey.

The Daily Record reported that particular attention will be paid to the feasibility of removing the mental

health institutions from Institutions and Agencies. This must be done if these unfortunate human beings are to progress and improve for our society.

Our patients are handicapped not by their own choice or desires, and they cannot even defend themselves in those buildings now called "human warehouses," "house of horrors" and "snake pit."

Boredom - and this refers to what the doctor had to say - and being confined behind closed doors can be very depressing. Isolation breeds deterioration. Memory must be retained. Money isn't the cure-all.

In February of 1969, Representatave Charles Sandman reported: The lack of institutional facilities in the state is not due to lack of money, but because the Hughes' administration was more interested in hiring architects than building buildings.

The State built two 1,000-bed hospitals for the mentally retarded. The buildings are identical, but, instead of using the same plans for both, the State got a new architect, delaying construction for a whole year and wasting a half million dollars.

Our Holy and Happy Holidays will soon be here. I expected more Senators and Assemblymen here and this is why I wrote this. I appeal to every person in this room to help all the patients in our "human warehouses."

The patients and we, the parents, families and the dedicated "Brightstones" will beg, plead and do almost anything for your full support for the mentally ill and retarded.

We are human beings too and would like to share a little happiness not only at Christmas but every day of the year. You can do it and you will succeed if you can "temporarily" - and I have that underlined and in quotes so that I don't offend anyone - put your children, grand-children and others dear to you in the circumstances of our loved ones and we who suffer more, if that is possible,

for our long-forgotten, neglected and dehumanized "loved ones." And I sincerely mean that. They have been dehumanized and they are trying to do the same thing to the parents.

I have many things here. I have never met Mark Stewart. But Mark Stewart has printed several of my articles. I will just hold them up - "Broken bones and broken promises," etc. But I am not going to refer to mine.

I have something here from Assemblywoman Klein who is from Morris County. She visited Greystone Park and she said, "Conditions at Greystone State Hospital which is supposed to treat the mentally ill are enough to drive people insane instead." "One feels one's own sanity leaving when one enters the wards," - this was stated in a letter to Commissioner Robert Clifford of the State Department of Institutions and Agencies demanding more funds. I disagree with that to a certain degree. More funds are not going to correct the relationship between the attendants and the nurses and the patients. Money will not cure anything if there is not a good relationship. There has to be a good relationship. They are treated as prisoners, as I believe the lady before me said.

I have loads of these quotes. But with all these investigations that have gone on here and been reported, nothing has ever been followed up. As one girl reporter reports, everything is down to normal again, everybody has forgotten, the secrecy is all within the grey walls.

I have some comments by doctors which I think should be considered. These are only made by doctors who have dedicated themselves to mental illness. I will say what has been repeated before: Many doctors in Greystone -- and I have been going there nine years and find it more depressing every day I go -- are not qualified doctors. They are not really doctors. They have other titles and they are there under false pretense. And the doctor from Greystone was not really telling all that has been going on and there has been plenty. I was up to his office just the other day again.

I won't even give the complete comment of each doctor. But Dr. Menninger, who with his brother has dedicated his life to mental illness, said: It is the brains, not the bricks. They keep talking about building buildings, making Greystone this and making Greystone that. It is what goes on inside the buildings that is going to help the mentally ill.

Dr. Cole of Boston State, formerly of the National Institute of Mental Health at Bethseda, Washington, D. C. - and this is very important - found patients were disturbed by routine forms of treatment, restrictions on patients' movements for staff convenience, which is what goes on at Greystone, not for the welfare of the patient. He also stated that many times a patient's agitation was not always due to his illness, but a breakdown of relations between the staff and himself. Dr. Cole looks on an attendant as an important member of the treatment field, as a result his morale soars, his efficiency increases. Dr. Cole believes drugs can control but cannot treat; love, understanding and kindness used with different techniques have achieved significant results. Behind nearly every episode of seclusion, he found staff errors, staff weakness, ignorance, anger, inter-staff feuds and jail-house psychology.

Dr. Blain of Byberry, Philadelphia, said we have begun to function as a center, not a warehouse.- also, to short-change its mental hospitals is the poorest sort of false economy a state can practice.

Dr. O'Brien, St. Joseph's State Hospital in Missouri, was very dedicated to the mentally ill. He was very angry as he walked throubh the hospital saying, "These are our failures of the past and what is here to salvage so late? God knows! But we are going to try." Six months later his efforts were spectacularly visible. The wards are now empty. He was determined to make human beings of them again, and he did.

Dr. Davesin of Colorado State has said that patients respond when they are needed and useful to someone else and are entitled to dignity and respect. He also modestly says his only contribution to mental health was to bring the care of patients to a level good enough for my relatives and yours. And I don't think there is one person in Greystone who could say that and truly mean it.

I have just a few more here.

Dr. Burton Blatt wrote an article in 1967. All my relatives and friends, whenever they see anything, pick them up and send them to me. This is from the article. He says he is exasperated with institutional staffs that have offered excuses, rationalizations and explanations for their behavior. Inadequate budgets, over-crowded dormitories, are the poor excuses the institutional staff gives for the programs they conduct. Their actions speak primarily of their character. The retarded - and I will add the mentally ill - will not get the care and education they deserve until those who administer their needs become more rather than less sensitive. Dr. Blatt's final remark was: Perhaps we cannot stop the world in which children and adults are tortured, but we can reduce the number of tortured people.

There are many more, but I thought those were the most important.

My son Gary has been in Greystone nine years. He was born retarded, but no one knew about retardation then. When the first clinic opened in St. Mary's Hospital, he was diagnosed as retarded, but he was educable and he went to the educable classes until he was 16 1/2 when Wayne opened a new high school and wanted to limit the number of pupils in the school he was in. Gary is very shy and does not make friends easily. Most of those retarded and mentally ill are in the same category. They insisted on moving him. We were given the choice - either send him back to the school he was sent to or quit, which I think is disgraceful.

Wayne thinks they are so high up and that they know everything about education, but I consider that disgraceful. He was in a hospital in Summit, New Jersey, for three months. He was getting insulin treatments, I would say two and one-half months. In that time he bled internally and had convulsions and they had to stop. Once the treatment is over, these private hospitals are not interested in keeping the patient because the most money is in that area.

He did come home for a while and then in August we brought him back. In October there was no choice but to bring him to Greystone, and, believe me, I did it with great reluctance because Greystone already had a terrible reputation in 1963 when Gary got there.

When he first got there, Mr. Hopp -- rather Mr. -- well, his name doesn't mean that much. He was the technician on the ward and he insisted, which is not done now and is what is wrong with the system there - that the people that worked on the ward with him, the next shift and the third shift follow the same rules and regulations so that the patient would get accustomed to the same treatment. That's not true now. You approach somebody and they say, "I don't know. I just came on the ward." And you know darn well they are lying. They have absolutely no interest in the patients. I have been called a pest and it is passed down from one ward to another because I come to see my son every other day. He wouldn't even know his name. They say he doesn't talk now. Why should he? He is stuck in a hallway that isn't even as wide as this distance here with chairs lined there and there. I am not going to be stopped from taking him outside in the fresh air for a walk and having him sit comfortably in a chair for a while. I don't want anybody to call me a pest and I don't want anybody to send word from ward to w a r d to keep me waiting outside of locked doors. Every door you go into you have a 200-foot ward and a 75-foot hallway and for each door I have to wait

and then they pass the word down the line.

I am telling you what is happening now and I am very disturbed and I am sorry that Dr. Fenimore left. I am sure he heard part of this conversation.

They are starting a new program, but it really isn't new. When I started to tell Mr. Lyden, he left, because Mr. Lyden knows a lot more about mental health than anybody, I think, believes.

I and a few attendants that have been there a long time agree that changing the patients from ward to ward, upstairs and downstairs, is the worst thing they can do for anybody. When I came two weeks ago, they had him changed to another ward.

One of the gentleman got up. He said, "We're starting a new ward; I'd like to tell you all about it." While he was talking, Mr. Yore, who is ready to retire, joined us and I said, "Mr. Yore, you and I both know this is not really a new program." When my son first went there and a lot of the other people, they had locker attendants, they had shower attendants.

If anybody goes up to Greystone, you don't have to guess who are the mentally ill. Just look at their teeth. They are the ones who have the rottenest teeth you would ever want to see in the world. Nobody cares.

Now they are starting this program after so many years when nobody gave a darn. I am sure you have been up there. I know you have because one of my first articles here is about you. I have many more at home.

I am sure you know since they have medication, if they are left by themselves, they are not going to be very anxious to move around and they don't move fast. So consequently they get to the point where they look dirty, they are dirty, and their teeth are terribly neglected as is their health on the whole. The doctors walk through the wards, and that's it.

When this program is implemented, the idea is they have to ask for something if they want something. Then they will get a reward and they can come back, and they say the State gives them $25 for this purpose.

They told me that Gary doesn't talk. Now Gary has had three operations on his feet, three at Greystone and the fourth one, I took him out to St. Joseph's Hospital. It was performed by Dr. Santora. After the third operation, when he woke up, he said to me, "Ma, I had four injections and a nurse had to hold me down throughout the operation." He had a pin in his big toe this time. His toes went this way and underneath (indicating). And he had a cast up to his knee which he didn't have in the other two operations.

I was there the first day from one o'clock and at six o'clock when I left, he still hadn't had any medication for pain or for anything else. When they were coming around with the supper at 4:30, I very politely said to the attendant that was bringing them around, "Isn't Gary about due for his medication?" "I don't give medication and I don't know when he is due," he said. I don't think we have to be subjected to any such language by anybody because we pay taxes and they are getting paid.

After his third operation, I called his doctor when I got home and he said, "I left word he is to have medication in four hours and every four hours thereafter, and the following two days, every six hours." He didn't have any. This was Friday. Saturday he was still in good spirits. He wasn't a bit nervous, which I was afraid of. I was afraid really to see him go through this operation, but he came through it fine.

His father doesn't live with us, but he came on Sunday. When I came Monday, his hands were all clammy inside and ice cold and he didn't have a bit of color in his face. The regular doctors of the Medical Building were coming through the wards. The first doctor that I met, I spoke to when he got an infection in his left foot after the first

operation. I won't even try to remember his name now. I explained to him what happened. He said, "I think it is his nerves." Well, when the head doctor came, he said, "We will take his temperature." As a matter of fact, I was walking out of the door when he came in. He said, "Since they are taking his temperature, I will take a check and we will see what's wrong with him." I came back in the room and he had gone out another way. The nurse was still with him. I said, "Did the doctor find out what was wrong with Gary?" And she said, "No, but he said he is so cold that I should put another blanket on him." So she put a blanket on him.

He was taken out of bed the third day. I saw the doctor. There were things going on that made me feel he was not being taken care of properly. Dr. Anchia was across the room from where I was sitting and I motioned to him and he came over when he was finished what he was doing. He said, "Would you like Gary to go back to Ward 16 where he was?" Now this is where a patient was taking care of the men. This is the Men's Ward. This is a patient. And nobody can come close to him when it comes to treating the patients as Mr. Hopp because he himself knows what he went through. As the lady before me said, the attendants do not give the care they are supposed to give.

He sent him downstairs. This is the third day he is out of bed. We had to walk at least 75 feet down away from this building. No - then he walked. He had a walker. They took him down to the other buildings. There were two attendants. One was sitting in the TV room and the other one was down at the other end of the building. They never came to us. The attendant from upstairs came and gave her Gary's records and she walked away. He stood there and finally Mr. Hopp came out of the laundry room and got him a chair to sit down. By then I was beside myself. It was almost three o'clock. He got a chair out for me. When the attendant went down, I heard her say to the attendant who

brought his records down, "Is he back here again?"

Now is it any of her business? If he isn't treated well, if he needs medication, if he needs to have his feet taken care of, she is being paid to do this job. I was very upset and left by the side door. I wouldn't even ask her to open the door for me.

Now he has had a fourth operation. Since his third operation, he has been going downhill, downhill, and downhill. Whereas after the first operation, he improved so, mentally and physically, that the social worker -- He was operated on in April. In July I was taking him to the shore. The social worker passed and turned around and said, "Is that Gary?" I said, "Yes, I am very happy with him." She said, "Nobody could have convinced me that anybody could have improved that much in a different building in three months' time." And Father McMahon of Greystone said the same thing every time he passed, "I still can't get over it."

But now with this program -- I'm almost finished. I'm sorry to take up so much time. I think you will understand from the testimony you've heard and everybody else that will follow that there is definite neglect by the personnel and by Dr. Fenimore. Because he can do more. I don't want an answer like I got from one of the attendants when Gary was in the Bergen Building. I said to him, "Gary is supposed to be wearing white socks. I've brought so many socks in here. Why doesn't he wear them?" He said, "Go down and ask the supervisor." I did. I took him up on it. The supervisor said, "We can't do anything with him either." I think that should be corrected, and immediately. Because if they want a job and they want more money, they should do something to get that money.

I am almost finished. Getting to this token program, I go along with it. I go along with anything that they say is going to improve my son because he is a vegetable now. It is true that he doesn't talk unless I can reach

him by certain conversation. He went to the dentist. Twice he had an injection and once they had an oral surgeon there too because his teeth are so bad. When it came time to open his mouth, he wouldn't do it. They told me to go down and speak to him. When I explained the circumstances of the operation and of the other problems that he had, he said, "He has every reason not to open his mouth for us."

Anyway, as to this program, I wholeheartedly agree to anything they want to do, but are they doing it? That's the thing. When these men walk off the ward, are the attendants going to follow this through?

This is what happens. They have their breakfast at 6:30. They have their lunch at 11:30 and supper at 4:30. I bring milk and cookies in to Gary for an evening snack. The attendant definitely told me, "Don't you bring this in anymore because he is on the program." I went up to Dr. Fenimore's office and his secretary is an angel. She has been an angel to all the other previous doctors before him. She made several phone calls and one of the supervisors said, "Yes, this is the program. This is a follow-through."

I said, "I understood that it was not a follow-through." So she called somebody from the Social Services who would know more about this program. This person wasn't in the office. So she took me across the floor to where I would meet this person. Instead, the woman who started this program came and she said, "Are you waiting for someone?" I said, "Yes." She said, "I am in charge of the program and I am to take care of you." When I started to talk to her, the first thing she said to me was that the program does not exist at night. She said, "We would like it to. But there is no reason for anybody to tell you that you can't leave a quart of milk for two nights for him to have with a cookie." Now she degraded me to this extent - she even as much as said to me, "Why

don't you take him home?"

If I could have him home, which I did for many years, I would. It was only since last August that I haven't had him home. When he comes home now, he talks to himself just like he does there. Then he talks a little louder and he gets a little louder and a little louder, and the first thing you know, he gets up and throws a chair around. She said, "Why don't you let him throw the chairs around because he would get rid of all his frustrations." I said, "Unfortunately, I don't have a big enough house to throw chairs around."

Then she says to me, "Call up the Welfare Department and tell them that you cannot take care of your son alone and that they should send somebody to stay with you so that this person can take care of your son." I don't want that either. But until he can get in the Hunterdon Retarded School, for which I applied a year ago in August -- and I have two Congressmen working on it to help me. Until he gets in Hunterdon School, I want these conditions corrected and I don't want him moved from ward to ward simply because I know these men from a long time ago, and if I give them the milk, they are too darn lazy. They keep saying, "Oh, when this one comes on, he won't do what I tell him." I leave this milk with somebody that I know. She said to me, "Don't you leave that milk anymore." This I want corrected and I want them to stop moving him from ward to ward.

The ward he is in now is the worst one and he cannot be helped there. There is one who crawls around on his hands and knees. There is another one that can't stand up at all. God forgive me! I don't want to be mean to any of them because my son is mentally ill and retarded, both. But he should not be where people are worse than he. He should be with people who can help him, which is what they did before. The patients are more of a help than the attendants. Am I right?

I thank you for your time. I am sorry it took so long, but I have been holding this in for nine years and I had to get it out and I thank you very much.

SENATOR HAGEDORN: We appreciate your testimony, Mrs. Kardash, and hopefully there will be improvements as a result of this meeting today.

MR. KARDASH: There will be because now I don't bother to make any explanations to anyone else. I go up to Dr. Fenimore's office. I know he is available, but since he doesn't come out - he heard me talking one day and didn't turn around - he isn't interested - I will talk to his secretary because she really gets you right down to the person who is going to help you. She said to me, "Gosh, you sure have been through an awful lot." I do appreciate there is someone there who cares.

SENATOR HAGEDORN: Thank you.

Mrs. Rudner of the New Jersey Association for Mental Health.

A N N A L O U I S E R U D N E R: I am Anna Louise Rudner, Chairman of the Mental Health Services Committee of the New Jersey Association for Mental Health, which is composed of State Association and Chapter board members. I have served six years as a vice president of the Monmouth County Mental Health Association and Chairman of that Association's program for Bridgeway House, a psychiatric rehabilitation facility. In 1947, I was one of the first volunteers to work with patients at Marlboro State Hospital. My interest is the patient.

I am practically in tears after listening to the last testimony because I have visited Greystone. I have seen the people sitting there who appeared to be 60 years old and probably are 40 or 45. They have lack of physical activity and they are quickly deteriorating. It is because of these impressions that I wanted to come today and speak.

Many years ago the Council of State Governments

stated that when a state commits a patient and removes from him the choice of where he shall live or who his physician shall be, it obligates itself to provide him with the best that science has to offer toward his treatment and mode of living. New Jersey falls disgracefully short in its responsibilities to the mentally ill.

The periodic scandals at Greystone, the suicides and other unusual deaths, not only at Greystone but in the other hospitals as well, are vivid examples of a sick system. The American Psychiatric Association study teams stated that in no hospital did they fail to see evidences of dehumanization caused not only by the physical setting but also by administrative practices or by attitudes on the part of personnel.

Governor Cahill at the time of his visit to Greystone State Hospital found conditions, in his words, "deplorable." Mrs. Cahill upon visiting Trenton State Hospital - and I was there with her - was visibly shaken and moved to tears.

It does not require a scientific background or a great deal of observation to realize that one has entered the land of the living dead in a state hospital.

Although we as Mental Health Association volunteers regularly visit our state hospitals, our reactions remain as painful as though we were entering for the first time.

One of the first things you notice about a state hospital is its characteristic odor. It hits you at the front door and gets worse as you approach certain wards. There is no language to describe this institutional smell. By mid-winter it is almost over-powering. Most state hospitals have antiquated heating systems without thermostats. There is one choice regarding heat -- fullblast or none. Often the heat in these ancient buildings if overwhelming, and the low humidity in combination with the heat is reminiscent, appropriately enough, of Death Valley.

The patients come as a shock. They always seem older, more lumpy, and bedraggled than people outside. Actually

it is the absence of clothes, makeup, and often teeth.

Many people may have the naive assumption that a hospital is a place for treatment. Yet the Joint Commission on Mental Illness and Health, in Action for Mental Health 1961, reported that "More than half of state hospital inmates receive no active treatment of any kind intended to improve their condition."

In testimony given at the time of the APA hearings, physicians from our state hospitals gave accounts of sixty deaths from an influenza epidemic. These were due to lack of staff, overcrowding, and a simple absence of medication and intravenous fluids. They told of epidemics of amoebic dysentery and tuberculosis which were reported to the Department of Institutions and Agencies and treated with a casual silence.

Who cares enough to want to destroy these monuments to man's inhumanity? Most of us get over our shock and pass on to other things. Who is responsible? We know these conditions exist. Are we, therefore, responsible?

It is indeed regrettable that an occasion such as this - a hearing on an unusual number of suicides - should be required to move us. It is futile to make a single recommendation or even a dozen of them when the entire system is at fault. We do believe, however, that in addition to the investigations surrounding the suicides independent medical review teams should be assigned on-going responsibility for investigating circumstances surrounding all deaths in the hospitals.

This, at least until New Jersey no longer maintains warehouses for its elderly, its alcoholics and its mentally ill. As representatives of the Mental Health Association supporting Senator Hagedorn's efforts and the efforts of this committee, we prayerfully hope that day is not far off.

We also intend to testify on December 7th on the separate department.

SENATOR HAGEDORN: Thank you very much, Mrs. Rudner. We are very mindful of the great interest manifested by the New Jersey Mental Health Association and I know with their help we are going to bring about corrections in the evils that we have heard about this morning.

MRS. RUDNER: Thank you.

SENATOR HAGEDORN: Mr. Stephen Nagler of the American Civil Liberties Union. After this speaker, we will declare a recess.

S T E P H E N M. N A G L E R: Senator Hagedorn, my name is Stephen M. Nagler. I am Executive Director of the American Civil Liberties Union of New Jersey. We are an organization of 8,000 members in the State of New Jersey and I, myself, live in the City of Newark.

For sometime much attention, including attention of our organization, has focussed, particularly in recent years, on the inadequacies of our nation's and our states' prisons. Experts have said with considerable justification that prisons are viewed by our society as places in which we lock up society's problems, without making a genuine effort to provide rehabilitation.

The best that may be said of our penal system is that those confined behind its walls have been found guilty of committing some wrong against society after a trial in which they were accorded substantially due process of law in all of its splendor.

It must impress anyone familiar with our so-called mental health system in our State that many of the statements applicable to corrections apply here as well. Indeed those who are identified as mentally ill are locked up and hidden away without a genuine effort to provide rehabilitation.

If the prisoner is distinguishable from the mental patient, it is in that he has received far more in the form of due process of law. The other distinction, of

course, is that the mental patient has committed no wrong against society for which he may be said, even by the most conservative observer, to deserve punishment.

Some may debate what is to us an abundantly obvious proposition that the rehabilitation of prisoners serves society's best interests, but there is no argument whatsoever that people who are ill deserve treatment. Indeed, the involuntary confinement of a citizen against his will can have no other fundamental social justification.

Yet the record of our State in this area is nothing short of shameful. Consider, if you will, the plight of the family of modest means, never mind the poor. I think most of the people who you see here today whose families have been confronted with problems of this sort are not those who might be classified as poor. Those, I think, seldom come forth at hearings such as this. But a family even of modest means confronted by a serious problem of mental illness of one sort or another, for geographical reasons or reasons stemming from the acuteness of the illness, may not be able to secure help from one of the new and promising outpatient clinical facilities which have just began to spring up in our State. They will not be able to afford the extraordinarily high cost of private psychiatric care, much less the astronomical cost of institutions such as perhaps the Carrier Clinic, for medical costs in our State and in our country are high and costs for specialized care, such as psychiatry, are indeed astronomical. They would usually find available to them only one alternative, the county or State mental hospital.

These clearly are institutions which with few exceptions are totally incapable of providing adequate treatment, as you have already heard. Even the salaries offered by these institutions are commonly inadequate to compete in the market place for the best qualified professionals. Even beyond that, budgets do not provide for adequate ratios of professionals to patients to make meaningful treatment

programs possible.

The concept of a right to treatment, recently announced in Wyatt versus Stickney in Alabama, and echoed to some extent by the Appellate Division of our own Superior Court, is a mockery in our own State in our own time.

Let me turn for a moment, if I may, to custody. For at least if our State is not going to observe the right of mental patients to adequate treatment, the circumstances of their confinement should at least be conducive to rehabilitation.

The truth, however, is that custodial circumstances provided in typical State and county facilities with which we are familiar provide conditions which far more frequently contribute to patients' deterioration than to rehabilitation or even the maintenance of a status quo.

There are former patients from Greystone, Trenton State, Bergen Pines, Overbrook, Meadowview and other institutions who would swear to you that they would sooner die than return to those facilities under any circumstances. Conditions in many wards assault the senses. The stench perhaps first strikes our nostrils. The sores afflict our eyes. The filth offends our touch. The cries for attention where silence and stupor do not govern assault our ears. People sit for years and rot in these conditions. They are guilty of no crime. It is, if anything, we and our society as a whole who are guilty of the crime of neglect.

Stories that come to us are legion - individuals who describe members of their families confronted by hostile staffs that care little about conditions of the patients for whom they have responsibility. In one situation in Bergen Pines we were told by an employee of the hospital of a case in which the staff decided that a prescription from a psychiatrist for 50 milligrams of a particular drug three times a day was just as well administered in doses

of 100 milligrams twice a day, and it was easier. It required less attention - it required less time. Stories of visitors to institutions, volunteers, to whom the hospital owes no obligation and who in turn owe no obligation other than their own conscience to the hospital, tell us of visiting Greystone and seeing patients crying for attention and seeing attendants sitting in small ante-rooms playing cards.

I think this kind of neglect must be reviewed by our State, not simply from the standpoint of the horror stories that may arise - and indeed the horror stories are legion - but from the standpoint of establishing as a matter of law within our State the concept of a right to treatment, the concept that any individual within our society, confronted with a problem of mental illness, has that fundamental right to receive the treatment from the State, to receive the treatment from our society which would be required.

That is what the case of Wyatt versus Stickney begins to speak to. It begins to establish minimal requirements in the State of Alabama for the provision of care and treatment of patients in these institutions. Some have suggested that it will be impossible for the State of Alabama to provide the level of care and treatment that the Wyatt Case required. Yet the court has required it and Alabama is under judicial obligation to provide it and somehow or other it will find the means and the wherewithal to provide it.

I suggest that if the State of Alabama is capable of providing it with their even more limited facilities and even more limited professional population, then our own State could provide it much more readily and should do so without the requirement of a court order, which I suggest is likely to come about in the immediate future, if such does not flow from the beneficence of the State,

itself.

I suggest that beyond the right to treatment, a total reexamination of commitment procedures be looked into. That, Professor Alex Brooks from Rutgers Law School will be here to discuss this afternoon in greater detail with your leave.

I suggest also that the entire concept of confinement in institutions be reviewed from the standpoint that in our country and in our State it has failed, that what is needed today is a new approach to problems of mental health and an expansion and fulfillment of early measures that have taken place in the area of establishing community mental health facilities capable of providing citizens with needed mental health treatment, particularly on an outpatient basis, in their own homes and in an environment which, unlike our State and county hospitals, will not be hostile, but will be one in which they feel somewhat more at ease.

There is so much more to be said and I personally apologize for having failed to find the opportunity in the past day and a half to prepare more fully. I suggest, with the consent of your Committee, we will prepare and will submit fuller details in terms of our recommendations in the immediate future.

I thank you for your consideration.

SENATOR HAGEDORN: Thank you. And we will be happy to receive these recommendations.

MR. NAGLER: Thank you, Senator.

SENATOR HAGEDORN: At this time I would like to declare a recess so everybody can get a rest and a little refreshment. We will reconvene at 1:30 P.M.

(Recess for Lunch)

(Afternoon Session)

SENATOR HAGEDORN: The hearing will resume and the first individual to testify will be Bernard Berg who is the Student Coordinator of the Brightstone Volunteers at Fairleigh Dickinson University, Rutherford Campus.

B E R N A R D B E R G: My name is Bernard Berg. I live at 23A Pardlon Road, North Brunswick, New Jersey. I am the Student Coordinator of the Brightstone Volunteers of the Rutherford Campus of Fairleigh Dickenson University. I've belonged to this organization for over a year during which time I visited several mental institutions in the State of New Jersey but I will now limit myself to Greystone Park which I have visited about one-half dozen times over the year.

The first time I went there I was appalled at the conditions. I found patients living in a room no bigger than 8' x 12'. That is not one patient; that is two patients with two beds in the room; there is barely enough room for both of them to stand at the same time. I found broken light bulbs in the light fixtures in their rooms. I found food splattered over the ceiling and over the wall. We went there to paint. It was impossible to paint over the food, you couldn't even scrape it off. It was there for a long, long, time.

I found the bathrooms - that was the worst in the whole hospital - they were smelling from human waste. We tried to paint the walls. In one, the walls were so bad they were crumbling. We couldn't scrape them to paint them.

If I am painting a depressing picture, it is because that is exactly what the hospital is, at least to me, depressing.

As you stated, I do attend Fairleigh Dickinson University. I am a psychology student and I know that is no was to treat people. Everyone knows a little

psychology. Your environment affects your behavior. On a sunny day you are happier than you are on a rainy day. The same thing goes for the patients. If you are in a depressed atmosphere, you are going to be depressed and most of the patients are there because they are depressed.

One of the purposes of our volunteer group, the Brightstones, is to try to make it a little more cheerful and take away a little of the depression by painting and fixing up, cleaning up. I was hoping that the money we saved the State by doing this, by painting, by fixing, the State would use to hire new doctors, new aids, new nurses, to prevent a catastrophe such as the suicides you get. Thank you.

SENATOR HAGEDORN: We appreciate your interest and your comments and are delighted to know that in our younger generation there is this great interest in one of the perplexing problems our our society.

The next person I would like to call upon is Richard Garvin.

R I C H A R D G A R V I N: My name is Richard Garvin. I live at 301 Main Street in Riverton which is in Burlington County. I was employed for the past two years in the high school in Wayne, New Jersey and I am presently working at Pemberton Township High School in Pemberton.

I have been with the Brightstone Volunteers from almost the very beginning, which has been about two years, and we really had a fight to get into Greystone Hospital. It seems they wanted to lock us out when all we were trying to do was volunteer our time, free time that they didn't have to pay for, to help improve the conditions of the institution and, consequently, the conditions of the patients.

Things I saw there have been documented by the past few people who have been up here. They have told

you about the stench of the wash rooms, the dirtiness, the general filth, the crumbling walls - which incidentally can fall apart at the touch of a paint brush - the lack of care on the part of the attendants. I can go on and one and you have heard this before. I am really getting fighting mad about the whole thing. Maybe it is my red hair; I lose my temper. Nevertheless when you see people living in conditions like this where there is a room that I can only describe as being out of medieval Europe, just walls maybe 8' x 12' - I think we measured 7' x 11' - nothing to sleep on, if you have to relieve yourself no place to go - food, I think, is shoved under the door - this is occupied by not one person but two people - this is unbelievable that this exists in 20th century America. It is really shocking.

I'd also like to make a comment about the emptiness of the room here. It seems like, Senator, you are the only one here from the legislative body, which we are glad of. You have done a lot. However, I was wondering about the Board of Trustees for the Department of Institutions and Agencies. I was wondering if they would be around to take notes or listen in or try to heed our message here today.

SENATOR HAGEDORN: They have all been invited but I observe the same thing, the absence of the people that are really managing the whole program, the Board of Institutional Trustees. It would seem to me that this is one part of our problem; they should be here helping us to correct all these evils and distresses that we have listened to this morning.

MR. GARVIN: Well, I hope the next time - I hope there isn't a next time, I hope it gets done right now - they hear our message.

Greystone, to me, is a symbol of something that we will have to overcome and we have made a lot of progress but we have a long way to go. It is more than just painting the walls; I guess, it's getting the community

involved, getting the young people involved, getting just everyone in there fighting.

What the people have said about the attendants I guess for the most part would be true but I would like to compliment the painters at Greystone. They have really done a good job. I guess there is about one-half dozen of them. They are really great guys to work with. They really sweat when they are out there with the kids and they should be commended because they do a full days work.

That is all I have to say right now. Thank you.

SENATOR HAGEDORN: Again we thank you as one of the members of the younger generation for having such a real interest in this problem.

MR. GARVIN: Thank you, Senator.

SENATOR HAGEDORN: Is Lydia Paderi present?

L Y D I A P A D E R I: I just want to talk about some of the things I have noticed and seen while in Greystone on about four occasions this year. The first Sunday of this last month we went with a group of visitors to Greystone and later on we gave a ward party for the patients. I was talking to one of the patients and she mentioned to me that there had been no attendant in that day and she had not received her medication all day. There were about 45 patients in that ward and none of them had received any sort of medicine or anything they needed. On top of that there was filth on the floors, there are cock roaches crawling all around in the places where they eat and sleep. There is food all over the walls. I really don't see how we can let another human being live under conditions like that.

That is all I have to say.

SENATOR HAGEDORN: Thank you so much and again, we are overwhelmed and reassured by the fact that you young people are so vitally interested.

Is Linda Puntasecca present?

L I N D A P U N T A S E C C A: My name is Linda Puntasecca and I live at 70 West Hunter Avenue, Maywood, New Jersey.

I have been in Brightstone for about two years now and almost every time that we have gone to Greystone I have been there and I haven't seen any improvements at all over the conditions there since I have been going. It is really disgusting when you go in there. I know you have seen it but maybe some of the people here haven't. I have talked to some of the patients. For instance, one time we had a party instead of a paint-in there and we were circulating around talking to all of the patients and I was talking to this one woman that really got to me. She said that she didn't have any hope at all of getting out. She said, "I realize there is something wrong with me that has to be treated but it is not my fault and why do I have to be punished for it?"

I remember someone else said something about how the patients thought they were being punished. I got it first hand from this one woman. She said that things that went on in her ward were unbelievable and that it was covered up so much people didn't know about it. She said that the people around her - there had been cases where the patients were left alone when they shouldn't have been and that they had gotten into fights. One woman's eye was poked out. Things like this happened. She said everyone was in the same place when these fights went on.

I think in order for people to have some hope of recovering they have to have self-respect and this is one thing that the patients are not given, a chance to have any self-respect at all. They are in this place. It is really dirty; it is disgusting. There are bugs and things like this, things that if you were in a home like this you couldn't take it. There is nothing they can do about it and I know that if I had a child who was mentally ill

or mentally retarded, if I had to move out of the State, give up a job or anything like that to go to some better place than that, I would do it because I couldn't have it on my conscience that I had put someone in a place like that to suffer. That is all I have to say.

SENATOR HAGEDORN: Well, again, we thank you, Linda, for your interest and for your contribution to this hearing.

Is Frank Foster present?

F R A N K F O S T E R: Thank you, Senator. My name is Frank Foster. I am a senior at Hackensack High School and I have been a member of the Brightstone Volunteers for about a year, I guess.

Now a lot of things I wanted to say this afternoon have already been said so I guess that takes care of it. But I have a few things on my paper here. I don't claim to be an expert in the field of mental health but for the past year I have been visiting Greystone Hospital and I have noticed the conditions and I have spoken to the patients. I feel that patients cannot be cured under conditions such as these. There is an inadequate amount of attendants in the hospital itself. The living conditions are completely dehumanizing and the attendants beat the patients fairly regularly from what I understand. I can't see how conditions like these are going to prevent suicides and cure the patients. That is just my own opinion.

I guess in conclusion I would like to say while I was sitting in the back of the room before, listening to what was going on, I was looking around the room and it came to my attention that the seal of New Jersey is up on the wall above the Chamber here and at the bottom of the seal it says, "Liberty and Prosperity." Now, what kind of a chance are we giving the 7,500 patients in New Jersey for liberty and prosperity?

Thank you.

SENATOR HAGEDORN: That is a good observation,

Frank, and we, again, appreciate your testimony.

Is there anyone else from the Brightstones who wishes to testify? If not, I would just like to say thank you to this younger group and I really feel that they are going to give us a message. They certainly have manifested a great interest in mental health care to the embarrassment, I would think, of some of our older generation, and we look to them to help move this program forward under the direction of John Lyden, who has taken time out to come here today. We express our thanks to you, John, and to the young men and ladies that have come to testify and we are looking forward to your great assistance as we try to generate greater interest in mental health.

One of the problems I face in conducting this hearing is to bring before us people to testify that have been the victims of these tragedies. It is not really easy for anyone who has suffered these torments to come and say what is in their heart but we are grateful, indeed, that some have come and the first person I would like to ask to testify would be Mrs. Terrafranca.

M R S. C H R I S T I N E T E R R A F R A N C A: I am Mrs. Christine Terrafranca, Executive Director of Brightstone and mother of Larry Terrafranca who was a patient at Greystone for two years. Larry is now with God. He fell, or jumped, from the Washington Bridge on September 13th on his fourth walk away from Greystone. He went to God.

We are grateful for the many happy years we had with him, but we will miss him. He had so much to offer. He loved the great outdoors, to run, to hike, to take one-hundred-mile bike trips and sail his boat on Cape Ann. He spent the last two years of his life at Greystone. He had wanted to be a teacher and had his Masters from Fordham. He had so much to offer.

I am here in the hope that I can spread the word to as many as I can that mental illness can be cured.

We are not in the dark ages. However, until the average person knows this and can speak freely about mental illness, little progress can be made to combat it. Like cancer, which was an unmentionable word only a few years ago, but since it has become an accepted word, progress has been made. Only when mental illness is recognized as curable, and it can be cured, and only when we can mention it, can we make any progress in this field. But we are not curing them in New Jersey, we are making custodial cases, 30 or 40 year custodial cases, because of antiquated procedures.

For instance, Mrs. Sowdon, who testified here today, was at Greystone for one year diagnosed as a schizophrenic and given 12 different medications, none of which worked. She was fortunate enough to go to a New York private hospital later and she was immediately put on Lithium. In seven months she was released and is now a productive, tax-paying citizen, an eloquent, charming woman working and running her own home. If she had stayed at Greystone, she would have been a custodial patient for 30 years at a cost of thousands and at a cost of great misery for herself and her family.

Now with three 4¢ pills, 12¢ total daily, that is all, 12¢, she is fine. What price economy? I am saying this because I am begging, literally begging the people of New Jersey not to let what happened to me happen to them, and it can happen. We never thought it would happen to us.

An auto accident with even slight brain damage, even no damage, just the pressure of a big suit from an auto accident can make one mentally ill. I have seen patients made ill just from suits. Senility, menopausal symptoms, a bang on the head, so many things can cause mental illness. Then what? The long horrible road to Greystone or a move out-of-State to California, Colorado, or one of the other more progressive states.

But, please, if you are in New Jersey what can you do but go to Greystone unless one is wealthy?

Then you are introduced to Greystone, dismal depressing areas, bad food, lack of attendants, overworked attendants some or whom are wonderful and concerned but, still, overworked, who do not have the time for patients and patients need concern and love. If your son is suicidal, as mine was, he may be confined to a ward for months with no occupational therapy on wards, with his only companions those as ill as himself. He will then only get worse.

My son told me two years ago he would never get better at Greystone because no one really cared there. It was so impersonal. He said he would only get well at home and he was so right.

Why is it that at Greystone these conditions are allowed to exist? Anyone visiting Greystone has to pound on a door to a ward for ten minutes while patients shout down long corridors for an attendant to come and open the door. This can make any visitor nervous, worried and depressed. Why the degrading toilet facilities? Why is there a community sheet for all the patients to dry themselves with after showers? Why no table napkins? Why so many flies, even in winter, on food, on everything? If we went to visit my son we had to cover what we were eating to keep the flies off the food. My son needed an injection and I used to worry about flies getting on the needles. He would then get hepatitis. How he didn't, I don't know. Mice were running rampant in the dining room so I was afraid to put my tote bag down. I thought they would jump into the bag and I would carry them home. Why 45 patients and one attendant or, at times, no attendant? This is so tempting to the patients. In a case like this they can dispose of medications that are given them and then the doctors wonder why the patients don't get well. If no one is watching that

they take the medication, it can disappear very easily.

I would like to know why my son was sent to occupational therapy where the doors are left open. If he was sent to ward 8, which is a horrible ward, because he supposedly needed to be watched closely, why was he then sent to an unguarded area? Was he sent to ward 8 for punishment? Is Greystone part of the penal system or is it a hospital? I thought we were supposed to try to help patients, not punish them.

I would like to comment on Dr. Fenimore's statement that my son left the hospital three times and reached the bridge. The first time he left the hospital he had the good fortune to be picked up by a friend on the highway, a friend from Fordham. Meeting a friend changed his mind and he went back to Greystone; Greystone did not bring him back.

The second time he left Greystone he came home. He went to the bridge but he changed his mind. He had hope, so he came home. We spent a wonderful day and night together. We brought him back to Greystone the next day. Then he lost all hope, he was back in Greystone.

The third time he left Greystone, and mind you he was allowed to walk away a third time within a short period of time, he went to the George Washington Bridge and the hospital did bring him back from the bridge.

The fourth time nobody brought him back. That is all I have to say.

SENATOR HAGEDORN: Thank you very much, Mrs. Terrafranka. We sympathize with your great problem at this time.

Is Anita Bomm present?

A N I T A B O M M: I am a mother of a son who committed himself two months after he graduated from college because he felt like he wanted to commit suicide. I was told by Bergen Pines that he would be helped at Greystone, which I believed. But, when I got there, the impression I got

was that Greystone was a prison, not a hospital. Of course, I broke down like I am now and they would not let me see Robert for two weeks.

He wrote home and said, "Mother, please, take me out of here; this is terrible." When I went to see him two weeks later and I saw ward 8 it was terrible.

Another two bad experiences that he had was the time that he was ill and they did not know that he was ill. They had him strapped to a bed with all the mess; I don't know how long he had been lying there. When the doctor went to see him,he had pneumonia. He had dehydrated too.

The next time, which was last Thanksgiving, he had a broken nose, two colored fellows beat him.

These are the tragic things that happen at Greystone and I am not as brave as Mrs. Terrafranca. I am ashamed of myself for breaking up like this but Bob really has had his spirits broken at Greystone. He is not the brave boy and the ambitious boy that he was before he went there. He thought he would get help there but he didn't. He is the most dispirited boy I have ever seen and he can't seem to get back to what he really should be.

I think that is all I have to say, Senator. The only other thing I want to say is that we have no place to put our children that are sick. He spent two weeks at Bergen Pines and I got a bill of $1,068.

Now I pray that somehow we get a place for these deserving sick people. That is all I have to say. Thank you.

SENATOR HAGEDORN: Thank you very much for your contribution.

Is Professor Brooks present?

(not present)

Then may I ask Mr. Terrafranca to give testimony?

P E T E R T E R R A F R A N C A: My name is Peter Terrafranca, the father of Lawrence Terrafranca, one of the three suicides.

I am a professional architect and I design institutional buildings. I have had 24 years doing this kind of work and I could say a great deal about the decadence of our Greystone establishments.

I am also a member, and a very proud member of the Brightstone Volunteers. As you know, my wife told you, our son died recently on September 13th. We are going to miss him a great deal. We have a tremendous family. We had four kids, two sons, Peter is now 27 and Larry was 26. We have Marguerite who is 18½ and Mary who is 14. This guy, Larry, loved these kids tremendously. The void that is in their lives is indescribable.

I can only say that Mary, at 14, a beautiful little blond kid, is now developing an ulcer, we think. She won't tell us but she misses her brother so much. I can only say this, and I really mean this from the bottom of my heart, much as I am going to miss Lawrence, I thank God that he is in heaven and not in that hell-hole known as Greystone.

He was a fine son in every regard. He was a good kid from the very beginning. He was an Eagle Scout to give you an idea - and you parents here know what it means to bring a kid up to Eagle Scout. He enjoyed track at Fordham Prep. He loved to sail, as Chris said. He was a tremendous cyclist. He loved the outdoors. They put him in ward 8, recently before he died, in that horrible area which is in the basement, on concrete floors, mind you. How would you like to live in the cellar? When you get tired and haven't got a place to lie down because you are overmedicated, you lie on the ground on the concrete. This is the hellhole that they were living in and are still living in.

Larry was a gentleman. His confessor and his councellor down there can tell you this, Father William Hays and Father McMahon. He cared about his fellow man. He took care of the aged that were down there,

geriatrics, people that don't belong in that hospital. He took care of the sick. He cleaned the dining room floor. You couldn't tell the pattern of the floor but he cleaned it until he finally gave up. He was in despair, he couldn't take the place.

He wanted to obtain a Doctorate. He was a great scholar of the classics, a Greek and Latin honor scholar, but he never got his Doctorate because of this idiotic war, Vietnam, where many of our good young men have died and have been maimed. We speak about the dead but we never speak about the maimed, physically and mentally. We are going to have to contend with much of that yet before much more time passes and when that war is over.

I can only say that it was a terrible waste. As he said to me, 'Pop, I don't mind dying for my country but what the hell are we dying for?" So, my other son volunteered and spent three years in the Army and went to Viet Nam and received his wish, he never shot a man or hurt anyone over there, thank God. Only because we implored the Almighty, I think we received that grace.

Before we came here somebody in our Brightstone Committee, Nancy Giavasi, who was appointed by the Governor to one of our institutions for the retarded, joined a prayer group and I was asked to go over there on the Tuesday before Larry died. I met this most marvellous group of people. They introduced me to this bible. It is mine, I have had it around the house but they said, if you look into it from time to time, the Lord will speak to you, if you keep His commandments, if you do His will, if you love your fellow man. I haven't done these things very well in my life but I tried. One day Chris and I were approached by our friends and they said, "why don't you have a Senatorial investigation?" We thought about it a bit and I said, "let's pray on it."

We opened the book to Luke 12 and it said, "open and feel the speech." I'd like to read a little of this for the edification of all of us here. "Meanwhile the people had gathered in their thousands so that they were treading on one another, and he began to speak first of all to his disciples, 'Be on your guard against the yeast of the Pharisees that is the hypocrisy. Everything that is now covered will be uncovered and everything now hidden will be made clear for this reason, whatever you have said in the dark will be heard in the daylight, and what you have whispered in hidden places will be proclaimed on the housetops.'

"To you my friends I say, do not be afraid of those who kill the body"- and certainly they killed my son - "and after that can do no more. I will tell you whom to fear: fear him who, after he has killed, has the power to cast into hell; yes, I tell you fear him!" And it goes on like that. At the very end it said - 11 to 12 - "when they take you before synagogues and magistrates and authorities, do not worry about how to defend yourselves or what to say because when the time comes the Holy Spirit will teach you what you must say."

You know, many people say that God does terrible things to people. My son was not killed by God, He permitted Larry's death. He permitted Larry to steal out of that hospital somehow, find his way to the Washington Bridge - and by the way, the police did not patrol that bridge, they were at Fort Lee, they were notified, but nobody went beyond that point, to my knowledge. I'd like to have that investigated - he was smart enough to go to the next bridge, the Washington Bridge, the one beyond, and that is where he went to his death.

I might add this too, when we saw him at the wake, even though he missed the water by about seven feet, he hit the ground from that terrible height, and his face and his head and hands were not even scratched.

This was a consolation from Almighty God and I think unfortunately we don't look to Him enough for the aid that we are going to have to have and need, because we are only human.

I am going to say this, Senator Hagedorn is reflected in this Gospel that I read today because he has done a great deal, and is doing a great deal. I want to say this, I had a prepared statement that I tried to write while I was here today and in it I say, Senator Hagedorn, we appreciate what you have done and are trying to do for mental health and you are to be commended for your compassion and concern but what puzzles me is, why do we have to wait for the loss of three fine young men before an investigation into Greystone and its decadence takes place? It is much like a railroad crossing in River Edge, where we come from. I don't know how many people died at the crossing before they put up the gates to protect other lives and limbs. As a matter of fact, I almost got hit by a train and I wouldn't have even been here today if I did.

Governor Cahill visited Greystone and was eloquent in his expression of horror and sorrow at what he saw 2½ years ago. I know he is interested and we need his help. He saw, as we all have seen, the degrading and dehumanizing conditions that prevail. The only improvement we can note is what the dedication and hard work of 2,500 high school and college Brightstone Volunteers made by their painting, their cleaning of the many neglected areas of not only Greystone but, many of you have probably heard, they have done work at Overbrook and also Meadowview in Secaucus and so many other places. We did six, I think, in one Sunday. They brought music and love and compassion - there is something that is lacking at Greystone, compassion - and caring to the patients. These marvelous, magnificant kids, all under the fine leadership of John Lyden, an

incredible human being, and I know he doesn't even want me to mention his name. The kids are what matter in our lives because they are the ones who do the work, the dirty work.

Larry first went to Holy Name Hospital. I want to tell you a little about the history of Lawrence. Three years ago, December, he said, "Pop, I want to go to the hospital, I am going to die today, I feel I am going to die." He couldn't go on any longer. So I drove him to Holy Name Hospital. We employed specialists, I think I had five doctors work on him. They worked for six weeks. We had no insurance on him because he was already of age and I told him,"I want you to buy your own insurance for your car and your own Blue Cross, etc., you have to learn to stand on your own two feet," which he was very capable of doing. We went through $5,000 plus in six weeks. This is more than an attendant makes when he begins at Greystone, at least the salary at the time Larry entered Greystone. I believe they make $4,600 a year to start or in that neighborhood, which is an abominable situation as far as I am concerned. It is dehumanizing for the attendants too. There are some of them I'd like to say things about but I won't.

Then we took him home and we had to send him to Bergen Pines because we found that was more reasonable. And by the way, there is a law on the books that until a father is 55 he has to pay the obligations of his family, his children, no matter what age they are, over 21. We are still paying Bergen Pines.

Then we took him home again and from there we were advised to take Larry to Greystone, of all places, because he required medication on a long-term basis. He had to be supervised because if he stopped medication he wouldn't be able to function, he wouldn't be able to withdraw from this depression he was in. I asked one of the doctors at the hospital, I said, "you know,

we looked into the Institute for Living, which is in Connecticut, and you have to spend approximately $35,000 a year to maintain a patient in that institute which is a tremendous place, I understand." This very fine doctor said to me, "Mr. Terrafranca, do you have other kids?" "You are not a young man yourself, relatively speaking" - although I feel like an old man. He said, "I would recommend that you take him to the hospital at Greystone, save your money for when he comes out, he will require some attention, and I believe in six months to a year, because he is not a vegetable, he is a very brillient lad yet, he will be cured, he will be o.k., he will be able to function again. Use that money wisely at that time."

So, we went down to Greystone, Chris and I, and we took a look around and the only place that impressed me at all was the Bergen County Building, Unit #1. After looking around we decided we would try it. We could always take him out. That was the biggest mistake of my life, I guess. So, as I say, we considered our children and the rest of the family and the future. There is no use having tension in the house if you are going to have to suffer economic disaster, and then only injure the other children.

Now, you all heard that I am an architect and I do institutional work. I have done hospital work, a veteran's hospital with other architects. We have done many other things also. But my main concern has been with the church. I have done work for the Roman Catholic Church, as a matter of fact. In the last five years the economy in building has fallen, so for this reason I couldn't afford to give Larry better treatment, at least I thought I couldn't.

We had no alternative and we sent him to Greystone. We recently found out a family in River Edge took their son to Pennsylvania to a private sanitarium and they spent $70,000 before they were able to get him home, well.

He was suicidal, mind you. It is almost three years now, Senator, that he is out of the hospital. He is functioning. He has depressing days. We all do when it is cloudy and miserable out; sometimes we get depressed. They are concerned about him but he is functioning. He is working. He is not at Greystone, a burden to the taxpayer, etc. He is useful and, with God's help, he is going to make it. We are going to try to help him too if we can.

So the thing that bothers me about this is we hear that suicidals are inevitably going to do this thing. You know, there is so much said in the negative. This is one for the positive side and I am sure there are many more cases like this.

I'd like to now just give you a little accounting regarding Bergen County, Unit #1. I will be through here in a few moments. Bergen County, Unit #1, and I am interested in all of the State hospitals but I am mainly interested in ours because we come from Bergen County, has 450 patients, men and women. Now listen to the statistics on this that I just wrote down. I don't have all of them but I have the main ones. They have only three psychiatrists, I think they have two psychologists and I think Senator Hagedorn had an influence in maintaining two of the best psychologists we ever had at Greystone. We also have several social workers. However, if you divide the patients by three psychiatrists you have 150 patients per psychiatrist. I meant to tell you that at the private sanitarium in Pennsylvania they have one psychiatrist for 12 patients and the patient can see a psychiatrist every single day if he wishes. This I was told by this neighbor of ours. What a difference.

Dr. Pustrum, and he should be commended, is the most dedicated man in that hospital. He works incredible hours, as everybody can attest to who knows him. He works anywhere from 14 to 18 hours a

day. Dr. Volvo is the other one and I don't have any knowledge of him at all. I think he works in the wards. Then we have Dr. Esposito, he is the administrator of Unit #1. Dr. Esposito is a very capable psychiatrist and during a visit with him about one year and one-half ago he told me that he would like to be in the wards. He said, "I am a capable psychiatrist, I know my work, I love working with the patients but I am behind this roll-top desk"- he still has one from a century ago. He sits behind that desk and listens to complaints from the attendants and the personnel. Many of them are probably justified but they are things that require a great deal of his time away from the patients. So let's discount Dr. Esposito for a minute and then divide 450 patients by two psychiatrists and what have we got? We have a disaster.

So, again, I say this is another reason that Larry died, the lack of care. I agree with Dr. Fenimore in only one instance, when Senator Hagedorn asked him, "wouldn't it be better if we had more attendants, more help?" He agreed to that. I didn't agree with anything else he said.

These conditions, I feel, cry to heaven for help and help seems so darn far away that it is incredible.

I leave you with this thought, we have a Commissioner of Institutions, Bob Clifford. I understand he is doing a commendable job but he is working very vigorously with the prison problem. Besides mental health he has the other hospitals to take care of. So I say we desperately need an administrator of mental health, which Senator Hagedorn, I believe, is very much in favor of and I hope much of the Senate is and the Assembly is also. If we get a man who is really capable, who has the ability, who has the knowledge, preferably a man in medicine, who can instill in the attendants and the nurses and the other doctors at the State institutions, the mental institutions, a

compassionate approach to the patients, then we wouldn't have the tears that we have seen here today and these many, many, comments that were made in the negative regarding our State mental institutions. I think it is long past and overdue and I heartily recommend this to you. Thank you very much.

SENATOR HAGEDORN: Thank you, Mr. Terrafranca, we appreciate your comments and your contribution to this hearing.

Is there anyone else who wishes to testify at this time?

If not, we will close the hearing with the observation that this certainly has been a rather heart-rendering day for many of you who are victims of this disease and it will have been a day wasted unless we do take positive action and, hopefully, that will be the concern of the Senate Committee. I'd like to call your attention to the fact that Thursday we do have a hearing on the consideration of restructuring this Department, particularly setting up a Department of Mental Health or Human Services where we can focus in on this problem and get some dynamic leadership to correct some of the distressing things we have heard today.

I want to thank everyone for having appeared and for the contributions they have made with the wish that they will not have been made in vain but will be a real positive contribution. Thank you.

(Hearing Concluded)

Most Rev. Thomas A. Boland, S.T.D.
Archbishop of Newark

Rev. Msgr. Joseph A. Dooling
Archdiocesan Director

MIND
SIGHT
SOUND
SPEECH

MOUNT CARMEL GUILD

17 MULBERRY STREET, NEWARK, N. J. 07102

SUMMARY OF MOUNT CARMEL GUILD STATEMENT
AT
PUBLIC HEARING OF THE SENATE COMMITTEE
ON
INSTITUTIONS, HEALTH AND WELFARE - DECEMBER 1, 1972

RECOMMENDATIONS PERTAINING TO STATE HOSPITAL/COMMUNITY MENTAL HEALTH CENTER RELATIONSHIPS AND STATE FINANCIAL SUPPORT FOR MENTAL HEALTH.

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I. COMMUNITY MENTAL HEALTH CENTER AND STATE HOSPITAL RELATIONSHIPS

1. A STRONG BRIDGE MUST BE BUILT BETWEEN STATE HOSPITALS AND COMMUNITY MENTAL HEALTH CENTERS. THIS CANNOT HAPPEN WITHOUT AGREEMENT ON A TOP-LEVEL TO DEVELOP A SPIRIT OF COOPERATION. (THE GUILD HAS BEEN WORKING HARD TO DEVELOP GOOD LIAISON WITH TRENTON STATE HOSPITAL AND GOOD PROGRESS HAS BEEN MADE IN THE PAST YEAR.)

2. PATIENTS IN STATE HOSPITALS SHOULD, IF POSSIBLE, BE HOUSED ACCORDING TO SERVICE AREAS. IF THIS IS NOT FEASIBLE, THEN RECORDS SHOULD BE MAINTAINED TO ALLOW EASY IDENTIFICATION OF ALL PATIENTS FROM A SERVICE AREA. THIS, IN TURN, WOULD ALLOW FOR MENTAL HEALTH TEAMS FROM THE COMMUNITY CENTERS TO IDENTIFY, VISIT AND PARTICIPATE IN DISCHARGE PLANNING FOR SMOOTH AND PROMPT TRANSITION OF PATIENTS FROM HOSPITAL BACK TO THE COMMUNITY.

3. PRE-SCREENING OF PATIENTS BY LOCAL CENTERS SHOULD BE ACCOMPLISHED WHENEVER POSSIBLE PRIOR TO TRANSPORT AND ADMITTANCE TO STATE HOSPITALS. THEREBY AVOIDING HOSPITALIZATION AWAY FROM THE COMMUNITY WHENEVER POSSIBLE.

4. DISCHARGE PLANNING OF PATIENTS FROM STATE HOSPITALS SHOULD INVOLVE THE PARTICIPATION OF A LIAISON TEAM FROM THE CENTER TO ALLOW FOR COORDINATED PLANNING, EARLY RETURN TO THE LOCAL COMMUNITY, AND POSITIVE CONTINUITY OF CARE.

II. NEED FOR INCREASED STATE SUPPORT FOR MENTAL HEALTH

1. THERE ARE ONLY 2 COMMUNITY MENTAL HEALTH CENTERS WITH FREE-STANDING PSYCHIATRIC HOSPITALS OPERATING AT THE PRESENT TIME. THE MOUNT CARMEL GUILD AND CUMBERLAND. THIS CONCEPT OF A FREE-STANDING UNIT WE FEEL HAS GREAT POTENTIAL OF PROVIDING QUALITY SHORT-TERM INPATIENT CARE FOR SERVICE AREA RESIDENTS IN THEIR COMMUNITY, BUT WE ARE OPERATING

UNDER A SEVERE HANDICAP. FREE-STANDING PSYCHIATRIC HOSPITALS ARE DISCRIMINATED AGAINST BY MANY INSURANCE CARRIERS, INCLUDING MEDICAID, BECAUSE THEY ARE NOT OPERATING AS PART OF A GENERAL HOSPITAL. IF WE WERE OPERATING AS PART OF A GENERAL HOSPITAL, WE WOULD BE ELIGIBLE FOR FULL THIRD-PARTY PAYMENTS IN BOTH INPATIENT AND OUTPATIENT SERVICES.

THUS WE FIND OURSELVES IN A POSITION OF HAVING TO SERVE A LOW-INCOME POPULATION, REGARDLESS OF THEIR ABILITY TO PAY, AND YET ARE RECEIVING MINIMAL OR NO THIRD-PARTY PAYMENTS. WHAT THIS MEANS IN PRACTICAL FACT IS THAT OUR INPATIENT UNIT COSTS ARE ABOUT FIVE TIMES OUR INCOME IN PAYMENTS.

2. PROGRAMS ARE APPARENTLY UNDER WAY TO ASSIST MEDICALLY INDIGENT PERSONS - IT IS OUR UNDERSTANDING THAT MILLIONS OF DOLLARS WILL BE AVAILABLE TO ASSIST HOSPITALS TO PROVIDE CARE TO MEDICALLY INDIGENT PERSONS. THERE IS NO INDICATION THAT ANY OF THESE MONIES WILL BE MADE AVAILABLE TO COMMUNITY MENTAL HEALTH CENTERS UNLESS THEY ARE PART OF A GENERAL HOSPITAL.

   AGAIN, WE BELIVE THAT COMMUNITY MENTAL HEALTH CENTERS SHOULD HAVE HOSPITAL STATUS AS LONG AS THEY HAVE LICENSED, FREE-STANDING PSYCHIATRIC UNITS.

   THERE IS LITTLE HOPE THAT WE CAN EVEN APPROACH A SELF-SUPPORTING POSITION IN A POVERTY AREA, WITHOUT THIS KIND OF RECOGNITION.

3. THERE IS AN URGENT NEED FOR MORE STATE FINANCIAL AID. THE CURRENT PER CAPITA ALLOWANCE IS OF LITTLE HELP TO A COMMUNITY MENTAL HEALTH CENTER'S TOTAL OPERATION SINCE SUPPORT IS NOT AVAILABLE FOR ALL THE SERVICES RENDERED NOR IS THE AMOUNT OF MONEY ADEQUATE.

   WE WOULD RECOMMEND THAT STATE AID BE INCREASED BY AT LEAST 100% AND THAT CONSIDERATION BE GIVEN TO THE STATE PARTICIPATING IN THE SPONSORS SHARE OF THE FEDERAL GRANTS FOR STAFFING OF CENTERS. THIS WOULD BE A GREAT HELP DURING THE EIGHT YEARS THAT A CENTER IS SHARING THE COST OF OPERATING MONEY WITH THE FEDERAL GROVERNMENT - IT WILL BECOME VITAL TO THE EXISTENCE OF A CENTER, WHEN THE FEDERAL GOVERNMENT STAFFING GRANT TERMINATES.

4. FUNDING FOR FREE MEDICATION AND TRANSPORTATION TO AND FROM COMMUNITY MENTAL HEALTH CENTERS WOULD SOLVE A MAJOR PROBLEM IN REACHING THE MEDICALLY INDIGENT PERSONS IN THE COMMUNITY. MEDICATION, IF NOT AVAILABLE FREE TO INDIGENT PATIENTS, AT LOCAL CENTERS VERY OFTEN LEADS TO A RETURN TO STATE HOSPITALS WHERE MEDICATION IS DISPENSED WITHOUT COST.

5. FINALLY, THE GUILD'S MULTI-SERVICE CENTER IN NEWARK WOULD NOT BE OPERATING HAD IT NOT BEEN FOR THE SUPPORT FROM THE STATE FOR CONSTRUCTION FUNDING. WITHOUT SUCH CONTINUED CONSTRUCTION SUPPORT BY THE STATE, THERE WILL BE MANY COMMUNITY MENTAL HEALTH CENTERS THAT WILL PROBABLY NEVER GO BEYOND THE PLANNING STAGE.

   WE RECOMMEND CONTINUED STATE ASSISTANCE FOR CONSTRUCTION FOR COMMUNITY MENTAL HEALTH CENTERS.

RESPECTFULLY SUBMITTED

REV. MSGR. JOSEPH A. DOOLING
ARCHDIOCESAN DIRECTOR

MOUNT CARMEL GUILD - COMPREHENSIVE COMMUNITY SERVICE

The Mount Carmel Guild is a community service organization dedicated to meet the needs of individuals whose lives have been disrupted by physical, mental, educational or social impairment. This outline of Guild programs is submitted to the Senate Committee to provide an overview of the comprehensive nature of services available to individuals and families regardless of the original service being sought. For example, a person seeking assistance in the Mental Health Center, could become a rehabilitation candidate or a rehabilitation client could receive needed service in the Hearing and Speech Division.

WHOM DOES THE GUILD SERVE?

Any child or adult living in communities within reach of the Guild in eligible for service. Fees for services are established on a sliding scale which considers 1) total number in family; 2) total family income; 3) other extraordinary expenses. Clients are charged only on the basis of ability to pay, and no one is refused service because of inability to pay. There are no requirements of race or religion. The Visually Impaired and Narcotic Rehabilitation Divisions charge no fees for any of their services.

WHO SPONSORS THE MOUNT CARMEL GUILD?

The Guild was established in 1930 by the Roman Catholic Archdiocese of Newark as a community service agency serving people of all racial, religious and ethnic backgrounds. For more than 40 years it has brought help and hope to thousands of disabled and disadvantaged persons. The Archdiocese of Newark is still the principle non-governmental bearer of the Guild's operational cost.

Federal and State grants, corporate and organizational gifts, and private donations small and large combine with the Church's subsidy to provide the Guild's annual budget of more than $3½ million.

WHO WORKS FOR THE GUILD?

Full-time paid professionals:

Over 400 persons combine their professional skill and training to maintain Mount Carmel's broad variety of programs. Doctors, social workers, therapeutic instructors, teachers, teacher's aides, secretaries, nurses, hearing and speech specialists, rehabilitation counselors, psychologists, administrative and maintenance staff make up the full-time personnel roster.

Hundreds of volunteers:

The volunteer corps which served as a basis for the establishment of the Guild is still a vital force in its overall operation. They bring physical and social welfare aid to needy families and victims of natural disasters. They act as liaison for Mount Carmel in their local communities promoting the Guild's cause and directing those in need of its services to the proper departments.

WHAT COMMUNITY SERVICES DOES THE GUILD PROVIDE?

1. Mental Health

Mental Health care is available at the Comprehensive Community Mental Health Center in Newark and five satellite centers within the Guild's service area. The Comprehensive Center ties together five major mental health care services and makes them available and accessible to people in a community location. They are in-patient care; out-patient care; a Day Treatment Center for patients leaving hospitals or as a measure to avoid hospitalization; Crisis Intervention, an around-the-clock emergency service available to anyone experiencing an emotional crisis; and counsultation and education.

The five other units are out-patient clinics. The Clinics serving Union County and Hudson County also have Day Treatment programs.

2. Hearing and Speech

This division offers hearing and speech diagnostic and rehabilitation services for the communicatively impaired. These services are available for individuals of all ages. Ear, nose and throat specialists and psychologists are available for examinations and consultation.

The diagnostic center in Newark is the heart of a network of treatment centers in the Guild's service area.

An early education program (pre-school) for hearing impaired children and services for students in elementary and secondary schools are also available.

3. Visually Impaired

Services in this department are of a rehabilitation, education, social and counseling nature, aimed at developing independence and integration for blind and visually impaired persons. Braille, typing, travel training, home repair, cooking, amateur radio, sewing, grooming and other skills of independent living are taught.

A Communication Center is available containing a library of braille books and tape recordings, plus a closed circuit TV reading aid for partially sighted persons. Educational services are offered to children at all levels beginning at pre-school.

4. Special Education

Programs of education are available for retarded, neurologically impaired and emotionally disturbed children. They begin at the pre-school level - age 3 - at two Child Study Centers, one in Ridgefield Park and the other in Newark. The pre-school program offers a complete diagnostic evaluation of the child's disabilities from which evolves an individualized plan for educational development.

For children ages 6 to 18 there are academic and vocational classes in the 4-county area which are structured according to the child's potential. All special education classes are certified by the N. J. State Department of Education.

5. Narcotic Rehabilitation

This is the oldest Narcotic Rehabilitation program in the State of New Jersey, begun in 1959. Our philosophy stands on the premise that addicts can be more effectively rehabilitated within the framework of their own homes, with their own families, and in their own communities voluntarily.

The emphasis of the program is individual counseling, psychological testing and evaluation, and group psychotherapy. The clinic acts as an out-patient center providing supportive therapy, job information, and referral to other services within the community.

6. Vocational Rehabilitation

A rehabilitation and training center provides work evaluation and training services for hundreds of northern New Jersey citizens who are physically or mentally impaired, or who have been otherwise disadvantaged.

Components of the Center include training in power sewing, nurse's aide, clerical work, locksmithing, in addition to a sheltered workshop and therapeutic activities. A staff of professional, para-professional and clerical personnel combine their various expertise and backgrounds to maintain the Center's programs, which have a joint capacity for helping 300 persons.

7. Housing-Community Development

Through this department the Mount Carmel Guild has launched a three-pronged attack on the critical need for housing in our urban communities: rehabilitation of old but sound structures; new construction; and a Home Ownership program under the Federal Housing Act of 1968. New construction takes the form of garden apartments wherever sufficient land is available. The Home Ownership program has helped nearly 50 families purchase and maintain their own homes.

The Community Living Department, colaborating with other Guild departments and community agencies, offers family aid in such areas as eduction, budget and credit counseling, medical referrals, consumer protection and others.

COPY

As parents of a son who died at Greystone, I would like to have our statement included in this hearing.

Due to the prohibitive costs of private institutions, we were faced with the grim task of signing our son into Greystone. A more dismal, depressing place is not to be seen. The hospital is understaffed and the staff is overworked.

More highly trained, skilled professionals are needed, both in the medical and professional areas.

Dr. Prustrom has been extremely conscientious, kind and considerate both to Marc and to the family. He gave as much time as often as he possibly could. In no way would we want him to be the victim of this investigation.

But something must be done to correct the situation and fast before more lives are lost. After all, senility and other illnesses may some day force one of you or your loved ones to have to resort to Greystone for treatment. If you are fortunate enough not to have gone through what the relatives sitting here have suffered, remember to say each day - There but for the Grace of God, go I.

Shirely and Gerard Cohen