

PUBLIC HEARING

before

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

on

SENATE, NO. 1677
(Involuntary Civil Commitment)

Held:
October 14, 1976
Assembly Chamber
State House
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Alexander J. Menza (Chairman)
Senator John J. Fay, Jr.

* * * *

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ALSO SUBMITTED:

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SENATE, No. 1677

STATE OF NEW JERSEY

INTRODUCED SEPTEMBER 23, 1976

By Senators MENZA, HAGEDORN and SCARDINO

Referred to Committee on Institutions, Health and Welfare

AN ACT concerning the involuntary civil commitment of persons believed to be suffering from a mental disorder and who are believed to be dangerous to themselves or other persons, supplementing Title 30 of the Revised Statutes, and providing for an appropriation.

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

1 1. It is the policy of the State of New Jersey to assure, when
2 possible, treatment on a voluntary basis as preferred to involuntary
3 treatment and care; and in every case, the least possible restric-
4 tion on personal liberty shall be employed, and the procedures
5 used shall be in full compliance with all constitutional and legal
6 rights.

1 2. As used in this act:

2 a. "Mental disorder" means any organic, mental or emotional
3 impairment which has substantial adverse effects on an individual's
4 behavior and actions which does not include: epilepsy, mental
5 retardation, dependency upon or addiction to alcohol or drugs,
6 when such conditions are the primary diagnosis.

7 b. "Danger" means suffering from a mental disorder and
8 by reason of such a mental disorder: (1) poses a substantial risk in
9 the foreseeable future that the person will attempt to commit
10 suicide, as evidenced by behavior causing or attempting the
11 infliction of serious bodily harm upon self, or (2) poses a sub-
12 stantial risk in the foreseeable future that the person will inflict
13 serious unjustified bodily harm on another person, as evidenced
14 by behavior causing or attempting or threatening such harm on
15 others, or (3) the capacity of a person to exercise self-control and
16 judgment in caring for his own personal needs is so lessened that
17 his physical health is seriously threatened. The physical health

18 of a person is seriously threatened if from malnutrition, significant
19 neglect of personal or medical care, shelter or adequate super-
20 vision, it is probable that death, substantial bodily injury or serious
21 physical disease or debility will ensue within the reasonable fore-
22 seeable future unless adequate care and treatment is afforded.

23 c. "Certificate" means a written statement signed by an ex-
24 aminer, a psychiatrist, or a psychologist, stating that the person
25 examined requires involuntary care and treatment.

26 d. "Hospital" means any place providing inpatient mental
27 health services, which may be a ward, wing, unit or a complete
28 structure or any part of a structure, public or private, designated
29 by the Department of Institutions and Agencies. This hospital
30 may be an institution exclusively for the care and treatment of the
31 mentally disordered, a community mental health center, or a
32 general or community hospital.

33 e. "County reception center" means a place or portion thereof
34 to examine, diagnose and evaluate and treat persons who are
35 alleged dangerous due to a mental disorder.

36 f. "Examiner" means a person actively engaged in treatment
37 and diagnosis of mental disorder during the last 2 years, prior
38 to appointment and licensed to practice in New Jersey and is:
39 (1) a psychiatrist who has completed 3 years of residency in
40 psychiatry in an accredited or approved program by the American
41 Medical Association or American Osteopathic Association, or (2)
42 a psychologist who has earned a doctoral degree in an accredited
43 program with clinical experience in treating and diagnosing mental
44 disorders.

45 g. "Psychologist" means a New Jersey licensed psychologist
46 who has earned a doctoral degree in an accredited program with
47 clinical experience in treating and diagnosing mental disorders.

48 h. "Psychiatrist" means a New Jersey licensed physician who
49 has completed 3 years of residency in psychiatry in an accredited
50 or approved program by the American Medical Association or
51 American Osteopathic Association.

1 3. The county board of chosen freeholders, upon recommenda-
2 tion of the county mental health board and after approval by the
3 Department of Institutions and Agencies, shall designate a recep-
4 tion center system for the county which may consist of one or
5 more agencies.

6 A reception center shall provide inpatient emergency care,
7 treatment and referral for those persons being evaluated and
8 diagnosed; staffed by the appropriate mental health professionals,

9 paraprofessionals, examiners and other personnel as shall be set
10 forth in regulations adopted by the Department of Institutions
11 and Agencies; and, provide 24-hour service 7 days a week.

1 4. A person may be taken to a reception center for an examina-
2 tion, diagnosis, evaluation and emergency care upon written ap-
3 plication as sworn to by the immediate family, next-of-kin, county
4 medical examiner, mental health professional (psychiatrist,
5 psychologist, psychiatric nurse, psychiatric social worker), phy-
6 sician, chief of police or police captain of any municipality in this
7 State, county prosecutor, or county or municipal welfare director,
8 said application shall be based upon personal observation and
9 shall set forth the probable cause constituting the grounds for
10 believing the person to be dangerous to self or others due to a
11 mental disorder.

1 5. Upon the receipt of a written and sworn application, the
2 director of the reception center or his designee shall authorize
3 police official, to take a person alleged in the application to be
4 dangerous to self or others due to a mental disorder to the reception
5 center.

1 6. Upon personal observation by a police official of conduct of
2 a person which is believed to constitute probable cause that such a
3 person is danerous to self or other due to a mental disorder and
4 needs immediate care and treatment, and said situation is of an
5 emergency nature, a police official may take such person to a recep-
6 tion center and make the appropriate application for emergency
7 care and treatment, examination, diagnosis and evaluation.

1 7. At the time of application or at the time when a person is to
2 be taken to the reception center, the reception center staff or
3 authorized officials shall refuse the application or refuse to take a
4 person to the agency if it is determined that the application is
5 improper or invalid or that the basis for said application is shown
6 to be untrue.

7 Upon accepting the application and admitting the person to
8 the reception center the director or chief or service or his designee
9 shall ensure that: in an emergency, a person will be examined and
10 cared for as soon as possible after entering the reception center
11 and in all cases, an appropriate examination or examinations shall
12 be completed and no person shall be detained in the reception center
13 for more than 72 hours.

1 8. Upon admitting a person to the reception center the director
2 or chief of service or his designee shall:

3 a. Inform the person detained of his rights, which shall include:
4 the right to counsel; and if the person is unrepresented or cannot
5 afford counsel, that one will be assigned or appointed; the right
6 to communicate with others; the right to know the reasons for
7 detention; the right to reasonable use of the telephone; and the
8 reception center shall attempt to aid the individual in notifying
9 and communicating with individuals named by the person.

10 b. Informing the appropriate officials and agencies so that the
11 dependents of the detained individual shall be cared for and the
12 personal property and living premises are secure.

13 c. Notify any agency or service or program to which the reception
14 center has referred a person and assist the person in obtaining
15 the alternative services.

1 9. The examiners and other personnel shall at all times con-
2 sider all possible alternatives to involuntary commitment, including
3 voluntary hospitalization and residential care, with due considera-
4 tion of the individual's relationship to the community, family and
5 the availability of community resources.

1 10. The individual shall be examined by at least two examiners,
2 one of whom shall be a psychiatrist and any other appropriate staff
3 persons in order to obtain a proper diagnosis and evaluation. The
4 examiners shall determine whether the person is suffering from a
5 mental disorder and if released would be a danger to self or others,
6 and in the event that:

7 a. The person is not a danger due to a mental disorder, he shall
8 be discharged;

9 b. The person is not a danger, but is suffering from a mental
10 disorder, he shall be discharged and given referral to a hospital
11 or mental health program or agency or other appropriate service,
12 public or private;

13 c. The person, if released, would be a danger due to a mental
14 disorder, and that immediate care and treatment is needed, the
15 reception center shall continue to detain the individual, certify the
16 person as an involuntary patient, and file with the court the appro-
17 priate documents as set forth in section 12 a (2):

18 d. The person is being referred or detained, the examiners and
19 other staff shall place the results of all examinations, diagnoses,
20 and facts that were the basis for the determination in the patient's
21 record and what alternatives for care and treatment were consid-
22 ered and why they were dismissed in favor of detention or referral.

1 11. After the reception center staff and examiners have completed
2 their examinations, diagnosis and evaluations, and in no case said

3 completion being more than 72 hours after the person's entrance
4 into the reception center and the finding is that the person is a
5 danger to self or others due to mental disorder two certificates shall
6 be signed by the examiners, at least one certificate shall be signed
7 by a psychiatrist.

8 The certificate shall set forth:

9 a. The date of the making of the personal examination of the
10 individual, which shall not be more than 72 hours prior to the
11 admission of such person to a hospital;

12 b. Each statement shall contain the name and address of the
13 person who has made the examination;

14 c. The particular facts concerning the examined person's mental
15 and physical conditions;

16 d. The facts and circumstances which the examining professional
17 relies upon in his decision;

18 e. The facts which the examiner relies upon for which he believes
19 that the person examined requires care and treatment due to a
20 mental disorder and that the person is a danger to self or others;
21 and,

22 f. The number of the examining person's license to practice in
23 the State of New Jersey.

1 12. a. The reception center, after the certificates have been signed
2 by two examiners shall:

3 (1) Have the person taken to the most appropriate hospital, by
4 a first aid squad or police official;

5 (2) Immediately file with the county court of the county in which
6 the reception center is situated, the application for involuntary
7 commitment, the two certificates for involuntary commitment and
8 the relevant examination results.

9 b. The court shall immediately review the documents after the
10 clerk has docketed them and if it feels it is necessary it shall call
11 the patient and relevant persons before it. If it concludes that there
12 is probable cause to believe that the person is a danger to self
13 or others due to a mental disorder, the court shall sign a temporary
14 order of commitment which shall:

15 (1) Set a date for final commitment hearing of not more than
16 10 days from the date the temporary order was signed, however,
17 the court may grant a continuance of the trial date for an addi-
18 tional 15 days for good cause requested by the attorney of the
19 detained individual;

20 (2) Appoint the Division of Mental Health Advocacy or assign
21 counsel if the person is unrepresented;

22 (3) Require personal service by the county counsel, as set forth
23 in section 15a, at least 5 days before the hearing upon the person,
24 the person's immediate family if known, the applicant, the person's
25 attorney if known, appointed or assigned counsel, county adjuster
26 of the county of the person's legal settlement, the chief executive
27 officer of the hospital detaining the person; and,

28 (4) Authorize the person's attorney to inspect and copy the
29 complete records of the person detained relevant to the person's
30 medical and mental conditions.

1 13. Upon the receipt of an application as set forth in section 4
2 and upon certification by two psychiatrists, or one psychiatrist and
3 one psychologist, that they have probable cause to believe that the
4 individual examined is a danger to self or others due to a mental
5 disorder, the individual may be taken to the most appropriate
6 hospital.

7 The certificate shall be the same as required in section 11 of this
8 act and it shall be the authorization for a first aid squad or a
9 police official to take the individual to an appropriate hospital.

1 14. a. Upon admission of the individual to a hospital under a
2 certificate for involuntary civil commitment signed by two psy-
3 chiatrists, or a psychiatrist and a psychologist, the hospital shall
4 immediately notify the reception center of the person's residence
5 of the admission to the hospital; and

6 (1) Immediately forward the application, certificates and admis-
7 sion records to the county court of the county in which the hospital
8 is situated, and request that a temporary order for commitment
9 be signed as set forth under section 12 b of this act; and,

10 (2) Make any appropriate examination, to determine if the
11 person is a danger to self or others due to a mental disorder;

12 (3) Inform the person detained of his rights which shall include:
13 the right to counsel, and if the person is unrepresented or cannot
14 afford counsel of the right to be assigned or appointed counsel;
15 the right to communicate with others; the right to know the
16 reasons for the detention; the right to reasonable access to a
17 telephone; that the hospital shall aid the individual in attempting
18 to contact those persons named by the individual and the hospital
19 shall attempt to assure that the dependents of the detained indi-
20 vidual are being cared for and the personal property and living
21 premises secured by notifying the appropriate officials and agencies.

22 b. Upon admission to the hospital, under two involuntary certifi-
23 cates, the staff of the hospital shall determine after appropriate
24 examinations whether the person is a danger to self or others due

25 to a mental disorder, and in no case shall said determination be
26 completed beyond 72 hours from the person's entry into the hos-
27 pital, and in the event that:

28-34 (1) The person is not a danger to self or others due to a mental
35 disorder, he shall be discharged; or

36 (2) The person is not a danger to self or others, but is suffering
37 from a mental disorder, he shall be discharged and referred to a
38 hospital, or mental health program, or agency or other appropriate
39 service, public or private. The staff shall notify the reception center
40 of the county of the person's residence of the referral and assist
41 in the follow-up services.

42 (3) The person, if released, would be a danger to self or others
43 due to a mental disorder, the hospital shall continue to detain the
44 person as an involuntary patient; and if,

45 (4) The person is being referred or detained, the hospital staff
46 shall place the results of all examinations, and diagnoses, and the
47 facts that were the basis for the determination in the patient's
48 file and what alternatives for care and treatment were considered
49 and why they were not used.

1 15. a. The county counsel of the county where the application,
2 certificate and temporary order of commitment were filed and
3 whose county court has jurisdiction over the matter, shall have
4 personally served upon those persons specified in section 12 b (3)
5 the notice of the hearing which shall include a copy of the appli-
6 cation, the certificates and the temporary order of commitment.
7 Said documents shall be served at least 5 days prior to the date of
8 the hearing and the notice shall be in simple, nontechnical language
9 and contain a specific delineation of the nature of the allegations,
10 the nature of the hearing, the basis for detention, the right to jury
11 trial, the names of the examining psychiatrists and psychologists,
12 the persons who will testify in support of the detention and the
13 substance of their testimony, the right to counsel, the right to an
14 appoined psychiatrist or psychologist, the right to be present at
15 the hearing and present witnesses, and the date, time and place of
16 the hearing. The person serving the notice shall certify said service
17 and explanation, and return the certificate of service to the court
18 and the county counsel.

19 b. The county counsel shall have the responsibility to proceed
20 with the commitment hearing, however, if the person detained does
21 not have legal settlement in the county, but does have legal settle-
22 ment in another county, then the county counsel's office shall be
23 entitled to a reasonable fee as set forth by the court and reimbursed
24 by the county of legal settlement.

25 c. The patient's legal settlement providing for the payment of
26 the expense of his care and treatment shall be considered at a
27 separate hearing on notice to the patient, immediate family, the
28 applicant, and person's attorney, which shall be held by the county
29 adjuster of the county in which the patient has legal settlement,
30 however, if there is no county settlement, then by the county process-
31 ing the commitment. The results of the hearing and the approval
32 and order of the court pursuant to said hearing shall be forwarded
33 to all the above parties and the county adjuster of the county which
34 processed the commitment hearing if that be different than the one
35 holding the legal settlement hearing.

1 16. Upon motion of either the person or the person's attorney
2 or the court upon its own motion, the court shall appoint a
3 psychiatrist or psychologist as an expert, providing said expert
4 is acceptable to the person's attorney as to profession and creden-
5 tials, and said expert shall act on behalf of the person detained.
6 The fee for the examination and any testimony provided by said
7 expert shall be set by the court and shall be at the expense of the
8 person if financially able or the public body charged with the
9 person's legal settlement.

1 17. At the commitment hearing, conducted by the court sitting
2 alone or with a jury, if requested by the person detained or the
3 person's attorney:

4 a. The court shall consider questions relevant to the civil com-
5 mitment of the person, and

6 b. The court may hold a hearing at the institution or hospital
7 at which the person is detained.

8 c. The burden of proof for establishing the person's need for
9 commitment shall be danger to self or others due to a mental
10 disorder and the finding shall be beyond a reasonable doubt, and
11 if a jury is convened, the decision by the jury shall be unanimous.
12 The person shall be afforded the constitutional and statutory
13 rights and rules of evidence afforded to a defendant in a criminal
14 case except for bail or grand jury hearing and if the jury or court
15 finds that the person named in the application is a danger to self
16 or others due to a mental disorder, the court shall issue an order
17 for the commitment and treatment of the person in a hospital
18 providing the appropriate mental health services. However, the
19 court shall have the authority to designate in lieu of residential
20 confinement in a hospital, the use of outpatient services, partial
21 hospitalization, or other alternate services subject to the findings
22 made in the individual case and further subject to the court's own

23 findings and the principle of least restrictive alternative as set
24 forth in this act.

1 18. The initial order of commitment shall not exceed 3 months,
2 and any order for further commitment shall be made upon a
3 hearing, after 3 months, 9 months after initial commitment, and
4 then annually, and the hearing shall be in the same manner as
5 provided for in section 17 of this act. If at any time before the
6 expiration of an order of commitment, the medical director or
7 chief of service or designee responsible for the care and treatment
8 of the person finds the person is no longer a danger to self or others
9 due to a mental disorder, the director or chief of service or designee
10 shall notify the court which has issued the order of commitment,
11 and shall discharge the person with an appropriate plan for
12 continued treatment and rehabilitation in community after-care
13 services and agencies, if necessary. Said after-care services and
14 agencies shall be notified of the referral and plan. The person
15 to be discharged shall be given an opportunity to participate in
16 the formation of this plan. The person is under no duty or obliga-
17 tion to participate in the plan after discharge if he chooses. How-
18 ever, the appropriate after-care service or agency shall affirmatively
19 attempt to interest the person in said program.

1 19. Nothing herein shall in any way infringe upon the con-
2 stitutional or statutory rights of habeas corpus.

1 20. Nothing in this act shall preclude the appropriate care,
2 treatment and therapy being given after admission to a county
3 reception center or hospital.

1 21. No officer of a public or private agency or hospital, or
2 hospital, nor law enforcement officer or professional or non-
3 professional personnel in charge of or attending the person or
4 staff acting in accordance with this act shall be civilly or criminally
5 liable, providing that action was not malicious or negligent, or in
6 willful disregard of any provision of this act.

1 22. There is hereby appropriated to the Department of Institu-
2 tions and Agencies, Division of Mental Health such sums as may
3 be necessary for the implementation of this act.

1 23. If any provision of this act, or the application thereof to
2 any person or circumstances is found unconstitutional, the
3 remainder of the act and the application of such provisions to
4 other persons or circumstances shall not be affected thereby, and
5 to this end, the provisions of this act are severable.

1 24. To the extent that the provisions of this act are inconsistent
2 with the provisions of R. S. 30:4-23, R. S. 30:4-24, P. L. 1965,

3 c. 59, ss. 9 and 11 (C. 30:4-24.1 and 30:4-24.3), R. S. 30:4-25, P. L.
4 1965, c. 59, s. 21 (C. 30:4-26.3), R. S. 30:4-24, R. S. 30:4-28, R. S.
5 30:4-29, R. S. 30:4-30, R. S. 30:4-33, R. S. 30:4-34, R. S. 30:4-35,
6 R. S. 30:4-36, R. S. 30:4-37, R. S. 30:4-38, R. S. 30:4-39, R. S.
7 30:4-41, R. S. 30:4-42, R. S. 30:4-44, R. S. 30:4-45, R. S. 30:4-48,
8 R. S. 30:4-56, P. L. 1947, c. 34, s. 7 (C. 30:9-12.7), or P. L. 1956,
9 c. 213, s. 5 (C. 30:9-12.20), said sections or parts of said sections are
10 superseded by this act.

1 25. This act shall take effect immediately.

STATEMENT

This bill prescribes a procedure for the involuntary commitment of a person who is a danger to himself or to others by reason of a mental disorder.

SENATOR ALEXANDER J. MENZA (Chairman): The hearing today is going to be on Senate 1677. It is a magnificent bill, sponsored by myself, providing for the involuntary civil commitment of certain persons believed to be suffering from a mental disorder and who are believed to be dangerous to themselves or others. It is to some extent the basis for a new screening process which will be utilized, hopefully, in the very near future. It is the result of the efforts of the Mental Health Planning Committee, specifically the Subcommittee on Law Revision.

This is the Senate Institutions, Health and Welfare Committee. I chair the Committee. Senator Scardino, the Vice Chairman, can't make it today. To my right is Senator John Fay from Middlesex County. Senator Hagedorn from Bergen County will be here shortly. Senator Joseph Hirkala from Passaic County cannot make it today. So we have two people here and then Senator Hagedorn is coming.

I ask you to please keep your remarks brief and to the point. We realize there are some technical difficulties in the bill, in draftsmanship and the like. We intend to rework this bill to the best of our ability.

We are going to stick to our list of witnesses. I will read them off very quickly: Michael Perlin; Dr. Harold Feldman; Vincent Maressa; Joel Ellis; Dr. John Patterson; Dr. Robert Garber; Dr. Michail Rotov; H. Corley White; Dr. Arthur Sugarman; a representative of the Academy of Family Physicians, Dr. Semour Kuvin; and Dr. Harvey Shwed.

The testimony this morning is being taken stenographically. If you have any written statements, please give them to the stenographer before you testify.

The first witness will be Michael Perlin. And please, Michael, do not cite any Philippine Law Review reports today. I imagine Michael Perlin now is the foremost expert lawyer in the area of mental health in the State.

M I C H A E L P E R L I N: Senator Menza and Senator Fay, on behalf of both the Public Advocate, Stanley Van Ness, and myself, it is with great pleasure that I appear here today to lend my support to S. 1677, the revised involuntary civil commitment bill. It is a bill that has been, clearly, a long time in the planning; but, even more clearly, it is a bill whose time has come.

The strides that New Jersey has been making in the past several years in the reformation of mental health law have been, bluntly, remarkable. I expect that you might find me a bit subjective in my assessment of the matter, but I suggest to you that the following all do, in fact, form such a remarkable pattern:

-- In May 1974, of course, the Legislature passed A. 1409, the Department of the Public Advocate bill, which, for the first time, established, among other innovations, a Division of Mental Health Advocacy. Without sounding too self-serving, we have opened over 5,000 files in two years with a success rate of over 72 percent in all litigated cases, and we have been litigating class actions on a wide variety of procedural, substantive and economic issues affecting virtually every institutionalized person in psychiatric facilities in the State.

-- In November 1974, Chief Justice Hughes promulgated Administrative Memorandum #4-74, setting down for the first time regularized scheduling and docketing procedures for civil commitment cases, and, for the first time, initiating the concept of periodic review.

-- In the fall of 1974, the New Jersey Mental Health Planning Committee was formed and was mandated to prepare, in effect, a manual for reform of this State's mental health care system. In the course of its work, which culminated this summer in a comprehensive document outlining many reform recommendations, the Committee and its staff took testimony from hundreds of witnesses to study the more vexing problems in greater depth. The

bill currently before this Committee is, to a great extent, an outgrowth of that Planning Committee's work, and especially, a result of the work done by its Law Revision Subcommittee, which, I believe, Senator Menza chaired.

-- In May 1975, the Legislature passed, and Governor Byrne signed, the Patients' Bill of Rights, extending to those persons in psychiatric hospitals the civil rights possessed by the rest of us.

-- In September 1975, the Supreme Court totally revised and repromulgated the Court Rules, which, for the first time, made a host of procedural due process rights available to a person facing the involuntary civil commitment process, including, specifically, the right to counsel at all final hearings and at periodic reviews.

This survey, of course, does not even take into account other relevant court decisions involving right to vote, right to independent psychiatric examination, right of a juvenile to voluntarily commit himself, right of a patient to control his or her own assets.

I am also heartened to see, by the way, that the bills that would rewrite the laws governing determinations of criminal incompetency and criminal responsibility are to be covered by this Committee next week.

With this backdrop, then, it is both fitting and proper that S. 1677 be considered for, in many ways, this bill may be seen as a culmination of this entire litany of progress, and, beyond that, as a clear and vivid statement by this State that persons with mental disorders be afforded the full range of constitutional and civil rights in any matter involving their institutionalization. Of all the bills this body will consider this session, few can be considered as significant as this one.

I need not indulge in a section-by-section analysis of the bill to point out the great advances it makes in at least four separate areas: the definition of such troublesome legal terms as "danger"; the establishment, for the first time, of county reception centers; the specification of procedures to be followed prior to the entry of a temporary commitment, of findings to be made prior to such an entry and the need for adhering to the constitutional right to the least restrictive alternative at all stages of the proceeding; and, finally, the availability of the full panoply of constitutional procedural due process rights at the final involuntary commitment hearing. In each of these areas, S. 1677 focuses attention on those problems which have plagued the civil commitment process in the past and suggests a clear and practical way of dealing with those problems, while maintaining fundamental human and constitutional rights.

Although alluded to in the State v. Krol, for instance - I had to cite one case - "danger" has never been adequately nor fully defined in New Jersey law. S. 1677 states for the first time (in section 22b) clear and coherent guidelines for the determination of the existence of such a condition, guidelines made all the more timely in light of the American Psychiatric Association's recent statement which concluded that "'dangerousness' is neither a psychiatric nor a medical 'diagnosis.'" That is from the American Psychiatric Association's Task Force Report, "Clinical Aspects of the Violent Individual." The specification of either physical harm to oneself or others or the existence of a serious threat to one's physical health as the keystones of a "dangerousness" finding make the statute workable in a context which both judges and psychiatrists should find comfortable. With this sort of definition, it is likely that fewer persons in the future will face the grim prospect of unnecessary or inappropriate institutionalization.

The creation of "county reception centers" in section 2e is an excellent idea on several levels. First, it serves as a way to simultaneously screen out of the system many

persons who may not need hospitalization, and to insure that those persons who do need medical care and treatment are able to receive it quickly and properly. Secondly, it will provide a mechanism whereby each county must have a round-the-clock mental health center to provide emergency services and through which many persons will be spared the unnecessary and harsh process of dislocation far from their homes to a foreboding and grim state facility many miles away, at a time when such dislocation might be especially destructive to them. Finally, it serves as a way of assuring that every person who is brought within the mental health system is examined, cared for, informed of his rights, and evaluated within 72 hours. Again, the principle of least restrictive alternative must be adhered to at all stages. Such a system should be a true breakthrough in patient care.

By specifying the contents of the certificate of need for further care and by carefully adumbrating the procedures to be followed prior to the signing of a temporary commitment, the bill insures that all persons involved will be individually and speedily assessed and evaluated and that, at each step in the proceedings, the question of dangerousness will be carefully examined. Two special points should be noted in connection with these reforms: the specification that mentally-disordered, non-dangerous persons are to be referred to appropriate community facilities upon discharge (section 10b) is tremendously salutary; also, the need for certification by expert psychiatric or psychological examiners, setting forth with specificity the grounds upon which the need for temporary commitment is based will help insure that the individual facts and circumstances of each patient's case are being considered by a professional whose training makes him or her uniquely capable of dealing with the sort of decisions involved.

Finally, the procedures for final hearing are a due process model: persons are afforded nearly the full range of constitutional rights currently made available to criminal suspects; counsel is made available throughout; family is given personal notice; the burden of proof is specified; adherence to the least restrictive alternative again continues, and outpatient and aftercare services may be specially provided for in discharge orders. Moreover, the imposition of a durational limitation on commitment, coupled with frequent periodic reviews, will insure that each person hospitalized will be given regularized, individual judicial consideration so that patients never again will "fall through the cracks" of the system.

Having said all of this, I must point out that the Department has only one or two minor cavils to the bill. For instance, I think it would probably be helpful if "mental health professional," used in section 4, were better defined so that it would be more clear who could be considered a "psychiatric social worker" or "psychiatric nurse" under the bill. In addition, it would probably be even more helpful if the Department of Human Services were to be given some kind of supervisory power over the range of determinations made by the county reception centers to insure that persons in all areas of the State are being evaluated in a relatively uniform way. Also, the presumption of ex parte proceedings in section 12b (providing that a patient shall be produced prior to the signing of the temporary commitment papers only if the court "feels it is necessary") is similarly disturbing; a better course of practice would be to make appearances by patients the norm rather than the exception. Finally, although we would hope that the procedural aspects of this bill would go into effect immediately upon signing, we recognize that there may be the need for a brief time lapse prior to the creation or designation of the county reception centers. Ninety days would probably not be an unreasonable period of time.

These minor objections notwithstanding, the Department of the Public Advocate is proud to endorse S. 1677. We feel that it is legislation which will be of benefit to every patient and every future patient in the State, and that it will, indeed, go a long way, towards both making quality psychiatric care available to those in need, and insuring that those who do not need inpatient hospitalization are afforded all their basic human and civil rights and human dignity. We urge its passage.

Thank you.

SENATOR MENZA: Mr. Perlin is the Director, Division of Mental Health Advocacy, Department of Public Advocate.

I'm sorry, but I didn't hear your last point about appearances.

MR. PERLIN: In section 12b, the bill states: "The court shall immediately review the documents after the clerk has docketed them and if it feels it is necessary it shall call the patient and relevant persons before it." This is prior to signing the temporary commitment. I had some question as to whether or not the bill should be phrased that way, whether there should be a presumption of non-production and only produce a patient if the court feels it is necessary.

SENATOR MENZA: Mike, you have had a great deal of input with regard to this particular bill. There will apparently be some amendments to the bill. Will you continue to work on these amendments?

MR. PERLIN: Yes, I will be glad to.

SENATOR MENZA: Thank you very much.

Our next witness is Dr. Harold Feldman, New Jersey Psychiatric Association.

Before Dr. Feldman testifies, let me say something, please. I would very much not like us to get involved in the role, credentials and expertise - I guess we must though - of psychologists versus psychiatrists. The effect of this may very well be to kill what I think is a rather good bill. Perhaps you can address your remarks today towards possible compromise in certain areas. I am a legislator, but most importantly, I am a politician. I know that I don't want the psychiatrists opposed to the bill or the psychologists opposed to the bill. I may very well be in a terrible bind if I give to one group and lose the other group. Both groups have become very vocal. We will go on from there.

Dr. Feldman.

D R. H A R O L D F E L D M A N: Senator Menza, in your opening remarks, you referred to the fact that this bill has some technicalities. But in the eyes of the New Jersey Psychiatric Association, these are more than technicalities. They are problems and defects, perhaps, in your humanitarian approach to the problem, and would cause severe hardship and medical difficulties with the mentally-ill patient.

I would like to refer briefly to page 1 of your bill, section 2a. It says: "'Mental disorder' means any organic, mental or emotional impairment which has substantial adverse effects on an individual's behavior and actions which does not include: epilepsy, mental retardation, dependency upon or addiction to alcohol or drugs, when such conditions are the primary diagnosis."

Unfortunately, I have seen many patients who have been emotionally and mentally disturbed from the effects of drugs, and especially the hallucinogenic drugs. I have been a Director of the first drug rehabilitation program at the Essex County Correction Center, the Walter Quinn Program. I have seen many bad effects from drugs. Alcohol, likewise, causes severe organic brain syndromes which make the patient emotional and mentally disturbed and dangerous to himself and others. These organic brain syndromes are medical diseases and are diagnosed primarily by primary-care physicians and psychiatrists.

SENATOR MENZA: Do you have a suggested definition? We had a great deal of difficulty with that definition.

SENATOR FAY: For instance, how would you have phrased a definition for "mental disorder"?

DR. FELDMAN: A mental disorder is both a functional and organic disease of the mind. It is due either to a disturbance of the thought processes or to an injury to the brain itself by a trauma, by a tumor, by a viral infection, by bacterial infection, by retardation.

SENATOR FAY: If you were writing this bill, this is the way you would define "mental disorder"?

DR. FELDMAN: Exactly.

SENATOR FAY: Then when you got down to the language, "which does not include," you would not have included "alcohol or drugs."

DR. FELDMAN: They should be included because they do cause brain injury and damage.

SENATOR MENZA: Senator Fay just asked you a question. Suppose we used the following definition: It means any organic, mental or emotional impairment which has substantial adverse effects on an individual's behavior and actions, period. It shall not include epilepsy, or mental retardation, period.

DR. FELDMAN: No, it must include epilepsy, Senator, because epilepsy, especially temporal lobe epilepsy ---

SENATOR MENZA: Would your Association, Doctor, be so kind as to send us a letter with a suggested definition for "mental disorder"?

DR. FELDMAN: We will be glad to. May I continue?

SENATOR MENZA: Yes, certainly.

DR. FELDMAN: On page 5, Senator, line 14, (c), it says: "The particular facts concerning the examined person's mental and physical conditions. . ." Physical conditions, Senator, are determined by a complete physical examination administered by a primary-care physician or a psychiatrist, not by a non-physician.

I would like to briefly qualify my remarks by telling the Committee a little bit of my background. I am both a physician-psychiatrist and I have four degrees, including a PhD in Medical Sciences. Prior to my going to medical school, I was teaching at the faculties of Harvard and Boston University, both the graduate schools and the medical schools. Candidates for the PhD in Clinical Psychology were part of the student body I taught. In no instance were our curricula giving any clinical courses - by "clinical courses," I mean the courses the medical student takes in his third or fourth year. Psychologists do not receive any clinical training in this area.

Certainly the psychologists have a duty to perform. They are well trained in the work that they do. But they are not medically trained.

I have practiced Internal Medicine in the Township of Livingston for 14 years. Then I went into Psychiatry and I have been practicing that for 10 years. I am qualified by both the American Board of Internal Medicine and by the American Board of Psychiatry. And in my Internal Medicine family practice, I have worked with psychiatrists in committing patients. An important point I would like to make is that the primary physician should not be excluded from committing a patient if he is available to the family of the disturbed patient. He should not be aborted by a psychologist.

SENATOR FAY: Then you would be suggesting one physician and a physician-psychiatrist?

DR. FELDMAN: Yes, sir, especially if the physician knows the patient who has become mentally ill and the physician is aware of the medical problems behind the illness.

SENATOR FAY: As opposed to the status quo, would you agree it would be a major improvement for everyone concerned if it were a medical doctor or intern and a psychiatrist?

DR. FELDMAN: Please keep in mind that the psychiatrist is medically trained also.

SENATOR FAY: We are assuming that. But I am saying - a doctor who is not a psychiatrist.

DR. FELDMAN: A non-psychiatric physician and a psychiatrist or two psychiatrists would certainly be quite good in this area.

In conclusion, I would like to read into the record a statement on behalf of the New Jersey Psychiatric Association. I might add Dr. Jack Patterson is here this morning, along with Dr. Harvey Shwed and Dr. Semour Kuvin.

This statement is titled, "Senate Bill 1677: A non-reform of the Mental Commitment Law."

Senate Bill 1677 represents one of the more controversial proposals of the "Manual for Reform" developed by the New Jersey Mental Health Planning Committee. It proposes a sweeping change in the State's involuntary civil commitment law.

The bill would repeal the current section of the law requiring two physicians to certify most involuntary psychiatric commitments. Instead, it would permit certification of mental illness only by two psychiatrists, or by one psychiatrist and one psychologist.

While the economic and professional status of psychiatrists might be enhanced by this change, the New Jersey Psychiatric Association believes that there are compelling reasons why it should not be enacted. They are:

1. Mental and nervous disorders are often manifestations of physical illness which physicians are trained to recognize. Psychologists, because they have no medical training, cannot consider this basic aspect of mental illness.

2. Family physicians or attending specialists very often work closely with psychiatrists when diagnosing and treating mental problems of their patients. Frequently, the psychiatrist will prescribe a course of medication which must be administered or supervised by the attending physician. It is often in the course of that collaboration that the two physicians will decide on institutionalization. With the change, the psychiatrist would be unable to utilize the judgment of this medical colleague, but would be forced to call in another psychiatrist or a psychologist.

3. The proposal assumes that, under the law, psychologists' services include treating disease. They do not. The law defines psychological services as "the application of psychological principles and procedures in the assessment, counselling or psychotherapy of individuals for the purposes of promoting the optimal development of their potential or ameliorating their personality disturbances and maladjustments as manifested in personal and interpersonal situations."

4. The greatest advance in treating mental illness over the past two decades has been in the area of drug therapy. Psychiatric hospital population has been reduced dramatically since the introduction of drugs; only physicians have been trained in the use of these important drugs, and only physicians are permitted by law to prescribe these drugs.

5. Proponents of the change say that psychologists are more familiar with mental illness than are non-psychiatric physicians, and thus are better equipped to make judgments or commitments. This is not accurate. All physicians, regardless of specialty, have received psychiatric training. As a practical matter, physicians who are not familiar with mental illness will disqualify themselves from commitment actions just as a pathologist would not undertake brain surgery, although permitted by law to do so.

The threat of malpractice litigation is an effective deterrent.

6. The basic goal of the "Manual for Reform" is to reduce institutionalization and to promote a system of "least restrictive alternatives." To make it easier to commit by using non-medical judgments contradicts this goal.

The Legislature and the public look to the medical community for guidance in this highly-sensitive matter. The New Jersey Psychiatric Association hopes that this paper contributes to that objective.

And it is signed Thomas Houseknecht, M.D., President, New Jersey Psychiatric Association.

SENATOR MENZA: Dr. Feldman, I take it that this is the official position of the New Jersey Psychiatric Association.

DR. FELDMAN: Yes, sir.

SENATOR MENZA: In bold letters at the top of your statement, it says, "A Non-Reform of the Mental Commitment Law." Are you telling us now, Doctor, that this bill that has evolved from the Mental Health Planning Committee after two years of work has no merit? Or does it have merit if we only have psychiatrists included?

DR. FELDMAN: I believe it has some merit, Senator.

SENATOR MENZA: Specifically, Doctor, you made two points with regard to the bill. One was with regard to the definition of "mental disorder" and you may very well be right. We most likely will make that amendment. Secondly, you discuss the role of the psychiatrist as against the role of the mental health professional. Those are your only two objections, I take it, to the bill. Now, this bill is a very elaborate bill. It sets up a screening mechanism. It sets up alternate restrictive care. It sets up the civil rights in the processes by which a person is committed or not committed. It defines, as best we can, danger to oneself and others. So what objections do the psychiatrists have to the remainder of the bill, if any?

DR. FELDMAN: Well, I would rather leave that for further discussion. I can't say.

SENATOR MENZA: I also would like to ask you, Doctor, in view of your background as a PhD and a psychiatrist: Do you think psychologists have a role in the commitment process at all - clinical psychologists with a PhD?

DR. FELDMAN: There is a problem there, Senator, because of the particular training. Mentally-ill patients do not just suffer from functional disorders or diseases. There are organic conditions, which are numerous, that will cause problems in the method of diagnosis by a non-physician. And this will endanger the health of the patient.

SENATOR MENZA: You are saying, in effect, they do not have a role in the commitment process?

DR. FELDMAN: That is my opinion.

SENATOR MENZA: For the benefit of the audience, I am stating right now that I am not going to get involved in this colloquy between psychologists and psychiatrists because the person who suffers is the person who needs the services. I really mean that. There has got to be an area of compromise and I am a compromiser. But I am not going to have this bill defeated or killed. I know exactly what I am going to hear today when I look at the list of those who are going to testify.

I respectfully suggest that the bill is a good bill and I respectfully suggest that you offer compromises that we all can live with.

Thank you very much, Doctor.

DR. FELDMAN: You're welcome.

SENATOR FAY: I have one question, Doctor. In this statement, you say, "All physicians, regardless of speciality, have received psychiatric training."

DR. FELDMAN: Yes, sir.

SENATOR FAY: What training?

DR. FELDMAN: Well, the first year of medical school, they are given psychiatric courses. There are clinics that begin in psychiatry. In our school - I am the Social Professor to the New Jersey Medical School; I am also Chief of the Forensic Unit of the Essex County Courts and the Essex County Jail - I am giving first- and second-year medical students training in psychiatry as well as residents. As third- and fourth-year medical students, the doctors do get involved with psychiatric patients. As interns, they take care of psychotic patients. They work in the emergency room. They are exposed to psychiatric illness. In fact, they take national boards in psychiatry. They are supposed to know as much psychiatry as they know medicine or other medical subjects.

SENATOR FAY: Therefore, you are assuming even the doctor who specializes in the eye, ear and throat, or whatever, that ---

DR. FELDMAN: He has a background in psychiatry. That's correct, sir. Of course, as the official statement says, if any of the primary-care physicians, such as an obstetrician, or a gynecologist, or an internist, or a family practitioner, feel they are not qualified, they will call in a psychiatrist.

SENATOR FAY: Say, ten or fifteen years later, the doctor is now a specialist and he hasn't had any courses or any dealings whatsoever with a neurotic or a psychotic person.

DR. FELDMAN: That is not really true because with the advent of the psychopharmaceuticals, there are many mentally-ill patients who would be acutely psychotic and dangerous if they were not on this medication; and these patients are patients of specialists and they are familiar with the psychiatric history of the patients who come to them. If the patient becomes acutely ill, I am sure they notify the family practitioner, who, in turn, perhaps obtains the services of psychiatrists and the commitment procedure is indicated as the disease progresses.

SENATOR FAY: Just one last question, Doctor: Do you stand by the status quo? Do you think the commitment law, as it is, is working? Is it just?

DR. FELDMAN: I have been working under this law for the past ten years and I find it adequate for my work.

SENATOR MENZA: Okay. I won't even comment on that.

DR. FELDMAN: I mean the commitment law, as far as signing the papers. I am not going into the other aspects of your bill.

SENATOR MENZA: Doctor, just one question: Don't you think that psychologists have the ability to recognize mental illness?

DR. FELDMAN: Yes, they have an ability, but they don't have the training to diagnose organic brain diseases.

SENATOR MENZA: Well, the examination is made by two persons, one who is a psychiatrist and the other, let's say, who is a psychologist.

DR. FELDMAN: No, a non-psychiatric physician would be the one because the bill, itself, calls for a physical examination.

SENATOR MENZA: You talk about a physical examination. But suppose the commitment process was a psychiatrist and/or a psychologist. You would be opposed to that. Suppose it was a psychiatrist and a psychologist.

DR. FELDMAN: I think our position is that it would have to be two psychiatrists or a psychiatrist and a non-psychiatric physician.

SENATOR MENZA: Why do we have psychologists in psychiatric hospitals working for the State and receiving good money?

DR. FELDMAN: That's a good question, Senator.

SENATOR MENZA: You tell me.

DR. FELDMAN: I will try to answer.

SENATOR MENZA: Why do they offer these courses? Rutgers has a Clinical Psychology Course. Is this all fraud?

DR. FELDMAN: But it is not a medical course, Senator.

SENATOR MENZA: But they are treating people.

DR. FELDMAN: They are treating them with certain modalities that they are well qualified in, such as psycho-therapy, group therapy, and all these areas. But they cannot treat with drugs. They cannot administer electro-convulsive therapy.

SENATOR MENZA: I know that. But they diagnose, do they not?

DR. FELDMAN: They make diagnoses, yes, Senator; but we physicians feel that they are not qualified to make a medical diagnosis.

SENATOR MENZA: All right. Thank you very much.

The next witness is Mr. Maressa, Executive Director, Medical Society of New Jersey.

V I N C E N T M A R E S S A: Thank you, Senator.

I am Vincent Maressa, Executive Director of the Medical Society of New Jersey. I will bear in mind well your admonitions concerning conflicts between professions. However, there are certain areas of this legislation and the other package which are of concern to the Medical Society of New Jersey. Some of them have been touched upon by Dr. Feldman.

I think the first one is the definition of "mental disorder." I think it is very well accepted today that there is no question that addiction to drugs, to alcohol, and the disease entity, itself, of epilepsy creates a great many acute manifestations where hospitalization will be required through the involuntary commitment mechanism. I think the Committee has to readdress that issue and certainly has to work that out.

The problem we have is that the proposal here, in effect, removes at least 9,000 practicing physicians from this mechanism because these physicians are not psychiatrists and hence do not qualify under the definition contained in the bill.

A further feature is that the restriction of the definition of a psychiatrist to those physicians that have perforce served in AMA-approved residency may indeed have a dramatic impact on the number of available psychiatrists. It is well known that a fair number of our practicing psychiatrists are, in effect, foreign trained. When they come to the United States, in order to prepare for the licensure examination, they have to go through what is known as the ECFMG mechanism. Beyond that, the only requirement for licensure if they have come from a recognized medical school in a European country is to serve the current internship or AMA-approved internship. While from this point on it may well be that that internship is part of an integrated residency, it has not been the case up to this point in time. So a fair number of the foreign-trained physicians may indeed be excluded from functioning under this very role and I include in those remarks people who have been trained, for example, in Canada, in England, in Australia, in Austria or any European or Asiatic country, who may be darn well qualified as practitioners and as physicians.

Beyond that point, the exclusion of a fair segment of the practicing physicians is again a critical factor. You must recognize that the majority of people going in the voluntary commitment route are first seen probably in a hospital emergency department. It is unlikely that any of the people on staff or on duty at the time the patient is

brought in would be psychiatrists. Most of these would be treated by emergency room physicians who may or may not be psychiatrists, but the majority generally have their background in general surgery, general medicine or perhaps pediatrics. So some consideration has to be given for the catchment-basin approach.

The final area with which I certainly am concerned is the certificate of need legislation. In this bill there is no mention of it, at least at this point in time. The mechanism, perforce, I would think, either creates a conflict of law or, at least, is going to mean you have quite a few certificates of need to process. I don't know what the position of the Health Department will be in that regard and I don't know what the overall costs are going to be.

SENATOR MENZA: Are you talking about the county reception centers?

MR. MARESSA: Yes, everything. Even if you segregate out a part of the hospital, under the current statute, that does require a certificate of need. It is either an expansion of an existing service or a new service. If it involves any cost at all, even hiring salaried personnel, it has to go through the certificate of need route. So that issue would have to be addressed.

I would assume the other speakers will adequately cover all other areas we perhaps might raise. Our position is quite similar to that of the Psychiatric Society. And, again, I cannot overemphasize that a fair number of the persons that ultimately may have to go into involuntary commitments or into mental facilities may, indeed, be primarily the patients of physicians, for example, such as neuro-surgeons, neurologists, internists, cardiologists, family practitioners and, at times, pediatricians. And to remove them from the mechanism is certainly not desirable.

SENATOR MENZA: Mr. Maressa, we will check out the certificate of need problem. It is something we never thought of.

Of course, you and the prior speaker made a good point with regard to the definition.

MR. MARESSA: Let me even offer you this: We are willing to appoint several representatives to work with you on the entire package. We see need.

SENATOR MENZA: The only problem, Mr. Maressa, is that a similar bill was introduced by me two years ago, three years ago, four or five years ago. I only have a year left in the Legislature and I really would like to see this bill become law before I leave.

Now, I always thought that physicians knew everything - and I am not trying to be rude - but are you telling me that an internist, a pediatrician, a surgeon, is more qualified to diagnose a mental disorder or to admit someone for a mental disorder than a clinical psychologist with a PhD?

MR. MARESSA: You are asking me whether I can testify as the ultimate truth, Senator, and I have to tell you I am not that big a fool yet. However, I would hazard the guess that there are quite a few neuro-surgeons, neurologists and internists who probably know as much about psychiatric disorders as psychologists, yes. Now you will ask me to prove that and I will say I can't.

SENATOR MENZA: But don't you understand that in the Krol Case it was a podiatrist, I think. Harold, was that a podiatrist?

MR. GARWIN: He was a foot doctor.

SENATOR MENZA: He was a podiatrist. But let's assume that the man is not a podiatrist - let's assume that he is a radiologist. Wouldn't the Kohl Case be just as applicable?

MR. MARESSA: Well, I haven't read the Kohl Case so I will not commit myself to

rendering a legal opinion on a case I have not read.

SENATOR FAY: Mr. Maressa, what I would like from the Medical Society of New Jersey is a critique of the bill. I think Senator Menza's point is well taken. If it is the position of the Society that the status quo is perfectly proper and adequately serving the needs of the seven and one-half million people here and if you stand on that and are ready to defend it, so be it. But there seems to be a need for change and a need for reform in some people's minds. Some people believe there have been abuses. The courts have obviously had a few cases where there were, at least in the minds of the court, terrible abuses of individuals and their families.

Now, if you feel that the definition of "mental disorder" in section 2a of Senate Bill 1677 is not worded properly, that alcohol and drugs, in particular, play a major role in mental illness, fine. But there are other parts of the bill. I don't think it is enough just to say you are against it unless you are saying you are against all of it, period; that's your position; and, as professionals and as a Society, you are willing to defend that position.

I also feel you have a responsibility to come up with specific critiques and specific recommendations on this bill before it comes to the Senate for a vote, we hope, before the next year is out, unless we all have nervous disorders by then and are down to 20 Senators. I think it would be helpful to all the 120 people in the Legislature who will eventually have to vote yes or no on this to have such information.

MR. MARESSA: I couldn't agree more, Senator. In fact, I did preface my remarks by saying that we were willing to sit down and cooperate with you in this venture. There is no question that for any organization to adopt an inflexible position on a point of law or a point of science is somewhat to defy reality. Obviously, we cannot oppose change because we would like constants. We only oppose change if the constant is much more desirable than what we see the effected change to produce. So I think we have to take a very rational approach, and we will.

All I am saying to you at this point is that there are major problems here and you may darn well be excluding 40 to 50 percent of the people that ought to be encompassed in this legislation, just by definition.

SENATOR FAY: And that is the very purpose of a public hearing. Too often, for example, the professionals, themselves, do not come forward in the first place. But after ten years in Trenton, human nature being what it is, I don't expect any more of the Medical Society than I do of the NJEA or the Chamber of Commerce or the AFL-CIO when it comes to being out in front and leading the reforms. Be that as it may, we are now "center stage." We are dealing with a most important bill. As a layman, I have never wanted to act presumptuously and make dogmatic judgments when the professionals are making a certain point. But the professionals, I feel, have a very, very real responsibility and obligation to say, "Look, here is what is right with the bill and here is what is wrong with the bill," or even, "Here is a model bill, drafted after looking at what some of the other 49 states in the Union, or some European countries, or other places have done to deal with this very real, very serious problem."

SENATOR MENZA: Mr. Maressa, as the Executive Director, you are taking the brunt of this and I'm sorry. But Senator Fay used a few very important words - "responsibility and obligation." I don't agree with the position of the New Jersey Psychiatric Association that this is a non-reform of the Mental Commitment Law. This bill has been worked on for two years - two years. We have had a great deal of input from lawyers, from physicians, from practically everyone. I think it is an important bill, a major bill. And I am not going to have this bill buried because of an argument - and, in effect, that is what

it boils down to - between psychologists and psychiatrists over the vested interest of each. No way is that going to happen.

I also make it quite clear to you that, as far as I am concerned, an internist, a radiologist or a surgeon is not as qualified, in my opinion - I am the sponsor of the bill - as a clinical psychologist with a PhD to determine mental disorders.

I have been involved in this now for five years. I took a very simplistic approach to it at the beginning. I thought it was a very simplistic question with very simplistic solutions. I realize now after five years, with a sense of urgency about my time now, that it is very complicated, extremely complicated. For example, I know that psychiatrists on occasions may refer people to psychologists for certain tests and the like. Municipalities send their police officer applicants to psychologists for testing. From the little I know about mental health, Freud pushed the idea of laymen or non-psychiatrists in this area.

I think that the psychologists and the psychiatrists are going to do a real disservice to this State if they kill this bill based only upon their vested interests. I am coming on as hard as I possibly can, Mr. Maressa. Honestly, I am not trying to be rude.

MR. MARESSA: Senator, I appreciate that.

SENATOR MENZA: The bill is extremely important. It is going to do an awful lot of things for a lot of people. That is what I am concerned about, not so much what it is going to do for psychiatrists or psychologists. I make that quite clear.

MR. MARESSA: Senator, I well appreciate that. I also recognize the fact that you are trained in the law as I am. And I have to tell you that I nowhere stated today that we were adamantly opposed to any reform in the area of the commitment procedure nor that we would not cooperate with you in making a sensible change in format. In fact, I offered you that very approach. I will leave it at that. I don't want to turn this into a haggling session any more than you do. I appreciate your comments. I appreciate your concern. I also appreciate the feelings of the Legislature that the Medical Society always acts from "their own selfish vested interest." You know, I can accept that criticism. It happens to be a fact of life and I think most of the time most people, even though they may be acting in their own selfish interest, sometimes happen to effect a great deal of good at the same time.

Certainly what we ought to be concerned with is the patient. I have to go back and again assert to you that quite often, if you are dealing with a brain lesion, you are dealing with a tumor, you are dealing with a cancer. My God, that diagnosis is more properly and can very well fall within the sphere of the radiologist, the neurosurgeon and neurologist. These are the people who are going to see these people perhaps before anyone else does.

SENATOR FAY: I am hoping it is not an "either, or" situation.

MR. MARESSA: I didn't suggest that and I don't know why you both keep returning to it. Again, let's look at it sensibly. That's all I am saying.

SENATOR MENZA: Thank you very much, sir.

Mr. Joel Ellis, President, New Jersey Association for Mental Health.

JOEL M. ELLIS: Senator Menza and Senator Fay: My name is Joel Ellis. I am President of the New Jersey Association for Mental Health. The Association sincerely welcomes this opportunity to appear before this Committee and share with it the views of the many citizens who have joined together in a voluntary mental health movement dedicated to improved care and treatment of the mentally ill.

For many years the New Jersey Association for Mental Health has been actively

involved in working for a change in the mental health system in our State. We have gone on record as advocating a network of mental health services that would assure adequate treatment, care and delivery of services for the mentally ill, with the community as the primary source of such care.

Sl677 will strikingly decrease the proportion of involuntary admissions to our state hospitals and will see one of the basic recommendations of the New Jersey Mental Health Plan of June 1976 begin to be implemented - the designation of a reception center system for all counties.

Establishment of Reception Centers in each of our 21 counties and mandated annual mental health plans to be drawn up by the County Mental Health Boards in all the counties will help prevent inappropriate commitment, will move toward integrating services among the regional psychiatric facilities and the community mental health center, thus implementing Federal Law PL 94-67, passed in August 1975.

The Community Mental Health Center Amendments of 1975, Title III, of PL 94-63, require that the State mental health authority shall establish and carry out a plan which --

1. is designed to eliminate inappropriate placements in institutions of persons with mental health problems, to insure the availability of appropriate non-institutional services for such persons, and to improve the quality of care for those with mental health problems for whom institutional care is appropriate.

2. provides for assistance to courts and other public agencies and appropriate private agencies to facilitate:

- a. screening by community mental health centers (or if there are no such centers, other appropriate entities) of residents of State who are being considered for inpatient care in a mental health facility

- b. provision of follow-up by community mental health centers or, if there are no such centers, by other appropriate entities for residents of the State who have been discharged from mental health facilities.

The past few years have seen heightened consciousness on the part of the public, the Legislature and the State administration with regard to the needs of the mentally ill. We are proud of our role as catalysts in bringing about change and we believe our legislators should be commended for the leadership role they have assumed in working to bring into our State, humane laws for the mentally ill and bring mental health care in New Jersey into the 20th Century, righting the wrongs of years and years of shameful neglect.

A great step forward will be achieved by supporting this bill and our Association is in complete accord with the New Jersey Mental Health Planning Report which states, "the reception service should be developed by the State and the counties in partnership." In keeping with the concept of community planning, the location and physical facilities to be used would, of course, be decided by the county board of freeholders.

In addition, may I quote from the Final Report presented to the Legislature made by the Joint Mental Health Subcommittee of the Senate and Assembly Institutions and Welfare Committee in 1975, which this Association has moved be given wide dissemination.

The Report stated: "No recommendation shall be issued by this Joint Subcommittee. History has demonstrated that it is a futile effort, easily ignored or forgotten. This Subcommittee has one central goal: change New Jersey's mental health care system so that people who need help will receive it."

It also stated, "We have reacted, but we have rarely acted on our own initiative. Our motto appears to have been 'minimum services for maximum numbers' - What will our

future be?"

On behalf of the New Jersey Association for Mental Health may I presume to answer that question by re-emphasizing that our future can and must be strengthened, continuing concern which will lead to decisive, positive action in the treatment, care and delivery of mental health services for the mentally ill. We must not always be reacting to crisis situations.

S-1677 spells out humane, compassionate and legally-stringent provisions for involuntary commitment.

In addition, the provisions for County Reception Centers is a new beginning that we can hope will provide a network of services that, as stated in the Plan will:

(1) be a network of primary entry points to inpatient psychiatric facilities for patients committed involuntarily.

(2) refer to appropriate community services those people who need care but who should not be committed involuntarily.

(3) coordinate after-care planning for patients when released from inpatient psychiatric facilities.

In closing, we thank you for this opportunity to present our views. Despite some gains, mental illness is still New Jersey's number one health problem, operating under a dual, out-moded system with archaic statutes. A law dealing with involuntary civil commitment, as proposed in S-1766 can have tremendous impact for much-needed, long-overdue change.

Thank you very much.

SENATOR FAY: Mr. Ellis, would you like to comment on the criticisms that have been made so far - (a) to the definition of "mental disorder," and (b) the need of keeping the medical doctors there?

MR. ELLIS: I think our Association has not taken a public position on those issues. My intent here on behalf of the Association was to speak on behalf of the thrust and the philosophy inherent in the bill. I think it would be a shame if that gets lost in the process of bickering on what role various disciplines play.

SENATOR FAY: Thank you.

SENATOR MENZA: Thank you.

Dr. John Patterson, New Jersey Psychiatric Association.

D R. J O H N P A T T E R S O N: I am Dr. John Patterson. I am from Freehold, New Jersey. I got a license to practice medicine in New Jersey in 1943; certified in Psychiatry in 1951. I have had the pleasure of working and directing a VA mental hygiene clinic in Philadelphia where we had 10 or 15 of each of the major mental health specialties - psychiatrists, social workers and psychologists. I have been a Medical Director of a state hospital. I was Medical Superintendent of a state hospital for some eight years. I have directed their outpatient areas, all with extensive involvement of all types of mental health personnel, with all types of usages for them in whatever the situations demanded, and many of them had many demands.

I don't think we are involved primarily here as far as the New Jersey Psychiatric Association is concerned here today in a fight with psychologists. We do, however, have commitments that I think for some reason or other we have been unable to point out in the mental health planning processes that would actually involve psychologists in areas where it would be to their detriment if some of this planning were to be implemented further at this time.

We work very closely in the planning and treatment of mental disease on what is called a Diagnostic Statistical Manual. It is an official organ that is coded. All

these diagnoses are used throughout the world for general purposes of hospital records, for insurance purposes, for management of various types of research and for general planning in all types of treatment. These are medical diagnoses and, basically, the position of the psychologists has been that they have had no medical training or specific training in the many areas of diagnoses that are included in this. We are reviewing this in the American Psychiatric Association with quite some hassles among our members as to what changes should be made. But we do this every few years and a new issue is coming out shortly.

I do hope that we don't get involved in a continuing squabble just about the role of the psychologist, although, as stated already, we formally feel that this is at this point not an adequate assignment of function to them and that it would in many ways give them more problems and give our patients more problems.

In addition, we do have many areas of concern about the other issues involved in this particular bill. We have areas of concern about the companion bills that have been mentioned that will be brought up next week - I think they are 1676 and 1675 - on criminal responsibility and competence. We have similar areas of concern in them because again they involve so many of these areas that cannot be commented on. Among other things, this has grave malpractice implications if people are called on to use opinions about these illnesses when they are not trained in them. I just don't see the result of this as being salutary to patient or professional, whatever the profession, or whatever the problem the patient has.

There have been many efforts at legislation in this area throughout the country. I recently went to Atlanta to a hospital and community psychiatric institute sponsored by the American Psychiatric Association. The last legislation attempts, I understand, were in two states. One was in Iowa where a bill similar to this was changed, and with the arrangements and working out through the State Psychiatric Society, a more satisfactory bill was drafted and passed. Recently, I think in Maryland, there were some decisions made by the courts, not by the Legislature, in terms of the inability of the psychologists to participate because of their background in certain types of testimony.

These are not problems existing only in New Jersey. They are serious problems that have to be met and met with much greater effort on everybody's part.

Not forwarded as yet to the Assembly or this Committee is the Report of the New Jersey Psychiatric Association on the entire mental health planning area. We have such a basic report which we will be working on further. If the Committee wishes me to leave it at this time, I would be glad to leave it with you. Now it has other remarks that are tangential to this particular bill, but are involved with some of the other issues that you have mentioned, Senator Menza, and which represent formal attempts on the part of the New Jersey Psychiatric Association to verbalize where we feel the specific differences of opinion lie and have some of the specific recommendations we would like to see included.

As far as compromise, our basic approach to compromise is always there. But we see it on a further planning basis rather than --- I just have the feeling that this particular bill as it is formulated at the present time, with our commitment to these mental disorders and the whole concept of it, leaves a great area of work to be done. So I see no immediate compromises that can quickly expedite our approval of the passage of the major elements of this bill.

As far as the general planning or general relationship of medical effort altogether, we have had a lot of remarks this morning about the various kinds of medical involvement

aside from the medical specialists, the psychiatrists' involvement in mental illness. Perhaps we should think a little more about what is happening now in our emergency room planning. We are continually getting more and more doctors involved in the immediate handling of mental illness in our emergency room and they have to do this handling. Some of them are more competent than well-trained psychiatrists in many ways because of the volume of the people that they see with acute problems. They are well trained in all kinds of phases of medication usage and all kinds of emergency treatment that they do on the spot. And they enter into making decisions whether people need hospitalization further or not or whether they can be placed immediately on some type of special treatment regime that would avoid it and avoid the problem of hospitalization.

In the position of the general hospital, I think a great deal would be lost if people were diverted from what they have already set up in their emergency rooms throughout the State - and I am sure it is not only so in Monmouth County, where I function. I am an attending physician in one of the largest hospitals in that area and we do a great deal in this field. We have a residency program that participates in it. We train all types of personnel in various ways. We have medical students there. This is a continuing part of our training. I have a son who is in his third year of medical school currently. He has had many courses in various areas of psychiatry. He will soon be taking some two or three months in a special assignment just in psychiatry in his senior year, and more and more effort is being placed on the training of physicians.

I think it is pertinent to note too that the function of psychiatry, as with other specialties, had drawn away from the idea of the internship, an extra year after medical school between completion of medical school and the development of a specialty training program, which is pretty universally three years. Now, however, psychiatry, as many other specialties have done, has reinserted this extra year, not as specifically an internship - a year of internal medicine, a year in pediatrics or some year in some medical function - as essential to the training and effectiveness of any practicing psychiatrist. This is an extra year of effort beyond what the psychologist would get, if I might interject that here. It is just a different type of thing. We have many ways of relating to psychologists, as psychiatrists, whether in private practice or in various types of public practice. But we don't ask them to function in areas where they can't as far as this type of medical planning is concerned. And this happens to be a particular area where it is very much involved. In an acute emergency basis, this is where the more medical elements are of primary importance.

Essentially, the position of the New Jersey Psychiatric Association is that, if there are problems that we have not been able to work out yet in our current certification processes, we would be glad to work further on them. Those that have been brought to our attention, we have worked closely with the courts on. We have recently made some revisions in the current certification forms and certain planning in relation to them. We have standing committees that function in this regard and will continue to function.

Several other areas have been mentioned, such as other changes that are inherent in accepting this bill in general. The question of the overall planning, the development of reception centers, the crossing of administrative lines from those currently existing, as well as the eliminating of the function of the emergency rooms - all these things lead us to feel that we haven't clearly enough thought out some of the planning we might do in this area.

SENATOR MENZA: Wait a minute, Doctor. Let me ask you a few questions before you get off that point. You talk about diversion from the emergency room and you talk about the new regional concept. I presume this is contained in the comments that you are going to give us with regard to the Mental Health Planning Report totally, is that right?

DR. PATTERSON: Yes, there are some. We haven't fully developed this area, however. We haven't had a chance to get together with the emergency room physicians' groups. The emergency rooms, of course, are manned by physicians at this point. If this bill were to go through, they would no longer be able to participate in the certification process; and they are primarily participants, at this point, throughout the whole State.

SENATOR MENZA: You just made some remarks with regard to the regional concept, did you not?

DR. PATTERSON: Yes - and these are embodied in this report.

SENATOR MENZA: You had a representative on the Mental Health Planning Committee.

DR. PATTERSON: Yes - and these are primarily his comments that have been adopted or accepted by the rest of the Psychiatric Association at this point.

SENATOR MENZA: In working up your paper, I presume that the Association is well aware of the new guidelines from the federal government and the regional approach we are to take.

DR. PATTERSON: Very much so. They feel that with this regional approach, there are still conflicts in terms of what we have going now and adapting to them. We feel there will be a great loss of both professional effort and funds if we do not make further adaptations. We feel there is other survey material we could get if the Legislature wants us to, and we will be glad to work with them in any way that we can.

SENATOR MENZA: Yes, we would appreciate that. All of the bills that evolve from the Committee Report, of course, are in the Senate Institutions, Health and Welfare Committee. I understand that the staff of the Mental Health Planning Committee is still somewhat involved in this area on a continuing planning process; and that is under the jurisdiction of Dr. Rotov. I would contact him with regard to the regional approach and the like.

All right, Doctor. Do you have anything else you would like to add?

First, let me ask you a question: Is there any role as far as you are concerned for the psychologist in the commitment process from your point of view?

DR. PATTERSON: I didn't quite hear your question.

SENATOR MENZA: Do you feel there is any role for the psychologist in the commitment process?

DR. PATTERSON: At this point, he has a role in many situations in terms of his involvement with people. But as far as his getting involved in the formal certification, I think it would be premature to involve him. I just don't think because of the things I have just gone over that he can effectively participate without a great deal of difficulty on his own part.

SENATOR MENZA: How about later on when they get to court; do you think the psychologists should be permitted to testify as experts?

DR. PATTERSON: They do testify currently in many situations and they testify on the basis of their own expertise. I would like to point out that one of the things that has developed in the last few months since this planning was done has been that the American Psychology Association has requested through the Joint Commission on Accreditation of Hospitals and through the Federal Trade Commission that they be considered the equivalent of psychiatrists in treating patients in all respects. The American Psychiatric Association has taken a national stand opposing this, as well as the local New Jersey Section.

SENATOR MENZA: I really have two questions. In the initial commitment process - that is, the initial examination - you are saying, no, the psychologist does not have a

role in that. The second question I asked you was: In the final commitment hearing, does the psychologist have a role in that in determining whether a person should be committed or not?

DR. PATTERSON: As far as a psychologist or any other person - we have nurses and social workers involved in this - we feel that all should have a role in preparing the material for it. We rely heavily on their participation. But we do not see a specific role in terms of any recertification efforts, other than to make sure we utilize all of the input that they have had. And there is a role for any person who contributes or works in this whole area.

SENATOR MENZA: The work-up and the input can be done by the psychologist, but the conclusions drawn from all of this are to be made by the psychiatrist. Is that right?

DR. PATTERSON: In terms of anything dealing with mental illness.

SENATOR MENZA: Thank you. Did I cut you off?

DR. PATTERSON: I only had one other general comment to make and this is sort of an analogy. In dealing with mental health, we are somewhat in the position perhaps of people dealing with dental health. We send youngsters to kindergarten and teach them all kinds of things about dental health, but if they get a toothache, they go to a dentist. And, we are very much involved in the certification effort of real emergencies. There are real medical problems involved in so many of them. I think this is the key issue we have to face in relation to the role of the psychologist.

SENATOR MENZA: If you have a backache, Doctor, do you go to a chiropractor or an orthopedic surgeon? Or, if you have a foot ailment, do you go to a physician or a podiatrist?

DR. PATTERSON: People have their choice. People have their choice now to go to psychologists, but they aren't licensed to practice medicine. This is the stand, I think, of the State Medical Association, that this is another matter of a different type.

SENATOR MENZA: Thank you very much. Doctor Robert Garber, New Jersey Psychological Association.

DR. ROBERT B. GARBER: Senator Menza, Senator Fay, I had a position paper written to present to the Committee. Unhappily we were working from the manual for the form, not having been able to procure the actual bill, since our notification of this meeting did not arrive until last Friday afternoon, and even Senator Hagedorn, one of the sponsor's, was unable to get us a copy of the bill. In that paper we have referred to certain items that are really not relevant and I would like to have the privilege of submitting a formal statement to you via mail in the next few days.

SENATOR MENZA: Of course.

DR. GARBER: We in the New Jersey Psychological Association commend the mental health study team and commend the law revision group. We think they have done a superb job of dealing with the legalities of a very complex issue and dealing with the humanities of a very complex issue. I would like to be as concise as possible and address myself to the role of a non-psychiatrically trained physician. There have been a number of comments at this desk regarding what kind of training the M. D. non-psychiatric gets. I happen to have in my hand the catalogue of the College of Medicine and Dentistry of New Jersey. This happens to be from the University Heights of Piscataway. I have in my hand a copy of the same curriculum in Newark, this curriculum now being in the printer. The medical student receives in his first year three credits, Behavioral Science, and there is elaboration and detail, which I don't think the Committee wants me to read. The medical student, according to these two catalogues of our only two medical schools,

receives in his second year a three credit course, Introduction to Clinical Psychiatry. The medical student in New Jersey receives in his third year an eight week clinical clerkship in Psychiatry in both of our med schools. Most med schools do not even give this much, I am told by the Professors of Psychiatry in these two institutions. Enough to say that those, unless they are going on into Psychiatry, probably have had their last formal training in Psychiatry. In the fourth year they then go on into their internship and their residency; therefore, it is our belief that the non-psychiatrically trained physician has highly inadequate training to serve on involuntary commitment panels.

By way of contrast I hold in my hand the catalogue of the Graduate School of Applied and Professional Psychology, Rutgers University, which is in the shadow of the medical school. In the first year, Ph.D. clinical psychology students receive a three credit course, in terms of their competency now for diagnostic work-ups, Adult Descriptive and Experimental Psycho-pathology; they receive a four or five credit course, Introduction to Assessment Planning; they receive in their first year a three credit course, Behavioral Assessment. I beg your pardon, those are Fall Semester courses. The Spring Semester courses in the first year include Intellectual and Educational Assessment and the like.

It is clear that in the area of assessment skills, diagnostic devices, the clinical psychologist is far better trained than is the psychiatrist. And indeed many psychiatrists have had working relationships with psychologists asking them to do workshop work-ups and the like. Even in organisty, the Goldman-Sherer tests can be administered by a psychologist, although we clearly strongly recognize the lack of medical training and by ethical code precribes any commentary, any illusions, to medical implications.

Our basic point here today then is that we support S-1677 in its spirit, its philosophy and its vision. In the area of psychiatry, vis-a-vis, clinical psychology, I would like to address myself to the general concept of parity. We believe there are areas of common competence, and it is in these areas of common competence that we would seek parity. We also believe that there is equality in differences. There are some differences between the two groups and these differences can contribute to the welfare of the patient. Literally, according to one of our Professors in Psychiatry at the med school in Piscataway, there are now five to eight states - and he could only name for sure, California, Montana, Colorado and Wisconsin - having legislation which does impart clinical psychologists to serve on involuntary commitment panels. I will be sure to gather for the Committee those remaining states and include in it the position paper which we would like to present.

My main thrust this morning, if I may comment now on the fundamental issue that you are really concerned about, Senator Menza, is will this bill's future be jeopardized by internecine professional conflict, not from the Psychologists - we do strongly believe that this fight locally as it now appears is just a writ lodged, as you heard a moment ago, at the American Psychiatric Association level. And I would like to submit to you gentlemen certain data which many well educated and influential people in Washington, D. C. and Trenton, New Jersey, are surprised to learn about. This is now, if I may, a brief statement defending the parity of clinical psychologists with psychiatrists in psycho-diagnostics - not medical diagnostics - and psychotherapy.

First, candidates for doctoral training in clinical psychology are as rigorously selected as candidates for psychiatry. Here are the facts for New Jersey.

Last year, 2400 students applied for admission to 110 openings in the first year medical class, College of Medicine and Dentistry in Newark, a ratio of 22 applicants for each acceptance, 4.6; at the same time, 1500 students applied to the Graduate School of Applied and Professional Psychology at Rutgers University, for 50 openings, a ratio of 30 to 1. Without belaboring the point, across the U.S.A. there are on an average 25 to 1 applicants, so the quality of the student coming into the clinical program is comparable to that coming into medical school, which generally laymen find surprising. Again, the grade point averages - and I have securities from the American Medical School Admissions Requirements Director 1975-1976 - are 3.5 for the nation as a whole and the grade point average for students in the School of Applied Professional Psychology was 3.5. There is no way to precisely compare the graduate record examination, which is the admissions test for graduate school, and the medical college aptitude test, but both tests have a verbal score and a quantitative score and other different scores.

For one brief commentary, the clinical psychologists scored 590 on the graduate record, against 563 on the medical college aptitude test on the verbal scale, meaning they scored slightly higher. Whereas, the medical students scored 611 on the quantitative scale of the MCAT versus 600 on the GRE for the clinical psychologist, meaning the medical students out pointed the clinical psychologist on quantitative intelligence. Both groups then it would appear are equally comparable in terms of intellectual aptitude.

Now, let me come to a point which has been kicked around, I think, somewhat carelessly at this mike, and that is, what about the training which would qualify clinical psychologists for this kind of work since both student groups seem to start from a comparable base? These are the data as we see them. Clinical psychologists receive more education and training in the following fields than psychiatrists: Psychological Theory, Research Methodology, Diagnostics and Assessment, Psychotherapy and Community Mental Health. By a wide margin psychologists receive more formal education in human behavior than psychiatrists whose formal course work focuses necessarily on medical science and practice. In the three years of residency in a mental health facility, psychiatrists get very intense clinical training, especially a one-to-one supervised experience. They have more crisis intervention; they have experience in ward management; they gain much practical skill, and hence we feel that there is the possibility of comparability with diversity here.

Another support for the appeal for parity is psychology has evolved into a full-fledged health profession in the last 25 years, often being contested at every step by American psychiatry. There exists definitive national standards for health service providers in psychology. A statewide Professional Standards Review Committee functions as one procedure available to control the quality and cost of psychological services. Psychologists are increasingly recognized at federal and regional levels as autonomous providers of health care services - such services including diagnostics and psychotherapy - for example, the Rehab Act of 1973, the Federal Employees Health Benefits Act, Community Mental Health Centers, Veterans Administration, The Work Incentive Program, Work Injuries Compensation of Federal Employees, Health Maintenance Organizations, the Office of Child Development, Medicaid. Fourteen states now recognize Psychologists as autonomous providers standing in position with physicians. Enough to say, there is a good deal of federal recognition of this parity both for diagnosis and for treatment. I cite this because we are dealing with a diagnostic issue when we are talking about involuntary commitment.

I would like to conclude by pointing out that I think we deal with a consciousness raising issue. People do not fully understand how far clinical psychology has come in the last quarter century. It is comparable to the consciousness raising going on now for non-discrimination between males and females in employment - blacks and whites, younger and older. Society needs still more raising of its awareness to give full equality to the clinical psychologists, and I think this Legislature has been one of those recognizing its status, because three years ago this Legislature passed a Freedom of Choice Law which grants substantial parity between health service psychologists and psychiatrists. This law permits citizens to freely choose between seeking diagnosis or psychotherapy from either a licensed psychologist or psychiatrist, and provides that any relevant insurance reimbursements shall be paid for the services of the psychologist exactly as would be paid for the services of the psychiatrist. Twenty-three states have such freedom of choice legislation.

One could develop a greater array of data. You just heard a moment ago that the American Psychological Association is attempting to gain rights as a staff member at hospitals accredited by the Joint Commission. The psychiatrists are opposing this. We feel if we have a patient in psychotherapy and he has to go to the hospital he has a right to a continuing contact with his therapist if he chooses. We fully recognize that in all cases the care of any physical disorder shall be under the physician member. Several times I think there have been some slips at this mike, and that is, in statements that psychologists want to enter into, and I quote, "A medical diagnosis." At no point would a psychologist attempt to enter into a medical diagnosis.

I should therefore like to simply conclude by saying that we in the New Jersey Psychological Association are very impressed by the progressive spirit inherent in this S-1677, and want to commend its three sponsors for their continuing promulgation of humane legislation. Thank you.

SENATOR MENZA: Dr. Garber, I am not being facetious when I say this, but if the bill is so great --- Suppose we just took the psychologists out of the bill, would the bill then be so great? Would you still support the bill?

DR. GARBER: Yes, I think the legal and civil rights of the patients here guaranteed, the concepts of immediacy of attention, the concepts of least restrictive treatment, these are all very humane and wise. I think this whole differentiation between what is soma and what is psyche is very, very critical and we do not want to get into any technical professional arguments here, I am sure. But we can find psychiatrists here who would not agree with the massive mega-vitamin treatments and trace mineral treatments. There are psychiatrists probably in this room who would take opposing sides in that issue, but I am saying this whole mind/body issue is very, very critical and we are not all that smart. We have much to be modest about on both sides of the aisle. And we psychologists are not going to jeopardize a bill, I suspect, by virtue of any vested interest.

SENATOR MENZA: The psychiatrists have, in effect said that.

DR. GARBER: Well, I am speaking at the direction of our executive board, but as yet the board has not been asked this question.

SENATOR FAY: Five states do have this provision in their commitment law? I didn't quite understand that.

DR. GARBER: Professor John Athause, the Department of Psychiatry at the Med/Den School here in Piscataway, told me on the phone yesterday ---

SENATOR MENZA: We will check it out, Doctor. You don't know for sure what states are involved.

DR. GARBER: He was not completely sure, but he was quite convinced from going consulting in the field that California, Colorado, Montana, and Wisconsin, he believes.

SENATOR FAY: We will have to check that out.

DR. GARBER: But he believes that eight now have such laws.

SENATOR MENZA: Thank you very much, Dr. Garber. Dr. Michail Rotov, Director, Division of Mental Health and Hospitals.

D R. M I C H A I L R O T O V: Thank you, I have a prepared statement, but I am not going to read it all. Mr. Chairman, Committee Members, thank you for the opportunity to speak to you today concerning the proposed changes in the involuntary civil commitment law of New Jersey.

As you are aware, there has been a growing concern for the legal rights of the mentally ill. This concern has been most evident in the scores of lawsuits and case decisions throughout the country involving mental health treatment and involuntary civil commitment. These various court decisions have attempted to enunciate legal safeguards in the mental health care delivery system.

In response to these legal decisions and public pressure, a number of state legislatures have reviewed the commitment laws. In doing so, they have found that their commitment procedures are outdated and inadequate. California, Massachusetts and New York were leaders in this thrust to revise the commitment laws to reflect the legitimate concerns of civil rights, community screening, and the least restrictive alternative for care and treatment. Recently, Florida, Michigan, Pennsylvania and Wisconsin have revised their laws to meet procedural safeguards as set forth in several landmark court decisions.

New Jersey's involuntary civil commitment laws are primarily a protective mechanism emphasizing emergency institutional confinement. This antiquated procedure was revised to some extent in the legislative revisions of 1965. However, those changes do not meet the present day requirements and needs of our state. Therefore, our commitment laws remain outdated and regressive. I believe that this bill represents a progressive step for our state in New Jersey's attempt to move to the forefront of public mental health care.

This bill represents the recognition of the need for statutory revision to eliminate the procedural ambiguities in the present commitment system. During the last two years, the involvement of the judicial system in mental health care has been unprecedented. This has clearly exemplified the need for legislative direction in defining the responsibilities of the mental health professional and the judiciary. This must be done in order to eliminate the past history of neglect by both of these professions.

The responsibility of the mental health system in the involuntary civil commitment procedure is to examine the individual and determine what must be done, if anything, to meet the needs of the patient. The determination that the individual's liberty must be restricted is a legal matter and therefore a decision for the courts. In this respect, I believe that the evaluation of the person's mental health needs in the commitment procedure while clearly stating that the restriction of liberty is a judicial decision.

Insofar as the other specific provisions of this bill, I have only a few brief comments. I am fully supportive of the concept and procedure in this bill that

requires the initial evaluation of the individual's mental condition to be completed in the community. The Division of Mental Health and Hospitals is in complete concurrence with the New Jersey Mental Health Planning Committee report that recommends the establishment of a county reception system. That system would facilitate the screening of an individual in the community rather than after admission to an institution. This bill reflects the recommendation in its requirement that individuals and police officials use the county reception system to determine the most appropriate place for treatment of an individual who is believed to be mentally ill. The Division itself has requested funds in its budget for the next fiscal year to begin implementation of a county reception system.

In closing, I would ask the Committee to consider two changes in the bill: First, that the bill require that the involuntary civil commitment hearing be held in the hospital where the patient is hospitalized. This would eliminate the difficulties that our hospitals are now facing. Under the current system the physician and other staff members must take the patient to the hearing at the various court houses around the State. This causes a loss of time from our already overburdened patient care professionals beyond the actual time in the hearings. I would suggest to this Committee that this bill require the court to hold a hearing in the hospital so that there will be a limited disruption of the overall patient care in our hospitals.

Second, I would ask the Committee to include in the bill the abolishment of the one physician seven day certificate. Under the system as set forth in this bill, there is no need for seven day one physician certificates, and its continued existence would only impair this bill's attempt to have a unified procedure for involuntary civil commitment.

SENATOR MENZA: Doctor, I know the bureaucracy and the chain of command, but can I address something to Harold Garwin?

DR. ROTOV: Yes.

SENATOR MENZA: Harold, didn't we put something in the bill with regard to the hearings at the hospital?

MR. GARWIN: The bill says "May be held at the hospital or institution."

SENATOR MENZA: And, Doctor, you think it should be mandated?

DR. ROTOV: Yes.

SENATOR MENZA: Okay. And, secondly, the seven day certificate, that is a good point. How did that ever happen, Harold?

MR. GARWIN: There seemed to be a narrowing in the type of plan through to the bill, and 46.1 was left out of the repealer section.

SENATOR MENZA: Did we figure the fiscal impact to the counties, for example, on having the hearings in the hospital?

MR. GARWIN: At the present time, it is my understanding that the Administrative Office of the Courts has encouraged the vicintages---

SENATOR MENZA: But it is permissive.

MR. GARWIN: They are now recommending it, and I think in the future they may mandate it themselves. I don't think that is going to be a factor to really consider. I think there are seven or eight counties already hearing cases in hospitals. They have ruled in that direction themselves, recognizing the need.

SENATOR MENZA: Yes, they do it in Essex County. All right, those two amendments are well taken, Doctor, and we will change them accordingly. Doctor, I don't want to put you on the spot. I know you are a psychiatrist with extensive

training in psychiatry, or extensive credentials, I should say. You are in effect saying that there is a role for psychologists and they should be involved in the commitment process. If that is what you are saying, tell us why you feel that way.

DR. ROTOV: There was testimony previously about physicians, non-psychiatrists, whether they should or should not be able to certify a commitment. I think maybe that is a good point. I think maybe the physicians do get training in psychiatry, and I think in most cases, they may be qualified to recognize the signs of mental illness and make the commitment.

As far as psychologists being able to diagnose, I think the previous speaker stated that they are not diagnosing diseases which may be an indication of semantic differences between who is to diagnose what. As I see it, the psychologist is being asked here in this bill to recognize the abnormal signs of behavior or thinking of an emotional nature and to state that he does recognize them, and this I think he is trained and qualified to do. I think it would be a contradiction on my part to say that they are not. Even if I review my own training, my most prominent teacher of psychiatry, when I was affiliated with Jefferson, was a layman, Robert Waelder, who was a student of Freud, was not a physician and he was teaching me psychiatric practice. Now I would be required to say that this Robert Waelder cannot commit a patient, which means he cannot recognize the signs of mental illness, and if this is so, why was he teaching me the practice of psychiatry? He died five or six years ago. His name is in all psychiatric books. He is the creator of many concepts that are pertinent to our practice. He is not the only one. The other one most prominent of my teachers was Sigmund Piotzovski. We consistently refer cases for psychological analysis and diagnosis when we are not sure of the diagnosis. When I say we, I am of course referring to my field of practice. There may be other territories where this has not happened, but again, I would find it paradoxical that as long as we are sure of what the diagnosis is, we psychiatrists are satisfied. When we become unsure, we refer for psychological detailed testing, which means that there is some acknowledgement there that they can make not only first impression diagnoses, as the case may be here, but even the very sophisticated diagnoses. This is, as I say, my personal opinion.

The other problem here was with the definition of mental disorder, and I want to point out that this bill does not speak of mental disease, as was emphasized many times before, that since this is mental disease, therefore, only physicians can diagnose. We have here a mental disorder, and a disorder is not a disease. A disorder doesn't have to be a disease, so that there is no inconsistency between the main term of disorder and having a non-physician diagnose. The definition, I may have some problems with it too, especially the last few words, "primary diagnosis." I think I know what it means, but it may create an impression that if somebody is psychotic due to epilepsy he does not need commitment or he has to be treated somewhere else. This may result in some damage to some people who are psychotic due to something else. I think what it means to say is that if these people are not psychotic and have these diseases, then they do not fall under this definition, so there is a need for codification. But, on the other hand, I don't think you will ever produce a definition that will be satisfactory to everybody. If you read definitions from different states - and somebody told me that the legislature is never wrong - and you compare those definitions with each other, they

are so different that it is just absolutely impossible that any number of them can be equal. The difficulty of defining - and I hope you are not going to ask me to define anything - I think was illustrated by one of the previous speakers who attempted to define mental disease and began by saying, "Mental disorder is a disease of the mind," which is a tautology. So you see it is very easy to detect the defects in a definition, but when you start putting it together yourself, you fall into a tautology to begin with, and later into some other things.

SENATOR FAY: Doctor, in these states that you have mentioned who have updated their laws on commitment, have all of those states included the psychologist as a committing ---

DR. ROTOV: I don't know. I don't have all the details.

SENATOR FAY: Maybe that is our responsibility to find that out. Do you think it would be the best of all worlds if we said a psychiatrist and/or a doctor or psychologist would be required for commitment?

DR. ROTOV: I think it would be proper to include physicians, because I think when you recognize the signs of mental illness, at that initial stage, which can be due to an organic symptom, you will not be requiring psychologists to state the cause of these symptoms - simply their presence. This is how I see it, and because there is a question, they are going to a medical institution who will make a more detailed, proper diagnosis, and I quite agree - I was the subject myself not so long ago to manifestations that could be considered emotional, but which were due to purely physical conditions - that there may be dangers in submitting a patient purely and exclusively to a psychological setting where there is no physical component, because then you may be treating something that is physical for a long period of time. Here, the combination of both, plus referring this person to a medical institution, seems to exclude this type of a danger.

SENATOR MENZA: Doctor, do you think a physician has sufficient training to determine the presence of a mental disorder?

DR. ROTOV: Well, as a physician goes through his training, I think he has some subjects that he likes more, and some that he likes less, and I think it depends on the attention he has paid to psychiatric courses when he was in training, plus whether he has developed any type of interest while in practice to deal with emotional disorders, but for maybe 80% or 90% of the mental disorder manifestations, I think anybody can recognize their abnormality, and for the rest, maybe 10% or 15%, it may take some sophistication and experience to detect abnormalities that are not direct but coded signs of problems that can only be detected by those who specialize.

I would give them a sort of benefit of the doubt that they have, up to now, had the charge of making these determinations and I don't see why it should be revoked from them.

SENATOR MENZA: You were saying also that laymen, without any training whatsoever, can make a determination of mental disorder, or the presence of mental disorder?

DR. ROTOV: Yes. I mean, the signs of mental disorder, most of them, are obvious. Some are subtle, and many of those that are subtle, this is where it takes expertise in detecting something that is escaping a conscious effort to control.

SENATOR MENZA: You have said what I have attempted to say and was unable to do so, because I am not as articulate as you are, but this screening process would mean that a psychologist makes a determination, or physician or a psychiatrist, as to

whether a mental disorder is present. Thereafter, he goes into a medical community where he is treated by various modalities including chemotherapy and the like. I presume - and I will find out from the next speaker whether this is true- the Psychiatric Association even objects to a psychologist making a determination on whether there is a mental disorder or not. The classic in the law, you know, is that a layman can always testify as to whether someone is drunk or not.

DR. ROTOV: I think what I heard a previous speaker say is that psychologists cannot discern with certainty as a physician can what the disorder is due to. It can be due to an organic base, and therefore a psychologist may overlook the organic basis of the disorder, which is, I am sure, true. I mean, I am sure there are a lot of psychologists who would also recognize physical disorders if they know the presence of different things, because I think they are taught. But what I am saying, I think, is that this bill asks for committing specialists to simply recognize the presence of this, and there is no time to dwell as to whether it is due to organic or whatever, and that is the subject of the next stage of examination.

SENATOR MENZA: Thank you very much, Doctor Rotov. Mr. Corley White, Counsel, New Jersey Psychiatric Association.

H. C O R L E Y W H I T E: Senator Menza, Senator Fay, I really don't think there will ever be enough said as to the distinction between the psychiatrists, vis-a-vis psychologists, but I think, of course, the committee at this particular time has heard at least the physician's point of view concerning what he considers his differences, and I also would like to clarify a point. I think that Senator Menza said somewhere in his questioning before - at least with Dr. Garber - that the psychiatrist, or at least the New Jersey Psychiatric Association, is against this bill if you do not take out psychologist. I think that is a fallacy. We again laud the Committee on the effort that they have put into this particular bill. I am well aware of the effort. I am also well aware of Senator Menza's availability, at least to the Psychiatric Association, whenever I asked.

The bill in and of itself is a good bill. Any bill that protects the civil rights of the mentally ill has to be a good bill. The psychiatrists agree that the civil rights of the mentally ill should be upgraded in the State of New Jersey. We differ on at least one point which we consider very vital, and that is that we are talking here about involuntary commitment, the sickest of the sick, if you want to use that phrase. These are people for whom obviously their rights for some period of time have to be determined by another party, be it a psychiatrist, and we contend when a person is that sick, where they are on the verge of an involuntary commitment, that a psychiatrist is the most qualified at that point. We in no way say that a psychologist has no role in the treatment of the mentally ill. They have a very important role in the treatment of the mentally ill.

But when it comes to involuntary commitment, we say that is one role they cannot perform in the mental health process, because we feel that because of their training, and because they are going to a medical facility, that a psychiatrist or physician is best suited. As has been explained here before, the psychiatrist or physician - and we include the physician in that category, because, as you know, family physicians may be well aware of the history of a particular case and may be well aware of the family history in a particular case - per se are the people qualified both morally, both training-wise, and again, as a lawyer, legally.

Senator Menza asked Dr. Rotov before if he would include physicians, psychiatrists and psychologists in the commitment process. What I think the bill is doing, and I really am only addressing myself to this point of the bill because we really don't have that kind of an argument with the rest of the bill, is enlarging a class to commit someone to a medical facility. And that basically is our argument. We have a Title 45 in the State of New Jersey, the Medical Practice Act, which traditionally and legally states that M.D.'s admit to hospitals. Whatever you would like to call them in this bill - you use the terms community care centers, in-patient treatment centers - they are still hospitals. When someone must be treated as an in-patient, doctors, M.D.'s, and whatever else the statutes allow, can commit to hospitals.

Psychologists cannot commit to hospitals because of their lack of training in the medical field. And, therefore, we feel this bill not only may enlarge an area ---

SENATOR MENZA: It comes after socialized medicine.

MR. WHITE: Well, it is not even socialized medicine. Everybody has certain training. Legal training qualifies you to be a judge, or qualifies you to be admitted to certain courts. We have statutes, which legislators such as you have passed, that said only these people can do these things, and we feel as if your bill may have a legal problem in that aspect under Title 45. This is by no means a threat, Senator Menza, because I realize with your legal ability you would be able to uphold this particular matter, but from the legal standpoint, I think doctors have explained - and validly so - that this may include psychologists, a class that may not be legally entitled. And these are the points that I want to bring out.

The definition, of course, we can work upon if it needs to be, and I think from the legal standpoint it needs to be, because a mental disorder under 2a is described and defined legally. And then under 2b where it says, "Danger," meaning suffering from a mental disorder, I can see where many courts would interpret then that if the mental disease or disorder - not to get into the semantics aspect of it - comes from epilepsy, drugs, or alcohol, you may not be able to commit.

SENATOR MENZA: We have no problem with that. You are splitting hairs, Mr. White. You are a good lawyer, and I really have no difficulty with the legal aspect of the other one.

MR. WHITE: I really think it comes down to this: It is not a personal fight. It is not a vested interest fight, and I really don't think it should be categorized that way. I think basically there could be a legal problem raised - not by us - somewhere along the line. Can you legally do this in this bill?

Also, this is one particular aspect of the treatment of the mentally ill that the New Jersey Psychiatric Association both morally and legally feels they cannot perform, and I think basically and simply that is the position of the Psychiatric Association.

SENATOR MENZA: Let me ask you a few questions. First of all, you realize the bill is really the backbone of a new structure. Is the Psychiatric Association so offended by the provision in the bill with regard to psychologists that they would not support what, I glean from your testimony, is a very good bill?

MR. WHITE: When you say that, obviously the Psychiatric Association supports the civil rights, the upgrading of the bill itself, but we can't support a bill if psychologists do remain in it, based upon our position. If that is

revised or removed from the bill, obviously we could support the bill.

SENATOR MENZA: I presume that the position of the New Jersey Psychiatric Association is extremely firm.

MR. WHITE: Yes, sir.

SENATOR MENZA: Keeping in mind, however, that I am the Chairman of this Committee and prime sponsor of the bill, and therefore the bill will be released in any fashion I so desire, I have a few suggestions. Suppose we did include physicians in the initial commitment process, as well as psychologists and psychiatrists thereafter in a court proceeding. If we limited it to psychiatrists only and not psychologists, would that satisfy the Psychiatric Association? I am also a very practical politician, and I would like to see this bill become a law. It is a good bill.

MR. WHITE: On the premise that you would amend the bill to include physicians, psychiatrists and psychologists ---

SENATOR MENZA: In the initial commitment, the initial application.

MR. WHITE: And you would like, so to speak, the support of ---

SENATOR MENZA: Because thereafter there is a hearing, you know. That is a very temporary commitment, very, and there is very little treatment rendered during that period of time. Thereafter there is a hearing, and the hearing then will be limited - assume for the sake of argument - to psychiatrists only; then what?

MR. WHITE: Well, we would support a bill, not because it is limited to us only, but limited to medical personnel. That is really our position. It is not only psychiatrists but also M.D.'s in the commitment process. We are not trying to eliminate them in any other field.

SENATOR MENZA: What about what I just asked you, Corley? We keep the psychologists in the initial commitment but we take them out of the court hearing.

MR. WHITE: I think you should be talking to me in the back room. You mean taking them out of the court hearing themselves? I don't think the court hearing is the problem in this bill. It is the commitment process, basically.

SENATOR MENZA: You know, for the life of me, I don't understand how a radiologist or an internist is more qualified to determine when a person is mentally disabled.

MR. WHITE: That is exactly what we are saying.

SENATOR MENZA: That is what you are saying?

MR. WHITE: That's right. I can't see it put any simpler.

SENATOR MENZA: Well, if you can carry that logic to its ultimate extreme, then you might as well take the licenses away from all the psychologists.

MR. WHITE: No, sir. They do not have a right to commit. Other than that they have a most important role, and they have a very functional role.

SENATOR MENZA: Corley, I don't want to have a dialogue with you. We just had Dr. Rotov as a witness - for whom I have a great deal of respect - and he is a psychiatrist and he tells us very simply this, that they have the ability, psychologists, to determine the presence of a mental disorder, not necessarily all the modalities of treatment, but they can make the determination. Dr. Rotov has told us that. He is the Director of the Division.

MR. WHITE: But based upon that premise, we don't argue with the point that they have the ability to recognize a mental disorder, whatever it might be, but

they do not have the power or capacity to commit because of that recognition. It must be a commitment by a medical person. They can treat in the facility as a non-medical staff member or whatever position they may have.

SENATOR FAY: I would find that argument to be valid if it was just the psychologists, but here we are saying a psychiatrist and a psychologist--

MR. WHITE: Besides being a little unwieldy - but that is really not what we are here ---

SENATOR FAY: --as opposed to two 70-year-old doctors saying that a patient should be committed.

MR. WHITE: I can understand your point, Senator. But still, the line has to be drawn --- I don't mean has to be drawn. I don't mean to make that statement to the Committee itself, but there is a line. Now, just for example, in the bill itself you define examiner. It says, "An examiner means a person actively engaged in treatment and diagnosis of mental disorder during the last two years." Then you go down further under "G" on the second page, "Psychologist means a New Jersey licensed psychologist who has earned a Doctorate Degree in an accredited program with clinical experience in treating and diagnosing mental disorders." A psychiatrist is defined as "A New Jersey licensed physician who has completed three years of residency in psychiatry in an accredited or approved program by the American Medical Association or American Osteopathic Association." Just in and of itself I think the bill itself puts more stringent requirements to qualify as a psychiatrist examiner than someone --- Where is this accredited program for psychologists? Who accredits? What determination do you make? We know psychiatrists must be M.D.'s at least by the definition in and of itself. They have to be from an approved school. You require them to be admitted to the American Psychiatric Association.

SENATOR MENZA: I have no problem with that, Corley.

MR. WHITE: I am just saying this is an example where you say ---

SENATOR FAY: Maybe I was wrong to jump to a conclusion, but I got the impression from Dr. Feldman this morning that he was stating, at least for himself, if not for the Association, that the status quo was perfectly all right and perfectly proper. When I asked him to comment on the present law, he found ---

MR. WHITE: I think what he said, Senator, was that he didn't have any problem with it. We are really interested in the patients. That is really what the Committee is interested in. We all are. We are interested in upgrading their rights.

SENATOR FAY: I found nothing in this release --- I found no recognition that there is something wrong with the present system, that there is any need for upgrading the present law.

MR. WHITE: I would say that is not the position of the Psychiatric Association. We definitely welcome an upgrading, and we are here not for criticism, so to speak, of the bill, but it is for this particular point, which we think is a valid point.

SENATOR FAY: Has the Association taken a close look and study of California, Massachusetts and New York, and Florida, Michigan, Pennsylvania, and Wisconsin, those that have upgraded and have brought their laws up to date?

MR. WHITE: If it was done, it was done at council, and I wasn't privy to it, so I cannot answer that question in all honesty to you, sir.

SENATOR FAY: I would like to recommend that to the Association.

MR. WHITE: We appreciate your recommendation, and will take it under advisement.

SENATOR FAY: I think you should look into these states that were mentioned and see the comparisons between the present law and this bill and the other states.

MR. WHITE: We appreciate that, and we will.

SENATOR MENZA: You know, Corley, this thing provides for two examiners, one to be a psychiatrist and another appropriate staff person. We are talking about a psychiatrist --- By the way, keep in mind that the local cop picks up the guy in the first place and only holds him for a period of time, and he is not anything, this guy. He is not a psychologist; he is not a psychiatrist; he is not a social worker. And yet he is able to take the fellow out of his house and hold him for a period of time in an emergency situation.

MR. WHITE: This is under this bill also.

SENATOR MENZA: Yes, well it has to be. There is no other way of getting him there. Now, you are saying in effect that he is qualified, at least, to make a determination for 72 hours.

MR. WHITE: I don't think we went that far. We are in the commitment process. As far as the Association ---

SENATOR MENZA: No, temporary commitment process.

MR. WHITE: For 72 hours we have him in limbo, so to speak.

SENATOR MENZA: Well, now, we have another period of time. Harold, what is the next period of time, ten days?

MR. GARWIN: After the certificate is signed, at least ten days.

SENATOR MENZA: This bill has said that psychologists and psychiatrists together can make a determination to hold this fellow for ten days - not with regard to modalities of treatment, and not with regard to anything else except that he may be dangerous to himself or others. Now, you are saying---

MR. WHITE: It is not holding that we are worried about. It is commitment that we are talking about. In other words, if we are going to commit him for ten days to a medical facility, there are legal requirements and medical requirements. Holding, I mean, we are not holding him up in the air, we are putting him somewhere. We are committing him to a hospital.

SENATOR MENZA: I don't know, Corley, I find this thing so amazing. I mean, we all are in accord, and we all agree that the bill is a good bill and that the bill is needed and it is way overdue, that it is a reflection of all the court suits throughout the entire country, including our own here in New Jersey, the couple we have had, and we are getting bogged down on one little provision of the bill, whether a psychologist has the ability to recognize a mental disorder on the initial commitment process only. That is a tragedy almost. That is a shame.

MR. WHITE: It is not a question of a tragedy, Senator, it is a question that you consider a very little portion of the bill, and unfortunately we consider it a major portion of the bill. That is really where the difference lies.

SENATOR MENZA: Thank you, Mr. White, for a wonderful presentation.

Dr. Arthur Sugarman, New Jersey Psychiatric Association.

D R. A R T H U R S U G A R M A N: Thank you, Senator. First, a correction, I am not representing the New Jersey Psychiatric Association. I am not representing any association. I am here as a psychiatrist and Medical Director of the Carrier Clinic, a private psychiatric hospital. May I say that although I am Board Certified in Psychiatry, and I have trained in England and I am also Board Certified there, I would

not qualify as an examiner under this bill, and I would certainly suggest that something of the wording of the present rule as saying "Board Certified or Board Eligible" be added.'

SENATOR MENZA: We will look into that.

DR. SUGARMAN: I am also involved in the teaching of medical students as Clinical Associate Professor of Rutgers Medical School and also in the teaching of graduate psychology students in doctoral programs as a member of the contributing faculty of the Graduate School of Applied and Professional Psychology at Rutgers University. I am one of the very few physicians on the faculty of the Graduate School. I just looked at Dr. Garber's catalogue and there are only two physicians in the contributing faculty and none on the full time faculty of the Graduate School.

I teach a course on Medical Aspects of the Psychological Symptoms. I chose to teach this course in an attempt to make psychologists in training aware of the numerous ways in which psychological symptoms can be induced by or associated with chemical, pharmacological, endocrine, neurologic or other organic mechanisms. As far as I know, there is no other such course given elsewhere. Psychologists in training do not learn enough to be familiar with the numerous medical aspects of mental disorders, subsumed as organic in this bill's definition of mental disorder. I hope that with the help of training by psychiatrists and other physicians psychologists in the future may be able to function in the diagnosis and treatment of such disorders, but at the present time, in my opinion, psychologists should not replace physicians in the certification of dangerousness due to mental disorder.

I do not claim that psychiatrists or other physicians are any better than psychologists in predicting dangerousness, as the evidence does not show that professionals do this better than lay persons. But I believe that as long as mental illness exists, although this bill no longer mentions it, that physicians will be called upon frequently as they are now to deal with the mentally ill and that they should continue to have the responsibility of certifying to the presence of mental illness.

You have raised the question of the function of psychologists and I would like to say that psychological testing is very helpful in dealing with the mentally ill. In our own hospital, the head of our Psychology Department, who is also a member of the State Board of Psychological Examiners, chooses not to make a diagnosis in any other psychological reports, as she feels, and as I do, that this is a medical function.

SENATOR MENZA: Doctor, at the medical school, do you have any psychologists teaching medical students?

DR. SUGARMAN: Certainly.

SENATOR MENZA: Thank you very much, Dr. Sugarman. Dr. Semour Kuvin, Chief of Psychiatry, St. Michael's Medical Center.

D R. S E M O U R K U V I N: I am also on the faculty of the New Jersey College of Medicine. I hold four degrees. I have been on the faculty in Bio-Chemistry ---

SENATOR MENZA: Is there anyone here from the Academy of Family Physicians?

DR. KUVIN: I have been on the faculty in Bio-Chemistry at the Pennsylvania State University. I am Certified in Pediatrics, and I have practiced in Morristown for about ten years in that specialty, and I have been in Psychiatry now for also approximately ten years. I have been in the practice of medicine for twenty-three years in this State.

I also sit on the Council for Mental Health for the Medical Society. I was very interested in the bill, and found it to be superb in the fact that it protects

the interests of civil rights of the patients, and that there is good indication that due process will take place, and that finally someone has had the guts to define dangerousness.

I have heard all of the previous speakers, and I am not going to make a long-winded speech as a result. I come down to two points, one is the definition. This has to be revised, because I think perhaps in haste or perhaps in oversight the definitions do not include certain things that may be necessary to include. For example, epilepsy specifically is excluded whereas epilepsy may be the sole cause of mental illness.

We get down to the big flaw in the bill---

SENATOR MENZA: Excuse me, what about the definition of dangerousness? Does that meet with your approval?

DR. KUVIN: The definition of dangerousness is fine. I think it is about time someone has decided to define it, because I certainly can't. I am a psychiatrist. I am not good at definitions.

The big flaw in the bill that causes me great concern and will serve to only delay the passage of the bill is the psychologist feature. Now to clarify, I think, some misunderstandings that I have tried to sense in your questions, Senator, Psychology is the study of human behavior. Psychiatry is concerned with the treatment of mental disease. When a person is committed to the hospital, he is committed to have his mental disease treated. We are not interested, primarily, in human behavior. We are interested in the treatment of mental disease. The psychologist in this State is precluded by law from even having any contact or touch with most of the patients that are admitted to mental hospitals. Most of the admissions have to do with schizophrenia, and a substantial number have to do with organic brain disease. A psychologist cannot treat a schizophrenic, because the psychologist cannot prescribe medication.

SENATOR MENZA: Can he diagnose a schizophrenic?

DR. KUVIN: He may be able to, perhaps, because the psychologist - as Dr. Garber has pointed out - is trained in experimental psychology which has nothing to do with what we are talking about, an assessment, as he called it, by diagnostic devices. We are talking about testing, which is invaluable, but it is a laboratory aid in the making of a diagnosis. A physician makes a diagnosis by doing a physical examination and then by using blood counts to substantiate his impressions---

SENATOR FAY: Doctor, can you just help me on one thing that is a mental block in my mind. We are talking about committing and treating. I can't argue with your point when it comes to treatment, but is it fair to say that there is a distinction between committing the person for this period and treating this person. Let's say everybody involved said that they can't treat, and they shouldn't treat, period. But is it another category or another totality to say they can't treat but they can commit? I don't know. I am asking you.

DR. KUVIN: That is like saying those who can't teach--- I hate to use analogies, but the psychologist is analogous to the one-armed mechanic. He has certain faculties, but he can't do everything. He is very limited in his field. Now, it is sort of silly to go ahead and use a psychologist who is limited in his area - and very expert in his area. I am not saying anything--- The point is that the psychologist is simply not qualified to make medical diagnoses. We are not talking about marital problems. We are talking about people who are - to use street language - bananas, who are dangerous, who must be put away, who must be locked up for their own safety as well

as the safety of others. Senator Menza brought up the question, would you trust a radiologist over a psychologist? He kept on bringing this up. Now, I work in a general hospital. I am the Chief of Psychiatry in a 500-bed hospital. We have a 20-bed in-patient unit. We have a huge out-patient service in the City of Newark. I have asked for other physicians. I have two physician forms, and I will take care of one part and I ask other physicians to do the other examination, and no radiologist in his right mind who has not had contact with the clinical patient is going to sign that form. He will say, "I don't know anything about psychiatry."

SENATOR MENZA: Why not? He has gotten such good training in medical school.

DR. KUVIN: He sure has, but he has not used it in the past 15 years, and he is rusty.

SENATOR MENZA: So the response to my question is that he is not as qualified as a psychologist.

DR. KUVIN: No, I say the psychologist is not qualified, nor is the radiologist out of school for 10 years qualified, but certainly the family physician, the internist, the pediatrician, and all the other various medical specialties are. The pathologist isn't qualified to open an abdomen on a living person, and yet he is licensed by this State to do so. It becomes ludicrous, and I think we are nit-picking here. What I am trying to point out is that physicians should be the persons to commit, whether it be for 72 hours or 72 years. It should be a licensed physician who should commit.

I would trust the family physician of a family in Sussex County over the specialist in Newark, because the family physician in Sussex County knows the family, and all of a sudden if little Joey starts to act very peculiar and throws a knife at his grandmother, the family physician is perfectly capable of committing him. I do think that the bill is going to have difficulties. I don't want to see it have difficulties because it is an important bill. I work with this sort of thing weekly. A substantial amount of my income is derived from Mr. Perlin's Department and my appearances in the Essex County Court, and I am interested in the liberty and civil rights of people. I don't think that a person should be incarcerated for even one hour if he is entitled to that liberty.

SENATOR MENZA: This is a cause celebre for the psychiatrist.

DR. KUVIN: It is not a cause celebre for the psychiatrist. Notice, I said for the physician it is surely a cause celebre, because we as physicians are interested in patients. We are not interested in money. We have no vested interest in this. God knows there are only 400 odd psychiatrists in the State, and we can't handle the patients that come to us now. It is not a question of that at all. It is a question--- Those psychiatrists who are here are interested in the welfare of the patients that they are taking care of.

Mr. Garber who was the spokesman for the Psychological Association kept on using the word parity. My God, if you want parity, go to medical school and get a medical degree and earn it. But we are not talking about this sort of thing. We are talking about the interest of patients, and I think their interest will not be served if this bill is not modified.

One other point I wanted to bring up is the situation of the county reception center concept. This, to me, is not clear in the bill because we have now--- The concept is good, but if it means setting up separate centers at a cost to the taxpayer,

I would be adverse to it. If it means designating existing centers or creating new centers where there are none, then certainly that would be good, because every hospital emergency room is a center. Our hospital emergency room sees without exaggeration at least 20 to 25 psychiatric patients daily. We are a center ---

SENATOR MENZA: I would suggest that a psychiatrist give a lot more thought to that concept because it is crucial to the bill.

DR. KUVIN: Yes, the concept of a center in itself is not a bad one. I am not objecting to that. I am just saying that it is unclear at this point.

SENATOR MENZA: Existing facilities, of course, would be utilized.

DR. KUVIN: Yes, this is because in some areas they are abundant and in other areas they are abundant, and in other areas of course they are not.

SENATOR MENZA: I have a speech to make at one-thirty at the Mercer County College.

DR. KUVIN: My speech is over, sir.

SENATOR MENZA: Thank you, Doctor. Dr. Harvey Shwed.

D R. H A R V E Y S H W E D: I am Harvey Shwed, M. D. I represent the New Jersey Psychiatric Association and the Medical Society of the State of New Jersey. I practice Psychiatry with Dr. Kuvin at St. Michael's Medical Center in Newark, and I live in Passaic, New Jersey. I am a Clinical Associate Professor of Psychiatry of the New Jersey Medical School, and Clinical Associate in Psychiatry at the Mount Sinai Medical School. I also hold a Master's Degree in Social Work from Columbia University School of Social Work.

I welcome the opportunity to participate in the hearings today, Senator Menza and Senator Fay, and I think we all recognize that you are decent, honorable, and well intentioned legislators in the field of mental health. Part of the tragedy, I guess, in this situation is that we are all sitting around here today all committed to the same purpose, and that is, to improve the mental health needs of our citizens. I am reminded of the time when I participated in a child abuse hearing where there was an attorney for the Division of Youth and Family Services and an attorney representing the parents and a court appointed attorney representing the child, and it was clear that all the attorneys and the psychiatrist had the best interest for the child at hand.

Emotional illness is always a complex expression of ideologies that to a greater or lesser degree relate to the physical, organic, neurological, endocrinological, nutritional, bio-chemical, genetic, and metabolic functioning of the human organism along with the environmental- family, culture- and sociological factors. The final common pathway for the expression of all human behavior is the body through its cells, its tissues, and its organs. Effective speech, such as I hope I am participating in today, requires complex circuitry and neurochemical phenomenon in the brain which then triggers nerves to the muscles of the vocal chords to the muscles of my tongue to my lips and palate. Expression of depression results in lowered body functioning and food intake, sexual expression, constipation, sleeplessness, and the most dramatic manifestation of sadness requires complex neurological-biochemical and delicate muscular glandular functioning resulting in a flood of tears. Only a physician is equipped by training to fully comprehend these organic phenomena. Many purely organic and non-psychiatric humans may present themselves initially and acutely as a psychiatric problem. I think that is where confusion has come up today. We are not talking about

ongoing therapy; we are not talking about a psychologist's capability in diagnosing emotional disease once it is clearly designated emotional disease; we are talking about a phenomena of a person presenting himself as if he were crazy, as if he were psychotic, when indeed the ideology may have nothing to do with emotions. It may have to do with physical disease.

My wife who is a fourth year medical student and I stayed up last night to compile a list of physical diseases that present themselves, or can present themselves emotionally. They include infectious processes of all kinds, including meningitis and encephalitis; any infectious process that produces a high fever; multiple sclerosis; tuberculosis that spreads to the brain; brain tumors of any kind, including cancers that start elsewhere and spread to the brain; trauma of any kind; cardiovascular insufficiency; cerebral hemorrhage; endocrine disturbances such as hypo or hyperthyroidism; adrenal and pituitary problems; connective tissue diseases, such as lupus erythematosus; drug and alcohol abuse; prescription drugs prescribed by the doctor and improperly taken - I had the case of a 31-year-old airline pilot who was brought by the police to the emergency room because he was acting violently, and it ultimately turned out that he two weeks before was suffering from an extreme allergy. He was prescribed a drug called benadryl. The benadryl was not giving him enough relief, so he took two or three times the amount prescribed and this was what was causing the psychotic process - metabolic disturbances such as uncontrolled diabetes; chemical and nutritional imbalance; post-surgical psychosis; post-new born delivery psychosis. Only a physician - and I might add all well trained physicians - is aware of these phenomena as it has been part and parcel of their four years of post graduate medical school, and a year of internship, and anywhere from a three to five year specialty training.

We would be doing the citizens of New Jersey a serious and potentially dangerous disservice if we were to dilute the present regulations. As a former social worker, I respect the meaningful contribution that the psychologist, the psychiatric social worker, psychiatric nurse and other mental health professionals may play. But if they want to assume the awesome responsibilities, the horrendous, the onerous tasks of commitment--- It may seem today like the psychiatrists want to commit patients. We don't enjoy it.

Another issue that hasn't been at all addressed is the issue of malpractice, suit-conscious people. It is a very legally delicate procedure to involve oneself in, to commit. If they do want to assume this responsibility, then let them, like I, return to medical school at the age of 30 and embark on another eight years of additional training and become the physician.

In summary, the final common pathway, the total package we are dealing with is a human being, A psychologist expertly has a contribution to make on one aspect of that human being, his purely emotional functioning. It is, however, the physician who has been sanctioned by society and sanctioned by the state to be in the position of taking all of these phenomena into consideration. Thank you.

SENATOR MENZA: Thank you very much. That concludes the hearing for today. The bill will be brought up again at various times at public meetings of the Senate Institutions, Health and Welfare Committee. You can contact Michael Bruinooge, who is our aide, as to when the bill will be coming up. The bill will be considered, and I will be away for a period of three months. Senator Fay will discuss the bill with

the Committee in detail. Amendments, of course, will be drawn up. The crucial amendment relative to psychologists and psychiatrists is something we will in fact think about. Thank you very much for coming.

* * * *

(Hearing concluded)

Citizens Commission on Human Rights
a group member of the Association
of Scientologists for Reform

TO: THE Senate Commission on Institutions of N.J.

Gentlemen;

I am appearing before you today in behalf of the 70% of the population of New Jersey that is involuntarily committed.

We have found that those that are involuntarily committed "because they are dangerous to themselves or others" are considered as such by no other method than opinion. This opinion is from a professional group that has a higher ratio of suicide than any other professional group in the country.

Involuntary commitment keeps a captive audience for these psychiatrists to use for professional fees.

Dr. Thomas Szasz author of "The Danger of Coercive Psychiatry" is quoted as saying "Mental illness is a myth, used by society to conceal conflict as illness and to justify coercion as treatment. And involuntary hospitalization for this "illness" is a grave attack on the rights of those condemned to confinement. In a truly free society, involuntary psychiatry has no place." Dr. Szasz is a psychiatrist and an author..

The opinion of a psychiatrist as to the mental soundness of an individual we find to be inconclusive and to be vested.

Attached to this submission there are pieces of our research into ECT and other methods of psychiatric treatment.

There are few statistics available of those who have been involuntarily committed and actually rehabilitated.

Not to labor the issue with the tales of the horrors of involuntary commitment and the enforced psychiatric treatment we are offering the solution;

1) that an addendum to the 1677 that any treatment center for those who must be committed have a statistic the cost/?efficiency ratios.

2) that a complete physical examination be mandatory

3) that before any commitment this examination take place to ascertain whether or not there is suppressed physical pain.

4) that rehabilitation of these individuals actually does take place.

5) that drugs not be used as a substitute for rehabilitation

6) that electro shock treatment be discontinued as a treatment.

Our aims and goals like yours are to decrease the numbers of individuals that are wards of the state.

The revolving door the institutions now have must be corrected.

Both the taxpayers and those who are institutionalized must be helped.

The continuance of spending to incarcerate humans to the hands of those who do not rehabilitate but do drug and shock must be stopped.

We charge that involuntary commitment on opinion is a violation of the Constitution and the Declaration of Human Rights and hope that this will bring this commission to restrict the use of opinion in warehousing free men.

Thankyou,

Marie E. Mc Gahan

TESTIMONY ON SENATE BILL 1677

SUBMITTED TO SENATE COMMITTEE ON INSTITUTIONS, HEALTH AND WELFARE PUBLIC HEARING

October 14, 1976

By MORTON FRIEDMAN, M.D.

I wish to draw attention to a paradox contained within Senate Bill 1677: it would recognize that mental illnesses are associated with physical problems, and, at the same time, would permit persons with no training in physical problems to diagnose and certify the existence of mental illness.

The bill's definition of "Mental Disorders" as any organic, mental or emotional impairment which has substantial adverse effects on an individual's behavior recognizes the fact that mental disorder can involve the physical aspects of a human being. Further, it separates such disorders from other physical impairments which affect behavior, thereby requiring the examiner to be able to make a differential diagnosis out of a knowledge of the complete human being. This is something only a physician is trained to do. Yet, the bill would exclude the majority of physicians from the right and obligation to perform this function and instead would include psychologists, who are trained in only one narrow aspect.

In my sixteen years of practicing psychiatry in New Jersey, whenever I have had to sign a commitment form, my co-examiner has either been the family physician (family practitioner or internist) who had known the patient and the family and who was in an excellent position for evaluating the patient's condition and functions, or an emergency room physician well-trained in dealing with emergencies that befall human beings, including psychiatric emergencies.

We cannot separate mental disorders from the body. The mind does not function as some mystical ether floating outside the human body but is a function of the brain and its interaction with the rest of the body. What we call "functional" rather than specifically organic disease simply indicates that there is no structural abnormality and no organic cause is definitely known. However, in functional disorders we know that there are derangements in the neuro-hormonal balances and other changes on the molecular level, and much of our drug therapy is based on rationale growing out of the understanding of the inter-related physiology. Again, these systems are those that the physician has been trained to evaluate and handle.

The training of physicians is unique in that it inculcates a sense of responsibility for the whole person. To have had the experience of sitting up all night treating a dying patient; to have had the experience and responsibility for the delivery of a baby; to treat the many infirmities of elderly patients all help the budding physician to develop an understanding of the whole human being that no other profession can develop.

I have been involved in teaching medical students in New Jersey since 1960. The student is taught psychiatry in every year of medical school. In some ways, therefore, his training in psychiatry is more intense and more complete than it is in many other medical specialties.

As the Chief of Psychiatry at Overlook Hospital, I am involved in the psychiatric training for the Residency Training Program in Family Practice. The residents receive didactic training in psychiatry for all three years in which they are in residency (post graduate M.D.) training. In addition, they each have a psychiatrist as a preceptor so that they have continual training in the psychiatric aspects of their patient's problems. Furthermore, they receive training in our psychiatric ward and with psychiatric emergencies to which they must respond in the Emergency Room. These superbly trained people would be excluded by S-1677 from carrying out duties they are most intensively prepared to handle.

Let me finish with a question: If by unfortunate circumstances any of you, or your loved ones, were in a situation where you had to have an evaluation of a mental disorder, its differential diagnosis, and decisions made for treatment, and whether that treatment must include commitment to a hospital, would you wish to have that evaluation done by physicians trained to examine, understand, and treat the whole person or by someone with more limited training and perspective? I urge you to amend S-1677 to prevent non-medical persons from certifying the existence of a serious medical problem.

MORTON FRIEDMAN, M.D.
Fellow, American Psychiatric Association
Associate Clinical Professor of Psychiatry,
College of Medicine of New Jersey
Chief: Department of Psychiatry,
Overlook Hospital, Summit, New Jersey
Vice President, New Jersey Psychiatric Assoc.

NATIONAL ALLIANCE FOR THE PREVENTION
AND TREATMENT OF ALCOHOL

A group member of the Association
of Scientologists for Reform

Gentlemen:

We would like to address your attention to the involuntary committment of those who are considered dangerous because they have been or are addicted to alcohol.

Usually there is a distinction from those who are incoluntarily committed without signs of drug and alcohol.

Our research has shown us that crime is often drug or alcohol related.

We have also found that this is also the background of those who become institutionalized as incompetant.

In bringing this to your attention we would hope that the alcoholic be differentiated from those that are mentally ill.
That they be treated as alcoholic and not institutionalized.

That they be given full physical examinations.

That programs for alcoholics be made accessable to the community.

That these programs be used as an alternative measure to institutionalization.

that these programs be run on the basis of cost efficiency.

that they do not contain the use of antabuse.

That any such program as an alternative be operated on a cost efficiency basis and offer rehabilitation of reading and skills as part of the program.

That quarterly reports be submitted about any such program.

that they be discontinued if not producing a result.

Thankyou for your attention

Frank Meade



