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

before

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

on

SENATE BILL NO. 352

(An Act concerning the involuntary commitment of persons for treatment of mental disorders)

Held:
June 26, 1980
Room 223
State House
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Anthony Scardino, Jr. (Chairman)
Senator William J. Hamilton, Jr.
Senator Anthony E. Russo
Senator Garrett W. Hagedorn
Senator James P. Vreeland, Jr.

ALSO:

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

* * * * *

I N D E X

- - - - -

1--18:III
19-29:I

SENATE, No. 352

STATE OF NEW JERSEY

PRE-FILED FOR INTRODUCTION IN THE 1980 SESSION

By Senators HAGEDORN and PARKER

AN ACT concerning the involuntary commitment of persons for treatment of mental disorders, revising parts of the statutory law, and supplementing article 3 of chapter 4 of Title 30 of the Revised Statutes.

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

1. (New section) The Legislature hereby finds and declares that involuntary commitment of an individual for the treatment of a mental disorder necessarily requires the abrogation of certain fundamental human rights in order to provide protection for the interests of both society and the individual; that within this context the process of involuntary commitment must nevertheless include certain minimum safeguards for the individual's rights and welfare; and that it is the public policy of this State to establish commitment procedures which are in full compliance with all of the constitutional, legal and civil rights of the individual.

2. R. S. 30:4-23 is amended to read as follows:

30:4-23. As used in this article: "Chief executive officer" means the chief executive and administrative officer of any institution as designated for that purpose by the board of managers.

"County counsel" includes the chief legal officer or adviser of the **[**board of chosen freeholders**]** *governing body* of any county in this State or his duly authorized representative.

"Institution," includes, except as herein otherwise provided, any State or county institution for the care and treatment of the mentally ill**[**, the tuberculous,**]** or the mentally retarded in this State, as the case may be.

"Court" means the **[**County**]** *Superior* Court **[**of any county in this State,**]** or the juvenile and domestic relations court of any county.

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

"Medical director" means the physician charged with the overall professional responsibility for the operation of a mental [or tubercular] hospital.

"Patient" includes any person or persons alleged to be mentally ill[, tuberculous,] or mentally retarded whose admission to any institution for the care and treatment of such class of persons in this State has been applied for.

"Discharge" shall mean relinquishment by all agents of the department of all legal rights and responsibilities acquired by reason of the admission, with or without court order, of that person to any residential or functional service whose operation is in any way authorized by the department, except that the right and responsibility to pursue and recover unpaid charges shall be maintained.

"Police official" shall mean any permanent and full time active policeman of any police department of a municipality or a member of the State Police or a county sheriff or his deputy.

"Evaluation services" shall mean those services and procedures in the department by which eligibility for functional services for the mentally retarded is determined and those services provided by the department for the purpose of advising the courts concerning the need for guardianship of individuals over the age of 18 who appear to be mentally deficient.

"State school" shall mean any residential institution of the State of New Jersey which is so designated by the State Board of Control and whose primary purpose is to provide functional services for the mentally retarded.

"Mental hospital" shall mean any inpatient medical facility, public or private, so designated by the board of control. Such a hospital may be an institution exclusively for the care of the mentally ill, or it may be a general hospital providing facilities for the diagnosis, care and treatment of individuals with mental illnesses on an inpatient basis.

"Practicing physician" shall mean a physician licensed to practice medicine in any one of the United States; provided, however, that "practicing physician," with reference to admission to mental hospitals shall not include any physician who is a relative, either by blood or marriage, of the patient, nor the director, chief executive officer, or proprietor of any institution for the care and treatment of the mentally ill to which application for admission is being prepared.

"State residential services" shall mean observation, examination, care, training, treatment, rehabilitation and related services,

including family care, provided by the department to patients who have been admitted or transferred to, but not discharged from, any State hospital for the mentally ill [or tuberculous] or any residential functional service for the mentally retarded; "county residential services" shall mean comparable services provided to patients who have been admitted or transferred to, but not discharged from, any county hospital.

"Admitting physician" shall mean that physician designated by the medical director to act as his agent in authorizing the admission of patients to a mental hospital.

"Attending physician" shall mean a practicing physician in the community attending the patient in his home or in a mental hospital, or the physician on the staff of a mental hospital who is immediately responsible for the care and treatment of the patient.

"Chief of service" shall mean the physician charged with overall responsibility for the professional program of care and treatment in the particular administrative unit of the mental hospital to which the patient has been admitted, or such other member of the medical staff as may be designated by the medical director. He shall have the custody and control of every person admitted to his service until properly transferred or discharged.

"Custody" shall mean the right and responsibility to provide immediate physicial attendance and supervision.

"Family care" shall mean a program conducted under the regulations of the State Board of [Control] *Institutional Trustees,* for the placement with suitable private families or in boarding homes holding a certificate of approval in accordance with State law of individuals who are eligible for care in mental hospitals or for functional services for the retarded, who have no need for professional nursing services, who have no suitable homes of their own, and who have no relatives able to provide minimum sheltered care.

"Eligible mentally retarded person" shall mean a person who has been declared eligible for admission to functional services of the department.

"Functional services" shall mean those services and programs in the department available to provide the mentally retarded with education, training, rehabilitation, adjustment, treatment, care and protection.

"Mental deficiency" shall mean that state of mental retardation in which the reduction of social competence is so marked that persistent social dependency requiring guardianship of the person shall have been demonstrated or be anticipated.

"Mental retardation" shall mean a state of significant subnormal intellectual development with reduction of social competence in a minor or adult person; this state of subnormal intellectual development shall have existed prior to adolescence and is expected to be of life duration.

"Mental illness" shall mean mental disease to such an extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others, or of the community, *and shall include mental disorder.*

"Mental disorder" means any organic, mental or emotional impairment which has substantial adverse effects on an individual's behavior and actions, but shall not include mental retardation.

"Dangerous" means suffering from a mental disorder and by reason of such disorder posing a substantial risk in the foreseeable future of (1) attempting to commit suicide, as evidenced by behavior causing or attempting serious bodily harm upon oneself, (2) inflicting serious unjustified bodily harm on another person, as evidenced by behavior causing or attempting or threatening such harm on others, or (3) impairing one's physical health or causing oneself substantial bodily injury, serious disease, debility or death from lack of self-control or judgment in caring for personal needs such as shelter, nutrition and medical attention.

"Hospital" means a public or private facility or portion thereof designated by the Department of Human Services as a provider of inpatient mental health services, including any institution used exclusively for the care and treatment of the mentally disordered, any mental health center, or any general or community hospital.

"Screening service" means a service which provides for the examination, diagnosis, evaluation and emergency treatment of persons who are alleged dangerous due to a mental disorder.

"Director" means the chief administrative officer of a screening service or his designee.

"Psychiatrist" means a physician who is licensed to practice medicine and surgery in any one of the United States and is certified or eligible for certification by the American Board of Psychiatry and Neurology, and is not related by blood or marriage to the person for whom involuntary commitment is sought.

"Psychologist" means a psychologist licensed by this State who has earned a doctoral degree in an accredited program with clinical experience in diagnosing and treating mental disorders, and is not related by blood or marriage to the person for whom involuntary commitment is sought.

"Physician" means a person who is licensed to practice medicine and surgery in any one of the United States and is not related by blood or marriage to the person for whom involuntary commitment is sought.

"Department" means the Department of Human Services.

3. R. S. 30:4–25 is amended to read as follows:

30:4–25. For the purpose of this Title the method of commitment of mentally ill patients shall be divided into [five] *four* classes:

[Class A. Where immediate temporary confinement in an institution is not necessary before making final order of commitment.

Class B. Where immediate temporary confinement is necessary, owing to the condition of the patient, and where an order of temporary confinement can be obtained before the patient is taken into such institution.

Class C. Where immediate confinement in an institution before making the temporary order hereinafter referred to is necessary, owing to the condition of the patient, and where an order of temporary commitment cannot be obtained before the patient is taken into such institution.]

(1) Where a person is determined to be dangerous and in need of immediate involuntary commitment.

(2) Where a person is determined to be dangerous but is not in need of immediate involuntary commitment.

[Class D.] *(3)* Where a person voluntarily applies for admission to an institution for treatment. In all such cases the admission and maintenance shall be governed by the provisions of [section] *R. S.* 30:4–46 [of this Title].

[Class E.] *(4)* Where a person in confinement, under care of the chief executive officer of any correctional institution, is to be transferred to an institution for treatment. In all such cases the procedure shall be governed by the provisions of [section] *R. S.* 30:4–82 [of this Title].

4. R. S. 30:4–33 is amended to read as follows:

30:4–33. A person who shall sign an application or certificate or written statement [of a practicing physician] *concerning the examination of a person believed to be dangerous or* for the commitment of a person to an institution for the mentally ill[,] *or* mentally retarded[, or tubercular] in this State for any purpose or motive other than the *examination,* care and treatment of the [patient] *person* or who shall in any manner aid or abet in any such application, *certification or statement* shall be guilty of a [misdemeanor] *crime of the fourth degree.*

5. R. S. 30:4-48 is amended to read as follows:

30:4-48. A person admitted to any mental hospital under [section] *R. S.* 30:4-46 [of this Title] may be discharged therefrom upon the certificate of the medical director or chief of service, made to the chief executive officer stating either that the said patient is recovered or that further treatment in the hospital is unnecessary or undesirable. Any such person, not so discharged, who desires to leave such institution, shall be released therefrom, when, he or the applicant or some one acting in his behalf, shall give notice to the chief executive officer, the chief of service when so designated or the medical director of such institution of his desire to be discharged, and such person shall be released at the earliest opportunity possible in accordance with the rules and regulations of the hospital, the department, or the [board of chosen freeholders] *governing body*, as the case may be, but in every case prior to the expiration of 72 hours.

When discharge has been requested by or on behalf of any patient above described, and when, in the judgment of either the chief executive officer or the chief of service when so designated, or the medical director, together with the patient's attending physician in the hospital, [there is believed to exist in the patient a diagnosed mental illness of such degree and character that the person, if discharged, will probably imperil life, person or property,] *said patient is believed to be dangerous*, either the chief executive officer or the chief of service or the medical director, together with the attending physician, shall make application to the court for an order authorizing hospitalization of the patient as provided for in this Title. *Such application and subsequent court hearing and reviews shall be carried out in conformity with the procedures and rights otherwise applicable for the involuntary commitment of a person believed to be dangerous.*

6. R. S. 30:4-60.1 is amended to read as follows:

30:4-60.1. Upon the making of any order admitting or committing a person to [a mental hospital or] *an* institution for the mentally retarded supported in whole or in part from county, municipal or State funds, the county adjuster of the county in which the court making the order is located shall forthwith deliver to the chief executive officer of the institution a transcript of the evidence presented to the court or a copy of the testimony taken by the county adjuster on behalf of the court relating to the question of indigency including a statement of the kind, value and location of the patient's estate, or, in the event that a relative of the patient

is made chargeable with his support, a detailed statement of the financial means of such chargeable relative.

7. (New section) The governing body of each county, after consultation with the county mental health board and approval by the department, shall designate one or more screening services within such county or within such inter-county region as the department may approve. Any such service may be located in any existing mental health facility, general or community hospital, or community mental health project as defined in section 2 of P. L. 1957, c. 146 (C. 30:9A–2).

A screening service shall provide examinations, diagnoses evaluation and emergency treatment in accordance with standards promulgated by the department, which standards shall include, but not be limited to, staffing skills and patterns, operational procedures, evaluative methods and operating hours; provided, however, that the service shall be available for the admission of persons on a 24-hour per day basis.

The department shall, either through direct payments or reimbursement to the county governing body, pay all of the expenses for the establishment and operation of a screening service. The department and governing body shall enter into such agreements as are necessary to provide for such payments or reimbursements.

8. (New section) Whenever any person, who may be a resident or nonresident of this State, is believed to be dangerous by a member of the immediate family or next-of-kin of such person, or by a physician, psychiatrist, psychologist, county medical examiner, nurse, social worker, police official, county prosecutor or county or municipal welfare director, any such party may apply to (a) a screening service or (b) a psychiatrist and either a physician or psychologist, or two psychiatrists, for a preliminary examination to determine whether such person is dangerous and in need of involuntary commitment to a hospital. The application for such examination shall be on a form prescribed by the department and shall be a written and sworn document, based upon personal observation, setting forth the probable cause constituting the grounds for believing the person to be dangerous. Such examination shall be conducted in the least possible restrictive setting and in the manner prescribed by sections 9 through 13 of this act in the case of a screening service, and by sections 14 and 15 of this act in the case of a psychiatrist and either a physician or psychologist or two psychiatrists.

9. (New section) a. Upon receiving an application, if the director shall determine through home visit or other appropriate

means that it is valid, that the basis for the application appears to be true, and that the basis constitutes grounds for believing such person to be dangerous, he shall admit the person named in the application, and if necessary, authorize a police official to bring the person to the screening service.

b. In an emergency situation, a police official who believes that a person is dangerous, based upon personal observation, may take such person directly to a screening service for admission and shall file the appropriate application as soon thereafter as possible.

c. If the director shall determine that such application is not valid or that the basis for the application does not appear to be true or that the basis does not constitute grounds for believing such person to be dangerous, he shall dismiss the application and shall not admit such person.

10. (New section) a. No person shall be detained by a screening service more than 72 hours, except upon a determination after examination that such person is dangerous and in need of involuntary commitment.

b. The director shall take all necessary actions to notify officials of appropriate public or private agencies of the admittance of a person in order to provide for the care of any dependents of such person and the protection of the personal property and living premises of such person during the time such person is detained by the screening service.

11. (New section) Every person admitted to a screening service shall have the following rights:

a. The right to be represented by an attorney and, if unrepresented or unable to afford an attorney, to be provided with one;

b. The right to communicate with others, including reasonable use of the telephone for such purpose, and to receive assistance from the screening service in attempting to communicate with others;

c. The right to be informed of the reasons for admittance to the service;

d. The right to receive services as soon as possible;

e. The right to voluntarily leave the screening service after 72 hours, unless the person has been determined after examination to be dangerous and in need of involuntary commitment; and

f. The right to have services and examinations provided in the person's primary means of communication, or with the aid of an interpreter if such person is of such limited English-speaking ability or suffers from a speech or hearing impairment as to preclude an effective and objective determination of whether such person is dangerous.

A verbal explanation and written statement of such rights shall be provided to such person at the time of admittance.

12. (New section) As soon after admission as possible, a person shall be examined by appropriate screening service staff, which shall include, but not necessarily be limited to, a psychiatrist and either a physician or psychologist, or two psychiatrists. Said staff shall determine whether the person is suffering from a mental disorder and, if so is dangerous. The results of all examinations, diagnoses and evaluations shall be maintained in the person's record.

In the event that it is determined that:

a. The person does not have a mental disorder, he shall be discharged;

b. The person is not dangerous, but is suffering from a mental disorder, he shall be discharged and referred to alternatives to involuntary commitment, including voluntary hospitalization, residential care and treatment in a mental health program or agency, or other appropriate public or private service; provided, however, that the person shall be under no duty or obligation to participate in any such alternative;

c. The person is dangerous and in need of involuntary commitment for immediate care and treatment, he shall be retained by the screening service and proceedings for involuntary commitment shall be initiated pursuant to section 13 of this act; or

d. The person is dangerous but is not in need of immediate involuntary commitment, he shall be discharged in the care and custody of an appropriate family member or other interested party and proceedings for involuntary commitment shall be initiated pursuant to section 13 of this act.

13. (New section) Within 48 hours after such determination, the director shall file with the Superior Court an application for involuntary commitment on such form as the department shall prescribe and in conformance with the rules of the court, which shall include a certificate from a psychiatrist and either a physician or psychologist, or two psychiatrists, attesting to the fact that such person is dangerous and in need of involuntary commitment. Each of the two certificates shall be on such form as the department shall prescribe and shall contain the following information:

a. The date or dates of the examination;

b. A statement of the person's mental and physical condition;

c. The basis for determining that such person is dangerous and in need of involuntary commitment;

d. An explanation of the alternatives to involuntary commitment which were considered and found inappropriate; and,

e. The name, address and practitioner's license number of the examining physician, psychiatrist or psychologist; and,

f. Any other information deemed necessary to further explain the need for involuntary commitment.

14. (New section) a. Upon receiving an application as prescribed in section 8 of this act, if the psychiatrist and either a physician or psychologist, or the two psychiatrists, shall determine through home visit or other appropriate means that it is valid, that the basis for the application appears to be true, and that the basis constitutes grounds for believing such person to be dangerous, either examiner may, if necessary, apply to a judge for an order to authorize a police official to bring such person to them for an examination.

If either examiner shall determine that such application is not valid or that the basis for the application does not appear to be true or that the basis does not constitute grounds for believing such person to be dangerous, he shall dismiss the application and shall not proceed to examine such person.

15. (New section) Upon acceptance of the application, the psychiatrist and either a physician or psychologist, or the two psychiatrists, shall examine such person as soon as possible to determine whether the peron is suffering from a mental disorder and, if so, is dangerous. The results of all examinations, diagnoses and evaluations shall be maintained in the person's record.

In the event that it is determined that:

a. The person does not have a mental disorder, he shall be discharged;

b. The person is not dangerous but is suffering from a mental disorder, he shall be discharged and referred to alternatives to involuntary commitment, including voluntary hospitalization, residential care and treatment in a mental health program or agency, or other appropriate public or private service; provided, however, that the person shall be under no duty or obligation to participate in any such alternative;

c. The person is dangerous and in need of involuntary commitment for immediate care and treatment, the two examiners shall each file with an appropriate hospital an application for involuntary commitment and a certificate attesting to the fact that such person is dangerous and in need of involuntary commitment and containing the information set forth in section 13 of this act. The certificate

shall be authorization for a first aid squad or a police official to take such person to the appropriate hospital for admission.

d. The person is dangerous but is not in need of immediate involuntary commitment, he shall be discharged in the care and custody of an appropriate family member or other interested party and the examiners shall file with the court an application for involuntary commitment, which shall include the certificate from each examiner and such other documents as may be necessary.

16. (New section) Within 48 hours after admission pursuant to subsection 15. c. of this act, the hospital shall file with the court an application for involuntary commitment on such form as the department shall prescribe, which shall include the certificate from each examiner and such other documents as may be necessary.

17. (New section) Every person admitted to a hospital pursuant to subsection 15. c. of this act shall have the following rights:

a. The right to be represented by an attorney and, if unrepresented or unable to afford an attorney, to be provided with one;

b. The right to communicate with others, including reasonable use of the telephone for such purpose, and to receive assistance from the hospital in attempting to communicate with others;

c. The right to be informed of the reasons for admittance to the hospital; and

d. The right to receive services as soon as possible.

A verbal explanation and written statement of such rights shall be provided to such person at the time of admittance.

18. (New section) a. Upon receipt of documents from a screening service pursuant to section 13 of this act or from a hospital pursuant to section 16 of this act the court shall immediately review the documents before it and receive such testimony as it may deem necessary from any interested party in order to determine whether there is probable cause to believe that the person is dangerous and in need of involuntary commitment. The person shall have the right to appear before the court and to be represented by an attorney during this proceeding. If the person is unrepresented or unable to afford an attorney, the court shall appoint an attorney to represent such person during this and all subsequent proceedings pursuant to this act. Such counsel may be the Division of Mental Health Advocacy in the Department of the Public Advocate. If the court finds no such cause, it shall order immediate release of the person. If the court finds such cause, it shall issue a temporary order for commitment of such person to an appropriate hospital. Such order shall also:

(1) Establish a date for a final commitment hearing to be held no later than 10 days after the issuance of the temporary order; provided, however, that the court may grant a continuance of the hearing for an additional 15 days for good cause requested by the attorney of the detained person;

(2) Authorize the person's attorney to inspect and copy all records pertaining to the person's mental and physical condition.

b. In the case of a person discharged in the care and custody of a family member or other interested party, the court shall not conduct an immediate review for the purpose of issuing a temporary order for commitment, but shall proceed with a final commitment hearing in the manner prescribed in subsection a. of this section.

19. (New section) a. At least 5 days prior to such hearing, the county counsel shall cause notice of such hearing to be served upon the person, the person's immediate family, if known, the person filing the application for examination pursuant to section 8 of this act, the person's attorney, the county adjuster of the county wherein the person is detained, the two examiners who certified that such person was dangerous, and the director of the screening service or the chief officer of the hospital in which such person is detained. Such notice shall contain:

(1) The date, time and location of the hearing;

(2) A copy of the application for examination;

(3) A copy of the certificate signed by the examiners;

(4) A copy of the temporary order of commitment;

(5) The names of the persons who will testify in support of involuntary commitment and the basis for such support; and

(6) A statement of the rights of the person, including, but not necessarily limited to, the right to counsel, the right to a jury trial, the right to a court-appointed psychiatrist or psychologist who is acceptable to such person as to profession and credentials to act as an expert witness on behalf of such person, and the right to be present at the hearing and to cross-examine witnesses. The fee for any examinations and testimony provided by such expert witness shall be set by the court and shall be charged to the expense of such person, if financially able to afford such expense, or to the expense of the public body responsible for such person's legal settlement.

The person serving such notice shall certify such service to the court and county counsel.

b. The county counsel shall have the responsibility to proceed with the commitment hearing. If the person for whom commitment

is sought is subsequently found to have legal settlement in another county or to have no county settlement, then the county counsel's office shall be entitled to a reasonable fee as set forth by the court to be chargeable to the county of legal settlement or to the State if there is no county settlement.

20. (New section) a. The court shall conduct such hearing at the hospital to which the person has been temporarily committed, except that a hearing may be held at an alternative location upon the determination of the court after the filing of a motion by any party showing good cause in extraordinary cases. In the case of a person discharged in the care and custody of an appropriate family member or interested party, such hearing shall be conducted at a location of the court's discretion.

b. The person shall be afforded the constitutional and statutory rights and rules of evidence afforded to a defendant in a criminal case except for bail or grand jury hearing.

c. If the court, or jury in the case of a hearing by jury, finds that such person is dangerous beyond a reasonable doubt, the court shall issue an order for commitment and treatment of the person in an appropriate hospital; provided, however, that the court may designate in lieu of residential confinement in a hospital any partial hospitalization, out-patient service or other alternative service which would appropriately meet the person's needs in the least restrictive setting.

d. If the person is found not to be dangerous, the court shall issue an order for the immediate release of the person from the hospital or temporary care and custody in which such person has been placed. Under no circumstances shall a person found not to be dangerous be detained in a hospital or in the care and custody of another.

21. (New section) The order for commitment shall not exceed 3 months and shall be reviewed at subsequent hearings in the manner provided in sections 18 through 20 of this act in accordance with the following schedule: no later than 3 months from the date of the initial order; 6 months from the date of the initial order; and annually thereafter. If the court determines that commitment shall be continued, it shall issue a new order for commitment which shall be in effect until the date of the next review hearing. If at any time before the expiration of an order of commitment, the medical director or chief of service or designee responsible for the care and treatment of the person finds the person is no longer dangerous, the director or chief of service or designee shall notify the court which

has issued the order of commitment, and shall discharge the person with an appropriate plan for continued treatment and rehabilitation in community after-care services and agencies, if necessary. Said after-care services and agencies shall be notified of the referral and plan. The person to be discharged shall be given an opportunity to participate in the formulation of the plan. The person shall be under no duty or obligation to participate in the plan after discharge if he chooses. However, the appropriate after-care service or agency shall affirmatively attempt to interest the person in said program.

22. (New section) The person's legal settlement providing for the payment of the expense of his legal services, care and treatment shall be considered at a separate hearing on notice to the person, immediate family, the applicant, and person's attorney, which shall be held by the county adjuster of the county in which the person has legal settlement; provided, however, if there is no county settlement, then by the county processing the commitment. The results of the hearing and the approval and order of the court pursuant to said hearing shall be forwarded to all the above parties and the county adjuster of the county which processed the commitment hearing if that be different than the one holding the legal settlement hearing.

23. (New section) In determining the person's legal settlement, the court shall direct that the cost of the care and maintenance of such person, based upon a formula of financial ability to pay as promulgated annually by the Department of the Treasury, shall be paid out of the estate of the person or by the person chargeable by law with his support, or by contract, as the case may be, and the judgment shall specify the amount of maintenance as fixed from time to time for the hospital or alternative service to which such person is committed, which shall be paid thereunder, and shall in the discretion of the court, contain such direction as may seem proper concerning security to be given for such payment. As long as the amount contributed by the person's estate or his legally responsible relatives for the care and maintenance of such person exceeds the amount chargeable as fixed pursuant to R. S. 30:4–78, no order shall be entered against the county of legal settlement for any part of such maintenance.

If a person and his chargeable relatives are found unable to pay an amount for such care and maintenance in excess of the amount chargeable to the county of legal settlement, the court shall direct that the cost be chargeable to the county of legal settlement, if any, or to the State, and on reasonable notice to the persons to be

charged, may further direct that such person or chargeable relatives, or any of them, pay monthly in advance to the hospital or alternative service to which such person is committed, or the county treasurer of the county chargeable, or to the State Treasurer if the State is chargeable, such part of such cost as the court may direct. If such county treasurer, or the State Treasurer, shall receive from such person or chargeable relatives any money in excess of that paid by the county or State in support of such person, he shall pay such excess to the hospital or alternative service to which such person is committed for the use of such hospital or service.

24. (New section) No person acting in accordance with this act shall be civilly or criminally liable, providing that action was not malicious or negligent, or in willful disregard of any provision of this act.

25. (New section) The following are repealed:

Section 21 of P. L. 1965, c. 59 (C. 30:4–26.3),

Section 2 of P. L. 1971, c. 450 (C. 30:4–26.3a),

R. S. 30:4–27 through R. S. 30:4–31,

R. S. 30:4–36 through R. S. 30:4–39,

R. S. 30:4–41,

R. S. 30:4–42,

R. S. 30:4–44,

R. S. 30:4–45,

P. L. 1953, c. 418 (C. 30:4–46.1 et seq.),

R. S. 30:4–56 through R. S. 30:4–60.

R. S. 30:4–61 and 62

26. (New section) Nothing herein shall infringe upon the constitutional or statutory rights of habeas corpus.

27. (New section) If any provision of this act or the application thereof to any person or circumstance is found unconstitutional, the remainder of this act and the application of such provisions to other persons or circumstances shall not be affected thereby, and to this end the provisions of this act are severable.

28. (New section) This act shall take effect 1 year following enactment; provided, however, that sections 18 through 20 shall be effective immediately.

STATEMENT

The Final Report of the New Jersey Mental Health Planning Committee (June, 1976) recommended a major revision in the State's civil involuntary commitment laws. The Planning Com-

mittee found that the present statutes offer inadequate protection of the rights of the individual and lack safeguards against inappropriate commitment. Specifically, the Planning Committee was critical of existing civil commitment legislation for the following reasons: (1) it does not provide proper due process safeguards; (2) it is ambiguous or silent on such critical definitions as "mental disorder," "dangerous" and "in need of care"; (3) it does not reflect recent judicial decisions which provide certain civil and legal rights for the person subjected to involuntary commitment; (4) it permits such procedures as commitment for up to 7 days on the signature of one physician and up to 15 days on a court order without medical examination; and (5) it does not specifically require examination by a psychiatrist (only a physician) and does not provide a role for a psychologist in the commitment process. This bill attempts to answer all of these criticisms while providing for an entirely new mechanism for processing persons believed to be dangerous and in need of involuntary commitment. Fundamentally, the bill requires that a person who is believed to be dangerous must be examined in either a screening service established by each county or in the private offices of at least two examiners (either two psychiatrists or a psychiatrist and either a psychologist or a physician) for a determination as to whether involuntary commitment is necessary. Only after a determination is made that a person is dangerous can an application be made to the court for an order for commitment. This screening is designed to avoid inappropriate commitments and to refer persons to more suitable mental health programs.

This bill replaces the existing four classifications of involuntary commitment with two: (1) immediate commitment by temporary court order (to be followed within 10 days by a hearing for a final order) or (2) release in someone's custody until the date of the hearing for a final order of commitment.

The bill provides the persons subject to these proceedings with a number of rights while being detained in a screening service (the detention is limited to 72 hours unless the person is found to be dangerous) or in a hospital prior to the court hearing. It establishes certain requirements regarding the timeliness, order of procedure and assignment of responsibility for all events relating to the examination, detention and commitment of an individual. It prescribes certain due process safeguards concerning the court hearing on commitment and mandates a continuing court review of the commitment.

The requirement that each county must designate a screening service, either on its own or jointly with other counties in such inter-county region as the Department of Human Services may approve, should not be construed to imply the construction of new facilities. All such services must be approved by the department, and it is the department's intention, as outlined before this committee and as indicated in the bill, to locate the services in existing mental health facilities, general or community hospitals or community mental health centers. In fact, Federal law requires that community mental health centers perform such a screening service in order to guide individuals to the most suitable mental health program.

The department has indicated that funding for the screening services will be met through Federal Community Mental Health Center Act grants, State aid for mental projects pursuant to P. L. 1957, c. 146 (C. 39:9A–1 et seq.) and existing State-county cost sharing arrangements for mental health programs.

It should be noted that the bill does not become effective until 1 year following enactment, although the sections concerning the procedures for court hearings become effective upon enactment. These procedures can be followed without delay, while time is needed to prepare the screening services required by the bill.

SENATOR ANTHONY SCARDINO, JR. (Chairman): Good morning. Welcome to the Senate Institutions, Health and Welfare Committee meeting. Today we have two items on the agenda. One has to do with a bill sponsored by Senator Herbert of Bergen County, dealing with a bond issue, Senate Bill 1350, and the other matter is a public hearing on Senate Bill 352, sponsored by Senator Hagedorn and others. We are now going to begin the public hearing on Senate Bill 352. Sometime during the course of that public hearing, we will discontinue discussion temporarily so that we can deliberate on the bond issue bill, sponsored by Senator Herbert. We will do that when we have a quorum, which we do not have at this point.

As to Senate Bill No. 352, the purpose of the bill is to amend and supplement Article 3 of Chapter 4, Title 30, providing a new procedure for the civil, or involuntary commitment of persons with mental disorders who are believed to be dangerous. The procedure is designed to avoid inappropriate commitments and to refer persons to more suitable mental health programs.

The bill requires that a person believed to be dangerous may be examined in either a county screening service or the private offices of at least two examiners, either two psychiatrists or a psychiatrist and either a psychologist or a physician, for determination as to whether involuntary commitment is necessary.

That, of course, is just a very brief summary of what the intent and purpose of that bill is. But for those of you that have been involved in the deliberative process that this Committee has had over the years in this subject area, I am sure you will agree that that brief statement makes it sound all too simple, because it is a very complex area and there are some deep concerns on the part of the sponsor of the bill, Senator Hagedorn, and on the part of myself and the rest of the Committee, particularly dealing -- not solely, of course - with the definition of dangerousness and other questions involved with psychologists, psychiatrists, doctors, and just who should be involved in this process of commitment, and the question dealing with the screening services. I note that in the comments that accompany the bill the screening services seem to be separate and distinct units, or new units, that will crop up here and there throughout the State of New Jersey. But, that is only the impression I got from reading the comments. I could, maybe, have read them too quickly and misinterpreted them. But, I do recall that in the past we had pretty much narrowed that down and said that we might, in fact, get involved with contractual services with existing agencies, rather than talk in terms of new structures, or new facilities in various parts of the State.

But, in any event, that simply outlines only a few of the major areas of concern that we want to get into, and I am hopeful that as a result of the public hearing that we will be able to move on this bill and begin to move ahead progressively and, hopefully, have a meeting of minds and a feeling that whatever the outcome is, it will be a positive one, and one that is good for the people who we are trying to do something for.

Senator Hagedorn, before we call the first person who wishes to participate, do you have any comments that you would like to make at this point?

SENATOR HAGEDORN: Mr. Chairman, I certainly deeply appreciate your decision, as our very able Chairman, to hold a public hearing on S-352, which is designed to provide effective safeguards against inappropriate commitment.

And, S-352, which I have introduced, really was initiated, as you have indicated, by former Senator Alexander Menza, and was identified as S-1677.

This bill, of course, was influenced by the final report of the New Jersey Mental Health Planning Council, which in June of 1976 recommended a major revision in the State's involuntary commitment laws. And, we did have a public hearing on October 14, 1976, and actually S-1677 did pass the Senate, 27 to 0, but while it was on second reading in the Assembly, it never did get the opportunity for a vote.

At the time that S-1677 was created, it did create a great deal of interest and controversy, and after much study and deliberation by the Committee, compromises were reached that would satisfy all those who had manifested any interest.

The dumping of mental patients into institutions has been recognized as a national scandal by the House Select Committee on Aging, and S-1677 and now S-352 are both an attempt to provide safeguards to our New Jersey citizens. Since S-352 was scheduled for consideration by the Senate Institutions, Health and Welfare Committee, a pronounced interest has been manifested by psychiatrists, by psychologists, by social workers, and by other interested agencies. Of course, another concern has been the fiscal implication of the development of screening centers.

Since more than three years have elapsed, I appreciate your decision to have a new review and a public hearing so that everyone can participate and provide input so that we can ultimately provide the maximum safeguards to all our citizens.

SENATOR SCARDINO: Thank you very much, Senator Hagedorn.

We will now call upon our first participant, Dr. Bristow, New Jersey Psychiatric Association. Will you kindly step forward, Doctor?

W I L L I A M H. B R I S T O W, JR.: I am William H. Bristow, Jr., past President of the New Jersey Psychiatric Association and a psychiatrist in private practice in Bergen County.

SENATOR SCARDINO: Let me interrupt you at this point. I would like that door in the back closed. If someone would be kind enough, would you please do that. Thank you. Now, can everyone hear Dr. Bristow in the back of the room? Is anyone having any problem? (negative response) Okay. Fine. Proceed, Doctor.

DR. BRISTOW: We believe that S-352 is legally cumbersome, expensive to implement, and reflects an inappropriate concept of mental illness. By applying a model of social deviance, it will insure inadequate and inappropriate treatment for those who are mentally ill. The bill confuses criminal behavior and the behaviors of the mentally ill. In many places its narrow focus on "dangerousness" results in a model of social deviance which can result in the misuse of the mental health system. The definitions, in fact, preclude many mentally ill people from the commitment process, and thus can only lead to chronicity and more severe forms of illness.

The requirement of two examainers in emergency situations has no merit; the goal in an emergency is to provide rapid service in accord with reasonable practices. The notion here that two heads are better than one has little statistical justification.

The definition of mental disorder in S-352 can be interpreted to apply to all criminals, even those not considered by the medical profession

to be mentally ill. The bill could force the mental health system to be a haven for the criminal offender while neglecting many of the severely mentally ill.

The bill defines "director" as the chief administrative officer of a screening service, or his designee. He is not required to have any medical or psychiatric knowledge. The lack of professional psychiatric authority has already severely crippled many state programs. To extend this to screening or evaluative procedures would ensure a poor quality of care.

Because of the complexities of diagnosis and the problem of associated or inherent medical problems, the use of a psychologist for commitment purposes would not be appropriate to medical care. Most importantly, the significant psychotic disorders, those which most frequently lead to the question of commitment, are not treatable by psychological counseling approaches.

Under S-352, the director of a screening center may admit a person for detention on application of a police officer alone. In so doing, if the director were not a physician, and there is no requirement in the bill that he should be, it would allow an act involving the reasonable belief that mental illness exists to be determined by a non-medical person, clearly a violation of New Jersey's medical practices statutes.

S-352 would require an examination to be conducted in the least possible restrictive setting. What does this mean? We fear that it has no rational meaning at all.

S-352 also stipulates that a 48-hour period is allowed at a screening center; this period is too short for adequate evaluation.

The bill not only requires that the person be dangerous - without a mental illness requirement - but also uses the standard of "beyond a reasonable doubt" -- Section 20 c. The federal courts have already clearly established that the standard is to be that of "clear and convincing evidence." This standard, we feel, exemplifies the criminal law orientation of S-352, and its effect of "criminalizing" the mentally ill.

Section 21 of S-352 requires that a court discharge a patient from the hospital once he is "no longer dangerous" and refer him to "community aftercare services and agencies." The patient who still can benefit from care within the hospital and wishes to receive it, is thus denied such services unless he goes to another hospital and applies for them.

S-352 seems to ignore the availability of excellent screening services that already are provided in the emergency rooms of hospitals across the State of New Jersey, and seems to seek to duplicate these with funds that would be better used if applied to patient care services.

The New Jersey Psychiatric Association urges you not to release this bill and, instead, to develop a meaningful commitment statute which will assure appropriate treatment for those who need it. We stand ready to help you in this important endeavor.

SENATOR SCARDINO: Thank you, Dr. Bristow, very much. I do appreciate your comments. I think it is fortunate, in a way, that you were the first witness, because you certainly outlined, very succinctly, what the major areas of concern are, dealing with the bill. I am hopeful that the next person that addresses himself or herself to the Committee will be one that will speak directly in favor of the bill and perhaps counter some of the comments that Dr. Bristow has made.

I am particularly impressed with your comments dealing with the criminal element, and the fact that many might find themselves in an institution should the bill, as it is written now, be implemented. What I find interesting about that is -- and perhaps you would like to comment on this -- recently we had a follow-up, if you will, on a matter that has been of concern to this Committee for several years, and that is the question dealing with detainer patients in our mental institutions. Marlboro is a case in point. It seems we have had more involvement at that one institution than any other, and I think primarily it is because the local officials -- the mayor, the council, the police chief, etc. - have been rather vocial and have availed themselves of the opportunity to come before this Committee, and have asked for our time and attention, and we have complied accordingly. Each time that we meet and discuss the subject, we are told that there is a distinction between the detainer patient and the one that has not had a criminal charge against him or her. And, the question is, how do you deal with the detainer patient at the mental institution? Is he to be confined, or is he to be given the same "freedom" that is allowed to other patients at the institution? Should he be locked up, or given extra-special surveillance as opposed to the other patients -- the non-criminal patients?

What I find interesting in your comments is, if it is true that the mental institutions find themselves -- I always want to use the word "innundated"-- with detainer patients, because now the door will be opened wider, and if you are correct, what happens to those who are at the institution today who do not fall under that category? People who are in the institutions today would have to have the definition of "dangerousness" applied to them. So, conceivably, hundreds or thousands of people who are now confined, other than detainer patients - if the definition of dangerousness, as you interpret it, were upheld by the courts - would be released from the institutions. Do you see that as a possibility?

DR. BRISTOW: I think our concern is that the detainer patients, in most cases, are people who reasonably do seem to be dangerous. Because of the fact that they are detainer, I think this does result in a greater utilization of manpower and money to service those people. I think that would be our concern, that the detainer patient requires a special physical facility. If you are going to maintain security, you really have to have a person locked up, or else you have to have a sufficient number of personnel to guard them. That becomes a real problem, in that a mental hospital can become very much like a jail.

Now, there are individuals who are on a detainer who do have a significant mental illness and who do need to be treated. I think those people exist.

SENATOR SCARDINO: The point I am trying to make is that there are people at the institutions today - and I want you to react to this - who, if you apply the definition of dangerousness to them, as it appears in this bill, would have to be removed from that institution and would go back into the community.

DR. BRISTOW: Oh, yes. All right. Okay. Yes. Our concern is that we feel as though mental illness, at least from our point of view, is where we can help; we can provide services for this. When you have to discharge people because they are not dangerous, yet they are still severely ill, we feel that we are not in a position--

SENATOR SCARDINO: That is the point. I have to believe that many of them - I can't say all of them, but most of them - are there because they need help.

DR. BRISTOW: Yes.

SENATOR SCARDINO: Okay? And, if we apply the definition of dangerousness, as you interpret it here - and, quite frankly, as I have seen it too from the time we started on this - it is conceivable that it might not apply to the people who are in the institutions today.

The other question that comes into play - and I think Senator Hagedorn has heard me say this before, and the more I get into this the firmer I get in my position - is that I feel as though detainer patients and the mentally ill patients who have not been charged criminally, who are voluntarily or involuntarily committed, should not be mixed. They should be separate and distinct, and they should be dealt with separately. They should not be a mixed population, and I am wondering what your feeling is about that.

DR. BRISTOW: I don't know that I would be so worried about mixing them as long as adequate facilities existed. The difficulty, I guess, comes with those patients who have a need more for detention than they do for treatment. Those people, I think, if you have them in a general population in a hospital, can be very disruptive. In other words, I am talking about the individual who has demonstrated that he is dangerous, but who perhaps has not demonstrated that he is mentally ill. Those people can be disruptive, because they are kind of waiting it out. It is certainly much more helpful to spend some time in a hospital than it is in a jail.

SENATOR SCARDINO: My concern would be validated to a much greater extent if I followed your concerns with the bill. If this bill becomes law and we find that there is an influx of criminal, or detainer, patients at the institutional level, then that would even make my concern worse. It would compound that problem of mixing the detainer patient with the average patient.

DR. BRISTOW: It could be a terrible problem is if happened, yes. If it did happen--

SENATOR SCARDINO: But, you are saying that it will happen if we pass this bill.

DR. BRISTOW: It is possible that it would happen. It would depend again, essentially, on how the criminal justice system sought to use the particular law. It is easier, I think, to obtain a commitment than it is to establish a basis for indictment, so that would be the way it would happen, I think.

SENATOR SCARDINO: The bill deals with a person who is dangerous to himself or to others.

DR. BRISTOW: Right.

SENATOR SCARDINO: It doesn't say anything about property.

DR. BRISTOW: Right.

SENATOR SCARDINO: It doesn't say anything about doing damage or harm to anything, other than an individual himself, or to someone else. I would like someone, hopefully, to get into that question today because I am kind of perplexed and confused as to just why it was narrowed down to just someone who displays dangerousness to oneself and to someone else.

If the definition is dangerous to oneself or to someone else, couldn't that apply to someone who has comitted a criminal act?

DR. BRISTOW: It certainly could.

SENATOR SCARDINO: So, it would appear then that a shift from the penal institution to the mental institution would be far simpler than it is

today. There are many who contend that it is easy to do that as it is.

DR. BRISTOW: Yes. If would formalize the procedure for making that shift, yes.

SENATOR SCARDINO: Okay. I think we have to keep that in mind and, hopefully, get to some kind of resolution concerning that. I know I feel very uneasy about that myself, so I threw that out for those of you who will come before this Committee and either substantiate my fears or eliminate them -- one or the other.

Are there any questions?

SENATOR RUSSO: I would like to ask him a question. Generally speaking, looking at the overall picture since the time of its inception with respect to the hearings, what do you think of the entire program?

DR. BRISTOW: The entire program in the sense of what?

SENATOR RUSSO: The involuntary commitment -- the review hearings from beginning to end. Is it working? Is it something good? Does it provide for better health care and for better services for the people, or are we going too far overboard in freeing the patient as we would a criminal, vesting in him all his constitutional rights and thereby forgetting what is best for him by way of health care and treatment within the institution?

DR. BRISTOW: Well, I think at the moment it does protect the rights of the individual in a much more satisfactory way than previously. I think there are inconveniences to the treating staff, but I think the judiciary has made concessions which have been helpful, in terms of having hearings in the hospitals, or in locations that are much more accessible. So, I don't think at this point that we see that as a major problem.

SENATOR RUSSO: May I interrupt you at this point?

DR. BRISTOW: Yes.

SENATOR RUSSO: Tell me, if you will, how we are helping the individual with respect to his rights? What are his rights? And, if you know, what rights have been infringed upon prior to the advent of the hearings?

DR. BRISTOW: My feeling would be that their rights had not been substantially infringed upon. I think it was more a theoretical than an actual problem.

SENATOR RUSSO: You don't know of any cases where there had been an infringement on a patient's rights, do you?

DR. BRISTOW: I am not aware of any of any significance. The law, I believe, was changed. At one point, you lost your voting privileges when you were committed until the commitment was undone. But, I think that is no longer in the statute.

SENATOR RUSSO: My whole reservation about the entire program is that we are getting so concerned about the sick person's rights that we are forgetting the quality care that he deserves and that he needs and that he is asking for. As a result, what I see government as doing is it is releasing sick people to the streets, people who need care. We are in a hurry to get them out on the street because we are afraid we are infringing upon his rights. I see this happening.

DR. BRISTOW: Yes, that, I think, is true right now, because the question of dangerousness is the criteria. You come in on dangerousness; you go out when that has subsided, yet you still may be very, very ill. That is

a problem right now.

SENATOR RUSSO: I speak to you as a County Adjuster. I attend these hearings, all over the state, in all these institutions. Many times I am ashamed of what I am looking at. I am seeing judges releasing sick people to the streets for no apparent reason, because the judge sits there as a jurist and he is afraid that, again, he is infringing upon a man's rights. He doesn't want to infringe upon those constitutional rights, whatever they are, so the man is being released to the streets. This is a man who needs care. I think, in effect, what we are doing with the entire program in the State is, we are challenging our own hospitals, our own institutions, our own professional staff.

DR. BRISTOW: There is no doubt about that. There are many people who are released prematurely, who could benefit more from staying in the hospital for a longer period of time, even though they are not dangerous. There is no doubt about that.

I think it has gotten to the point right now where many people are reluctant to push for a commitment, knowing that it will not be for a long enough period of time to do significant improvement, so, "why go through all the trouble if the individual is going to come out too soon"? That is a real practical problem. That is perhaps the bigger problem

SENATOR RUSSO: That's a real big problem.

DR. BRISTOW: Yes.

SENATOR RUSSO: I am concerned about it. I don't like what I see. I think this is going to enlarge our problem.

DR. BRISTOW: We would like a different defintion of commitability than the particular bill embodies, but I did not speak to that since I was responding more to what the bill contains right now.

SENATOR RUSSO: I was looking at the definitin of danger in this bill, and it defines danger as something that is going to possibly happen in the foreseeable future -- whatever that means. I think if a person is a danger, we have to treat the danger and keep it in the proper context at the present time. Is he presently a danger to himself or to others? The bill relates to the foreseeable future, and if this bill should be adopted, that language should certainly be amended. In fact, it should be stricken -- "the foreseeable future." I think the bill in the Assembly relates to imminently dangerous, or words to that effect.

DR. BRISTOW: That's correct.

SENATOR RUSSO: The language is bad.

SENATOR SCARDINO: Okay. Thank you. You certainly stimulated the discussion here today, Doctor Bristow. Thank you very much.

Now I would like to call on Laura LeWinn, Deputy Director, Divison of Mental Health Advocacy, Department of the Public Advocate. I understand, Laura, that you are going to straighten everything out and tell us what is wrong and what is right about this bill, is that correct?

L A U R A L E W I N N: That is correct, Mr. Chairman, pursuant to the statutory mandate of the Public Advocate, we are here to make everything clear as mud.

SENATOR SCARDINO: Okay.

MS. LeWINN: Mr. Chairman, members of the Committee, I appreciate very much the opportunity to appear before you today and testify on behalf

of the Department of the Public Advocate concerning S-352. I did submit to your Committee Aide a prepared statement, which I would hope has been distributed to the Committee. I would like it to be made a part of the proceedings here today. I will refer to it in my statement before you.

I have to say, quite candidly, I had a bit of a different statement prepared to make to this Committee before I heard the last witness speak. The statement reflects sort of an itemized list of suggestions that we have for specific sections of the bill, section by section, which I would like to address later on, because I think there are some major cosmic threshold questions, obviously highlighted by the last witness, that should be addressed.

I don't come before you, obviously, as a medical expert or a psychology expert. I come before you, if I have any expertise at all, as a legal advocacy expert on behalf of the individuals who are the subject of the provisons of this bill. And, I think it is very important not to lose sight of who are the people whose lives this bill is going to affect directly. It is not going to be the judges; it is not going to be the psychiatrists or the psychologists; it is going to be the private citizen of the state. And, if you look at it from the perspective of the citizens' rights, the focus, as we see it, should be: under what circumstances does the State, acting in its parens patrie, or its paternal power, have the power to deprive - and that is what it is, deprivation - individuals, substantially, of their individual, private, civil rights in the name of treatment for mental illness? What standard should the state be held to before an individual can be locked up - can be confined - in existing facilities, as they are in New Jersey today? And, that is a very big issue.

I agree with you, Senator Russo. I think there are many travesties that go on in the interaction between the court system and the mental health system, but I don't think that is because there is that interaction. What you are seeing at these hearings, when you talk about the judges who are releasing sick people to the streets who are still in need of treatment, is, you are seeing judges who are frustrated by the lack of alternative services. A person may well be in need of mental treatment - psychiatric or psychological treatment - but may not need that treatment in the restrictive setting of a psychiatric hospital, but may face a community setting that is completely devoid of any alternative system of services. That is what the least restrictive alternative concept is about. The last witness referred to that as having no rational meaning. We believe, very strongly, that it has a very rational meaning. It doesn't have a realistic meaning in the sense that least restrictive alternatives simply don't exist, or they don't exist in any adequate level, to meet the need in the state today.

So, when you talk about civil commitment procedures, it is very important to talk about them in the context of the facilities and services that do exist, that will be the end product of the procedures that we are debating here today. And, in that regard, I would like to say at the outset that we very strongly endorse and support the screening center concept. As you know very well, Senator Hagadorn - I don't have to point it out to you - this screening center concept has as long and valued history as this legislation does generally. I believe in Senaor Menza's original bill they were called county reception centers. But, the focus was the same. The idea was to create a center, a service, that would perform an evaluation and screening service at the threshold. And, in fact,

one of the comments that I was prepared to come here and make today is that the screening center concept, as defined in this bill today, doesn't go quite far enough. The focus on the screening center in this bill, in S-352, talks in terms of providing examination, diagnosis, evaluation, and emergency treatment to persons facing involuntary civil commitment. We would like to see the language in the definition section of the screening service expanded to refer to it as a referral service to other less restrictive services, such as exist.

SENATOR SCARDINO: Laura, can I interrupt you for for a minute?

MS. LeWINN: Yes.

SENATOR SCARDINO: I am not saying that what you are doing isn't good. It is important and we are going to need that, but I would prefer, initially, if you don't mind, to have you deal with the surface concerns right now. You are getting too deep for us at this point, in terms of making substantive changes to the existing bill that is before us. I know personally that I would like to have some basic clarifications concerning the purpose and the intent of this legislation, and I think that the comments raised by Dr. Bristow, and the manner in which he did it -- which I didn't expect until I saw his statement -- pretty much highlighted the major concerns that we have. Now, someone supports this concept and someone doesn't support the concept. You have your reasons for supporting it, and those that don't have their reasons for not supporting it.

So far, quite frankly, the concerns that have been raised have put me in a position where - and I say this deliberately - I will tell you where I stand, so that you or anyone else who is here today to testify can react. Right now, I would not be disposed to vote for this bill. That is only because I feel it is too cloudy. I don't understand precisely what it is going to do, or how it is going to help. I am concerned because of the questions that were raised by Senator Russo in his comments -- you know, the constitutional question versus the medical treatment question, and which is the more important.

So, if you don't mind, I would like to discuss this with you if we can, because I know the Public Advocate favors the approach that this bill calls for. Senator Hagedorn, if you agree with the direction we are going in, we would like to pin down the expressed purpose and the intent that the drafters of this legislation had in mind in the first place. What is it going to accomplish? You talked in your opening comments about depriving people of their civil rights, and that is interesting because the thought that crossed my mind when you said that was that for years - for years - we have been tripping over ourselves trying to build institutions and provide medical care and treatment for people because they weren't getting it. Those that we thought were getting treatment were just being put out of sight and out of mind, as you know. They were just put out of the way and nobody really cared or knew what was going on in their lives. Then we turned that around and we built these institutions, or had them deeded to us by some generous doner, and we provided doctors, nurses, attendents, and whatever else we thought was needed to care for them.

Now, when you talk to me of depriving people of their civil rights - which conceptually no one in this room disagrees with - the concern I have then is the same one that Senator Russo so well stated, I think. What about their medical well being? What about their physical and mental well being? What have we done? Have we changed our attitude and approach, in terms of

what it is we set out to do in the first place?

MS. LeWINN: I think, if I may, Senator, that I started to speak to that concern, about the adequacy of treatment when I made the comment that we have to look at this bill in the context of existing available services in New Jersey today. And, as a practical matter, what this bill is addressed to is establishing procedures for civil commitment to the existing public and, to a certain extent, private hospitals in New Jersey -- Marlboro, Greystone, Trenton, Ancora -- as they exist today.

When I talk about civil rights, I don't want to minimize for a moment the role that the Legislature has played in protecting the civil rights of the institutionalized. New Jersey has the strongest state statutory bill of rights for individuals undergoing psychiatric treatment of any state in the Union. I think that is obviously to the credit of this Legislature.

I talk about civil rights in the context of this bill, when we are weighing what procedures should be . How do you balance? As I learned in law school, everything comes down to a balancing test. This legislation comes down to a balancing test. How do you balance the noble and proper motives of a society to provide social and medical services for individuals who need those services and who may not have the capacity or the ability to avail themselves of those services on their own, on the one hand, with the rights of people who are not commiting criminal acts, who are not creating a public nuisance, and who are not impinging on other people's social rights -- with the right of those people to be left alone; to be a little bizarre; to forget to eat if they don't want to eat; to forget to take medication if they don't want to take medication; to control their own bodily integrity; their own privacy; and their own rights? That is the ultimate umbrella statement of what we are facing here. What it comes down to in practical terms is, what kind of services are available right now? If this bill was implemented and was enacted and signed today, what kind of services would be the end product of these procedures? Where would these people be going? And, on the other end, who should be caught up in this process, and who should be going into those services?

That is why I did fixate for one moment on one specific aspect of the bill, which is the screening service concept. You used the word cloudy, Senator Scardino, and I think that pretty much sums up the work that this Committee has cut out for it. You think this bill is cloudy; just have a look at Title 30 of the statutes right now, with the civil commitment procedures that exist. They are in Title 30; they are in the curt rules; they are in administrative bulletins from former Chief Justice Hughes; they are in directives from the administrative office of the courts. There is no codification of the civil commitment procedures. This bill is light years ahead of what exists today, in just giving some kind of working set of guidelines for court attorneys and county adjusters to implement civil commitment procedures. And, when you are trying to go from a big cloud to specifics--

SENATOR SCARDINO: What is wrong with what we have now? What is happening today that requires the changes that are called for in this legislation?

SENATOR RUSSO: That is a good question, and if I may just add one point to it, I would like to have an answer to that question, Laura. Right now, when a man is committed, within a period of 20 days, as you know, the entire court room facility moves to the institutuon -- the county adjuster, somebody from legal services, the judge, the court reporter, and everybody.

Within a period of three months from that hearing, another hearing occurs to determine whether or not that person should be released or whether the treatment should continue. Three months from that date, another hearing occurs with regard to the same person, to make a determination whether the treatment should continue, or whether he should be released. Six months from that date, another hearing occurs with regard to the same person to determine whether he should be released or whether he shouldn't -- and yearly thereafter. So, there are a lot of hearings being focused on the treatment of that one particular individual.

Now, aren't we giving him sufficient rights with respect to his privileges and everything that should be vested in him, constitutionally, or are we short-changing him with all of those hearings?

MS. LeWINN: I will have to take that one item at a time. Unfortunately, the letter of the law is honored more in the breach than in the adherence. The court rule, yes, does provide for a hearing within 20 days, but in reality that 20 day hearing is very rare. The way the statutes exist now, a seven day emergency commitment can be piggybacked upon a cumulative seven-day emergency commitment, or a fifteen-day emergency commitment, before the court papers or the application for temporary commitment is filed. So, yes, once those papers for temporary commitment are filed then, theoretically, a hearing is held in 20 days. So, we may already have someone who has been in for two or three months on emergency commitment who never got a court review. Then the twenty day is adjourned -- ten days, twenty days. In our experience, we have seen people coming up for initial review six months after the day they set foot in the hospital. Now, granted, that kind of problem is gradually reducing in frequency, but when we first started providing hearings and representing people at hearings, this was a very frequent occurrence, and it still occurs much more frequently than we would like. So, even though the law says, or the court rule says, a final hearing must be held within 20 days of the filing of the application, that is not happening, and it is sometimes happening quite a long time after that.

As far as the periodic review hearings -- obviously, we think that this system of review hearings is very salutary, however, that is after the fact. The court, the hospital, the whole system, is almost in a position of a self-fulfilling prophecy. The person is already in the hospital. The presumption of commitability has been met. The presumption for need for treatment in that hospital exists and has to be overcome. The hearings are supposed to be de novo reviews from the start of the need for commitability, and we are finding that very often, with the constant reassignment of judges who hear these hearings - they are coming in without prior experience in the hearing process - the presumption of commitability, or continued need for confinement, prevades these hearings. So, you have a person who is already in the hospital caught up in the system. The way this bill addresses that is to go back to that threshold and say: let's scrutinize the doorway; let's scrutinize the people passing through the doorway a little more stringently to insure that people who get over the threshold - who are brought in, involuntarily or voluntarily - to the other side of the threshold are people who really need to be there, so that when they come up for reviews - three months, six months, and a year down the line - some of the presumptions that are, just by human nature, going to prevail at the hearings may be more appropriate because we were much more careful

at the threshold; we scrutinized these cases and were more discriminating at the threshold. That is one of the major salutory benefits of this bill that doesn't exist in current statutes.

There is no provision for really effectively screening out, at the outset, people who need to go into the state hospitals, as they currently exist. And, I have to keep coming back to that because you have been to the hospitals and you know what goes on there in the name of treatment. Keeping that in mind, the effort should certainly be made to minimize the number of people who get caught up in that kind of institutional setting. There is no mechanism in the current law to effectively do that. The emergency commitment statutes that do exist, in fact,are used on the other end of the spectrum, to bring into the system people who many not even belong there at all, but who get into the system because they don't get any kind of court review, they don't get any kind of outside review, or no outside light is shined on their case while they are in on emergency papers. That is strictly between them and the hospital.

Another salutory benefit of this bill is that it would eliminate that kind of -- what we see as abuse, really. It will eliminate just using the mental hospitals as a dumping ground for people who are "inconvenient", or a nuisance to somebody -- not even to society, but to some family member, or whatever.

SENATOR RUSSO: Have there been many of those instances? Does the record indicate that this has happened in the past?

MS. LeWINN: The use of the emergency commitments statute for hospitalizing individuals who otherwise might not have been found commitable if they had a court hearing is well documented, at least in south Jersey. We were involved in a challenge to - a court challenge - the constitutionality of the emergency statute, and in the context of that court case, we took discovery of the number of emergency commitments to Ancora, and the vast majority -- we reviewed something like 2,000 seven and fifteen day emergency commitments - of those people were released once a temporary order was filed -- either a temporary order was never filed, or if it was, somewhere down the line it piggybacked seven and fifteen day emergency stays -- or before the hospital felt it was necessary to get a commitment order, or they were released between the time an application for temporary confinement was filed and the time of the scheduling for final hearing. So, it never met the court test.

SENATOR RUSSO: Were they effected by psychiatrists or magistrates?

MS. LeWINN: The emergency commitments?

SENATOR RUSSO: Right.

MS. LeWINN: The fifteen day commitment is a magistrate commitment. A police official can go before a magistrate and say this person is acting bizarr and nobody wants to take care of him; we think he should go to the hospital, and that is it. The magistrate signs the papers.

SENATOR RUSSO: Laura, I think you ought to furnish this committee with some of that statistical information, if it is available.

SENATOR HAGEDORN: It is available, Tony. That is the very purpose of this bill, it is in order to screen the people before they are ever even admitted into an institution. We have had that history. You have had it in Hudson County, and in other places, where children would put their parents into this kind of an institution to get rid of them. This is the thing that

we are trying to avoid. As Vince said, by the proper screening process and diagnosis, I think they can also provide for better treatment when they are in the institution.

SENATOR RUSSO: Of course, Gary, once they go down there, if they are being institutionalized improperly, at the time of the review hearing that will surface.

MS. LeWINN: It may surface, but at that point everybody's hands are tied. The person is in the hospital and has no place to go. I am sorry that Senator Scardino had to leave because one of the issues that I wanted to address - he raised this with Dr. Bristow - was, first of all, about the detainer patients, which I want to talk to in a moment. There are thousands of people in the state hospitals right now who have come up for these court reviews, which are salutary as far as they go, and at these court reviews, that presumption that I talked about, of continued need for commitability, has been overcome. The only thing that the court can do - as far as the court can go at that point - is to enter an order discharging that person pending the finding of an appropriate place to send them. They are called "discharged-pending-placement" orders, and statewide there are probably thousands of people right now who are staying in the state psychiatric hospitals who are technically released. They are under discharged-pending-placement orders, but they have no place to go.

SENATOR VREELAND: Are those the kinds of people who are escaping from these institutions? We had them here from Marlboro. I know Greystone has the problem of them getting out into the community and disturbing people -- citizens -- and so forth.

MS. LeWINN: The escape problem that Senator Scardino spoke about with the prior witness concerned detainer patients.

SENATOR VREELAND: Right.

MS. LeWINN: We are not talking about detainer patients.

SENATOR VREELAND: You are not talking about them? Okay.

MS. LeWINN: Not in that case. But, I did want to mention that aspect because I gather from Dr. Bristow's testimony that he feels that the provisions of this bill are going to increase the number of detainer patients in the state psychiatric hospitals. We see it as just the opposite. It is going to reduce inappropriate admissions, not only for inappropriate civil commitments, but for inappropriate or unnecessary transfers of detainer patients - or individuals caught up in the criminal justice system - to the state hospitals. Again, that is one of the major aspects of the screening service. It will screen out inappropriate referrals. Right now, more people are getting caught up in the correction system because of the lack of mental health services. A lot of people are getting caught up at the local level, in magistrate's court. They are being arrested and the police don't have any place to take them, so they charge them with disorderly offenses, or with petty offenses.

The other thing is, as far as transfers of detainer patients who are prison inmates, this bill was drafted before the recent decison of the United States Supreme Court, in a case called Vitek v. Jones, which just came down a couple of weeks ago, which mandates very stringent procedures to be followed before an allegedly mentally ill prisoner can be sumarily transferred to a psychiatric facility. One of the comments that I had to the section of

the bill that refers to prison inmates is that the provison of this Vitek case should be implemented in New Jersey, and that can be done through this bill, if it is amended appropriately. What that means, if the mandate of the court is followed, is that no prison inmate can be transferred to a psychiatric hospital until there is a full hearing - a judicial court hearing - with testimony and with a factfinder making a finding of need for treatment in a psychiatric hospital. The way the laws are now, there is something called a Commissioner's Order ot Transfer that can administratively transfer a prison inmate to the state psychiatric hospital. That is where you start getting into the detainer patient problem. These are individuals who fall into a very unfortunate grey area. The prison doesn't want them because they are acting up. The hospitals don't want them because they are perceived as a much more disruptive threat on the civil commitment population. So, the irony here is that you have a chance to rectify that with this bill, through the recent court decison.

SENATOR VREELAND: Mr. Chairman, I think that is a good point because I know in our county, our prosecutor is in the process, along with other prosecutors who have the same problem that Marlboro has, of coming up with legislation that would do what you just said, because these people are coming out of these jails, and are sent up to these institutions, and some of them are constantly doing the same thing because they are shrewd and they are smart. They want to get back up there so they can get out and walk around, which is what they do.

MS. LeWINN: Well, I think that the screening center concept in this bill, and the section of the bill referring to criminal retainer patients, when implemented hand and glove with procedures set up by the Supreme Court in this case, would go a long way towards addressing the problem. That is obviously a thorn in every county prosecutor's side.

SENATOR RUSSO: I think it is very, very important that you give us statistical information, and be specific and do not just speak generally. Because this appears to be the basis for the implementation of this bill.

SENATOR HAGEDORN: I am sure some of that is available also, Tony, through the Mental Health Planning Council and the previous hearing we had back in 1976.

MS. LeWINN: Yes. There have been statistics. I am not sure, specifically, what statistics you are asking about.

SENATOR RUSSO: I am asking for statistics with respect to people who are improperly admitted and who should not have been admitted in the first place.

MS. LeWINN: I can give you one statistic right off the top of my head, and that is what we call our success rate. When I say "our", I mean the Division of Mental Health Advocacy. Since we have been in existence, we have been authorized to provide legal representation to people who are facing involuntary civil commitment and subsequent periodic reviews in the event of commitment. In the six counties where we do operate, our cumulative statistics show that in those cases where we appear and represent the person, 75% of those cases were successful. What that means is, either commitment is denied - the application for commitment is denied - or, if it is periodic review, the person is ordered released.

SENATOR RUSSO: Well, I wonder about that. Now, when you get them

released - when you appear at those hearings - aren't you challenging our system and telling us the doctors are improper in their thinking and that they are treating people who don't need treatment, and for that reason, "I, as an attorney, am asking you, the Judge, to have this person released. The doctor is wrong in continuing this treatment"?

MS. LeWINN: We don't just say the doctor is wrong. We retain independent psychiatric or psychological experts to come in and evaluate that client, and we leave it to the factfinder. Experts are retained on behalf of the client, and the hospital brings in its experts, and it is a question of burden of proof being met by either side.

SENATOR RUSSO: It depends on what side of the fence you are standing on. You would regard that as a victory. I regard that as a loss.

MS. LeWINN: Well, I said it in quotes when I said our "success rate." The question was about inappropriate admissions. I think the fact that courts, in 75% of the cases - and that is only the cases we are involved in; that is only 6 out of 21 counties - that we are involved in, where we are representing someone who is already in the hospital, the court is saying: "No, that person doesn't belong in the hospital. No, that person shouldn't be committed." Or, they are saying, "Yes, that person should be released, because he does not belong in the hospital."

SENATOR RUSSO: Laura, let me make this observation: I have been attending these hearings all over the state, and with respect to all of the hearings that I have attended, I have yet to see one person who was not justifiably confined.

MS. LeWINN: That a judge found?

SENATOR RUSSO: Right. All of those people who came before us I regarded as sick people, from my observation and from listening to testimony. They were sick people and they needed treatment.

MS. LeWINN: Well, see, that gets back to what I said before.

SENATOR RUSSO: There were no healthy people there; they were all sick.

SENATOR HAGEDORN: Well, that shows that that phase of the system is working then, isn't it?

SENATOR RUSSO: I don't even know if it is working. It is not working when they release them to the streets.

MS. LeWINN: I think it gets back to what I was saying before about the--

SENATOR RUSSO: If I had to revamp the system, what I would do is I would get rid of the judge; I would get rid of Legal Services; I would get rid of the Public Advocate; I would get rid of the Public Defender; and I would create a roving panel of medical experts. Let them travel all over the state. I would have three professional psychiatrists and they would review each case. These are the people with the knowledge. You, as the attorney, don't have it. I, as the adjuster, certainly don't have it. The judge doesn't have it. The three psychiatrists would have it. It is their field. Let them review each one of the files and talk to each one of the patients, and make the decison as to whether that person should be released, or whether that treatment should be continued. And, it can be done on a periodic basis. The reviews can continue as we have them now, the three month, the six month, the one year, and then yearly thereafter. That would make a lot of sense to me. What I see today

doesn't make sense. I think we are doing a lot of harm and creating a lot of injustice.

MS. LeWINN: I think, with all due respect, Senator, that we are long past the day when we can realistically adopt as a legal or a legislative proposition, that basic legal and civil rights are not implicated in the civil process that trigger the implementation of certain due process protections. Every court, from the United States Supreme Court on through our State Supreme Court, through all of our trial courts, have spoken to this issue and have found consistently that given the massive curtailment - that is the United States Supreme Court language - of liberty involved in the imposition of civil commitment, that the civil and constitutional rights that are implicated necessarily trigger the kinds of procedures that we have in effect today -- the right to a hearing; the right to confront the person who would have you locked up; the right to the assistance of legal counsel; the right to retain your own witness to counter the witnesses of those people who would have you committed; the right to have an impartial factfinder - in this state, a judge who would take evidence and make a decision, based on the evidence presented at the hearing. And, I think that when we talk about this bill, I would urge, very strongly, that we have to take those procedures as what the Supreme Court has called constitutional minimums in this area.

SENATOR RUSSO: In theory, all you say is good, but in practice it just doesn't work out. From my experience, it is not working.

MS. LeWINN: If it is not--

SENATOR RUSSO: The result is not good.

MS. LeWINN: I certainly agree with you. I would not be here testifying essentially in support of the underpinnings of this bill today otherwise. But, I don't think-- I think we obviously disagree on the reasons for the shortcomings in the system.

SENATOR RUSSO: Well, we have to be careful not to enlarge a system that is not that great. In my personal opinion it is not that great, what we have today.

MS. LeWINN: Well, as I said before -- I seem to use the word irony a lot -- I think it is ironic that the very fears that you have may very well be addressed by some of the provisons of this bill.

SENATOR RUSSO: I have read the bill carefully and I see an enlargement of what we already have.

MS. LeWINN: You see, I see a tightening because I see a screening function that doesn't exist at any level right now in this State, if it is put into operation as we would like to see it operated. As I indicated before, we have some problems with the concept in the bill as it is now. If it is appropriately implemented and properly functioning, it would, at the threshold, reduce the people coming into the existing civil commitment syndrome, and it would reduce the number of inappropriate admissions from the street, referrals from the prison, referrals from the jail. It would stringently reduce the numbers of people who end up in the psychiatric hospitals because of no appropriate alternative.

SENATOR RUSSO: I have a reservation about that. I read the bill carefully. It is poorly drafted. It is very, very poorly drafted. I see language in here concerning the fact that they have to prove beyond a reasonable

doubt that the person is dangerous to himself and to others. How in God's name can that be done? Is is not a court of criminal law. And, this is the point we are reaching in this entire field. We are taking off on a tangent and we are treating the sick person as we would a criminal.

I would ask you, as an attorney, Laura, how do you prove beyond a reasonable doubt that that person is a danger to himself, because that is a state of mind?

SENATOR HAGEDORN: Well, that is where you involve the psychiatrist or the psychologist.

SENATOR RUSSO: I think you are going to go beyond that. You are going to open up a big battle, courtroom style, at the screening level.

MS. LeWINN: You raised this comment before and I wanted to address that, the fact that we are treating the mantally ill like criminals. One one side we are, we are advocating that we would like to see at least the same constitutional protections that are afforded to a criminal defendent in a criminal trial afforded to a person facing involuntary civil commitment, because regardless of the name in which you bring this person into the process - and your mitives can be the highest - the net result is as devastating, or even more devastating, than the potential loss of liberty faced by a criminal defendent. A person facing involuntary civil commitment faces indeterminant, indefinite, confinement and loss of liberty. A criminal defendant at least has the guarantee of knowing that if he serves "x" number of years, and if his good time credits are "this" and his parole date is "that", he will be out in a certain time.

An individual who has an order of involuntary civil commitment against him doesn't know that. He knows he is going to get periodic review hearings, but he doesn't know that he has to be released at that hearing. He knows that he has to fight his case all over again. So, when you look at the end product, you can't take your eyes off the end product down the road, which is involuntary confinement in a psychiatric hospital. And, when you look at that, you have to go back to the threshold and say, "shouldn't we be very careful about who we are putting into those state hospitals"? And, midway down the road you have to say, "shouldn't we be very scrupulous about the procedures that we employ to insure that only the people who need that kind of treatment will end up in those facilities, and that inappropriate referrals and confinements are not made?"

That is why Senator Vreeland's concern about the detainer patient is so well addressed by this bill -- and you had raised this concern before, Senator Scardino. It came up while you were out of the room. The bill would, contrary to Dr. Bristow's concern that it would increase the interplay, or the comingling of detainer patients with civil commitment patients, this bill, if amended to comport with the recent case in the United States Supreme Court regarding prison transfers to state hospitals, would provide stringent procedures that must be employed before a prisoner can be automatically transferred, and it would avoid just that problem. It would reduce that issue.

You expressed your concern about detainer patients. This bill, as amplified, very strongly addresses reducing the detainer problem and, hopefully, the escape problem, and all of the very volatile issues that come out of that.

SENATOR SCARDINO: That's great. It sounds great. How?

SENATOR VREELAND: Screening.

MS. LeWINN: Screening -- a screening center, as this bill defines it, and we suggest certain amplifications to that concept, and the codification of the United States Supreme Court case that I spoke about before, called Vitek v. Jones, which, if translated into terms of New Jersey operating procedures, essentially means that there has to be a Class A commitment hearing before a prisoner can be transferred. At least, that is our interpretation. I have to state at the outset that there has to be a Class A commitment hearing before a prisoner can be transferred to a psychiatric hospital -- which means a hearing on a final order of commitment at the prison, or somewhere other than the hospital.

SENATOR SCARDINO: That is being done right now, even without this being done.

MS. LeWINN: Right now, a prisoner can be transferred on commissioner's order, under 30:4-84, for 30 days. And, that is strictly an administrative transfer. As we read Vitek - and we have been meeting with people from Human Services and from Corrections, and with the assignment judge of Mercer County to discuss the implications of this case - there seems to be unanimous agreemment, at least to the extent that that particular statute, allowing Commissioner's transfer, is effectively repealed, or annulled, by the mandate of the United States Supreme Court in Vitek.

SENATOR SCARDINO: Okay. Regardless, they would still have to comply with the Supreme Court position on that, wouldn't they? Wouldn't we have to do that now, as of this point?

MS. LeWINN: Yes, and the Supreme Court's position, hand and glove, with this bill, is to increase the screening that has to go on.

SENATOR SCARDINO: Let us assume we don't have this bill.

MS. LeWINN: Without the bill?

SENATOR SCARDINO: Yes. You are citing that Supreme Court decison, but we still have to do something about compliance, don't we?

MS. LeWINN: We still have to do something, yes.

SENATOR SCARDINO: We have to give them Class -- what did you call it?

MS. LeWINN: Class A commitment.

SENATOR SCARDINO: Okay. And, how is that done, and where is it going to be done? I am not asking you to answer the question but--

MS. LeWINN: Yes. It is an issue that has been undergoing a lot of discussion among all the various concerned departments and the judiciary.

SENATOR SCARDINO: Laura, if it is something that we have to do, what makes you think we necessarily need a screening center to do it?

MS. LeWINN: I am saying that the screening center concept in conjunction with the procedures that are mandated now by the Supreme Court as far as prison inmates are concerned -- I mean, the screening center goes beyond the applicability to detainer patients, obviously. But, at least, as far as detainer patients are concerned, if you codify the screening center concept and if you codify the mandates of the United States Supreme Court with respect to prison inmates, you are going to be effectively scrutinizing, screening and, hopefully, reducing in appropriate transfers both of prison inmates who may not legitimately be in need of psychiatric treatment or who, if are, maybe should be getting it at the prison rather than allowing the prison too easily to just dump unpopular or uncooperative inmates into psychiatric wards. At the same time, the screening center concept works to insure that people

coming through not from the criminal justice system but through the civil commitment process will be screened, evaluated and referred to alternative services where available to reduce the inappropriate civil admissions. So it works both ways.

SENATOR RUSSO: So anybody can drop the party off at the screening center. It could be a police officer or a welfare director or a social worker, etc. At that point when the screening takes place, a party can be admitted by a combination of psychiatrists and a psychologist and a physician, or two psychiatrists. Can you tell me, if you know, why a psychologist gets into the picture at this particular point? I don't think the psychologist has any business in the picture. It should be left strictly to the psychiatrist, not the psychologist.

MS. LeWINN: We are not here to lobby for the Psychiatric Association or the Psychological Association. They do that very effectively for themselves. But I can tell you that in our experience ---

SENATOR RUSSO: It is a medical problem; it is not a psychological problem.

MS. LeWINN: In our experience, it is not always a medical problem. When I say "it," I am talking about need for confinement for treatment of a mental disorder. It may be in many cases something other than a medical disorder or a medical basis for the disorder that is resulting in commitment. Maybe that shouldn't be, but that is what is happening. People are being found dangerous and committable for non-medical disorders: personality disorders; behavior disorders; disorders, because of being committed for them, appropriately invoke the expertise of the psychologist.

SENATOR SCARDINO: I am going to hold that question until we talk to the representatives of the psychologists.

MS. LeWINN: I just say that has been our experience.

SENATOR HAGEDORN: I have one question I would like to ask.

SENATOR SCARDINO: Yes, Gary.

SENATOR HAGEDORN: The testimony of Dr. Bristow disturbed me a little bit as it applied to Section 21, where he indicated that, "The patient who still can benefit from care within the hospital and wishes to receive it is thus denied such services unless he goes to another hospital and applies for them." Do you agree with that?

MS. LeWINN: No, I don't, Senator, because that concern presumes that a person is going to be automatically released once they are found eligible for release. And, as I mentioned earlier, what is happening as a practical matter is that judges are not releasing people outright. They are ordering conditional orders of discharge and the people are remaining in the hospital because the alternative placements are not being found.

I did have other comments to make that I submitted in my prepared statement. I think rather than read them into the record, I will just submit the prepared statement. (See page 1X for written statement of Ms. LeWinn.)

SENATOR SCARDINO: I would appreciate, Laura, if you would do that, because we do have other people who may want to speak. We will, of course, read your statement.

Gary, do you have another question?

SENATOR HAGEDORN: I just have one more question. Maybe you can't answer it. But the observation was made that we have adequate treatment facilities now in emergency rooms in hospitals for the screening process. Have you had any experience in that area to indicate whether that is a fact or not?

MS. LeWINN: The experience of our offices in the six counties where we do provide service is that unfortunately this is not true, that emergency rooms are not providing psychiatric or psychological intervention services that are necessary to prevent the emergency commitments that are replacing those non-existent services or substituting for them.

SENATOR HAGEDORN: Thank you.

SENATOR SCARDINO: Laura, describe for us the role of the Public Advocate in this matter?

MS. LeWINN: In this hearing today?

SENATOR SCARDINO: In this area of civil commitment, what are your experiences and why is it that you so strongly support this concept?

MS. LeWINN: The function of our division, the Division of Mental Health Advocacy in the Department of Public Advocate, is by statute to provide legal services to individuals who are the subject of civil commitment proceedings and who, once committed, are the subject of periodic review hearings as now mandated by court rule. In the course of executing that authority, we have become intimately familiar with the level of services at each of the State psychiatric hospitals and some of the county psychiatric hospitals. We have become very familiar with the interplay that has developed between the judicial system on the one hand and the mental health system on the other, because it is really a very recent development. Before the Public Advocate Department came into existence in 1974, civil commitment proceedings were paper proceedings. There was no such thing as a court hearing or no such thing as court process. So it is really a very new development. We are finding that the statutory system that now exists has much room for abuse and for arbitrary decision-making, arbitrary confinement, arbitrary deprivation of rights. The emergency statutes, particularly, we find have been much used to confine people who otherwise might not meet the court test and, in fact, never got to a court test.

SENATOR SCARDINO: Are you telling me that there are a number of people who are confined today who shouldn't be there?

MS. LeWINN: Certainly anyone who is there now under a discharge pending placement order shouldn't be there.

SENATOR SCARDINO: Say that again.

MS. LeWINN: Maybe you weren't here when we talked about this. The patients who come up for periodic review hearings before a court where the judge finds that that person is no longer in need of treatment in the confinement of a psychiatric hospital --- the judge is ordering the person discharged, but is entering a conditional order saying that the person will be discharged pending placement in an appropriate alternative facility. The appropriate alternative facility in many cases - a nursing home or a boarding home - doesn't exist. The person goes back to the hospital ward - to the psychiatric ward - and sits there until the next periodic review hearing with what we call a discharge pending placement order in his or her folder.

SENATOR RUSSO: Laura, you didn't answer the question. His question was: Are there any people in the institutions who do not belong there?

MS. LeWINN: Well, certainly, those people don't belong there. That is the first answer to your question.

SENATOR RUSSO: At that point.

SENATOR SCARDINO: What is this law going to do to change what is happening now with these people if you don't have a place to put them?

MS. LeWINN: This law is going to go back to the threshold and say, let's screen effectively the people who are coming in the doors of the psychiatric hospitals - let's screen and refer them.

SENATOR SCARDINO: But if you don't have a place for the person that is in the hospital now and you admit that we have a procedure which allows them to have periodic review, what do you expect to do for the people who are not in the institutions yet who are going through the screening process?

MS. LeWINN: We hope that the less the psychiatric hospitals are perceived as the panacea or the dumping ground or the "all things to all mentally ill people" as a place where all the mentally ill will go because they exist --- the less that those facilities are available, the more incentive and the more pressure there will be to beef up the alternative facilities.

SENATOR SCARDINO: Which are?

MS. LeWINN: Community mental health centers, half-way houses, licensed boarding homes, sheltered care facilities, work programs.

SENATOR SCARDINO: We are doing that.

MS. LeWINN: Not fast enough. If we have a thousand people who are in the hospitals with discharge pending placement orders ---

SENATOR SCARDINO: What is this bill going to do to change all that?

MS. LeWINN: Hopefully, it is going to put pressure on the powers that be to provide alternative facilities.

SENATOR SCARDINO: The only way it is going to do that is by keeping out of an institution those who have no alternative but to be placed somewhere. But, now, with this law, we are going to say they can no longer be placed where you were putting them before.

MS. LeWINN: The other end of the spectrum is, given the state of the institutions today ---

SENATOR SCARDINO: I think you are doing more harm to those persons by using them, because that is almost what you are almost saying to me. You are using them to force society to do something that you think is an alternative to what is happening now. Yet, I am sitting here and I am saying to myself --- People are shaking their heads.

SENATOR HAGEDORN: I don't agree with that either.

SENATOR SCARDINO: Well, isn't that what she said?

SENATOR HAGEDORN: No. What you are saying there is you are forcing them to go into an institution where they don't belong in the first place in an environment that might be detrimental to them. It is going to force us in the Legislature to go out and correct the situations so we keep them out of there and provide a facility outside the institution.

SENATOR SCARDINO: But, wait a minute. I am with you 100 percent in terms of providing what we think is the most adequate, the most humane --- you name it. You use the adjectives. I don't have to spell them out to you. You know what we all want. And I want them just as badly as you do. But you will have to impress on me what is wrong with what we have at this point in time. What is wrong with the institution in terms of the quality of care that it is giving? I know what is wrong. I have listened to it and I have heard it.

What you are saying to me is that the present mental institution is not the answer. Is that what you are conveying to us right now?

MS. LeWINN: Part of what I am conveying. It is a very sensitive subject because we are dealing with an inadequate reality on one hand and "pie in the sky" on the other. But what we are looking at and what this bill addresses, as we

see it, are two major areas of deficiency on opposite ends of the spectrum. One, it will afford due process protection that all the courts say people who are the subject of these procedures are entitled to; and will ensure that if they are going to be committed to the other end of the spectrum, which is the State hospitals as they exist today, they will be given the benefit of every doubt, they are going to be given every protection, and they are going to be given a hearing. There is going to have to be adequate and compelling evidence to establish that case and there is going to have to be an impartial factfinder who is going to have to make a finding of committability. And before we even get to that, there is going to be a screening activity that will go on to insure that the people who get to the next stage of the court hearings, the court procedures, are appropriately in need of being at that stage.

SENATOR RUSSO: Laura, in effect, you are telling us that there are instances that have occurred involving people who have been admitted to the State institutions who were not mentally sick - they should not have been admitted.

MS. LeWINN: No, I am not saying that, Senator.

SENATOR VREELAND: That's right.

MS. LeWINN: I'm sorry. I'm not saying that. I am saying who are not in need of confinement in a psychiatric hospital.

SENATOR RUSSO: They don't belong in that institution. So, my next point is that we have no evidence before us to indicate that this has ever happened in the State of New Jersey or how many times it has happened. I know of no instances. I am asking you to get the information to this Committee. Let us have all the statistical information: when it happened, where it happened and how it happened.

SENATOR HAGEDORN: I am going to suggest one thing.

SENATOR RUSSO: Let me just make my second point. Assuming what you say is true, that this does happen and that people are admitted that should not be admitted, let's go back to our periodic review system. Within 20 days the first hearing should occur at the institution. The judge, at that point, should be in a position to make a determination to the effect that that person does not belong here and, at that point, he is going to release him. If he misses out on that first opportunity, within 3 months he is going to hear the case again. And, if the evidence is there that that person does not belong, then that person will be released. So, what is wrong with that system?

MS. LeWINN: Because it is not happening uniformly. I referred before to statistics of our division.

SENATOR RUSSO: There may be a problem with the 20-day hearing. I realize that. It may not happen within 20 days, but the hearing comes off. It may happen 25 days later or 30 days later, but there will be a hearing.

MS. LeWINN: But that is a long time. That is a long time to be locked up.

SENATOR VREELAND: That's a good point. We had cases up in Greystone. We had a hearing on this very thing. It should be done at the jail. I am thinking of these detainers now. That is what this bill does. They should not be permitted to sit around there for 3 months. Why should they do that if they shouldn't have been there in the first place?

SENATOR SCARDINO: Jimmy, I understand what you are saying. But it is pie in the sky. I am saying this to you respectfully. I don't think that this is really going to do all that much to keep the detainer patients out of the institutions.

As a matter of fact, I see it as doing the opposite. Even with a screening program, I still see them maybe going through that process but, ultimately, ending up in a mental health facility -- I mean in the institution. I am disagreeing with you because I feel ----

SENATOR VREELAND: I disagree with you because I sat there and listened to these people who threatened in the jail they were going to commit suicide. And they do it constantly. Then they go up to Greystone. They are there. They walk around and harass the people. They are back in the jail again. They are smart. They know how to do this.

SENATOR SCARDINO: Why I am saying this is because I really don't get the sense --- when I say I disagree with you, I don't get the sense that you do that the screening program that is called for in this bill is necessarily going to keep the detainer patient from going to the institution. I think that person is still going to end up there. That is the part I disagree with.

SENATOR VREELAND: You have a right to your opinion.

SENATOR SCARDINO: I would extend that and say what we ought to be doing is making an effort to see to it that the detainer patient never ends up in an institution.

MS. LeWINN: That is what we are saying.

SENATOR VREELAND: You do it at the jail or wherever.

SENATOR SCARDINO: That's right.

SENATOR VREELAND: That is what we just said.

SENATOR SCARDINO: That is what you said. But that is not what this bill is going to do and to have it implied ----

SENATOR VREELAND: That is what I understand it is going to do.

MS. LeWINN: If this bill is amended to comport with the recent United State Supreme Court mandate, it will.

SENATOR SCARDINO: It will keep the detainer patient from being mixed with the general population of the mental institution? Answer my question. Will it keep a detainer patient out of the mental hospital - out of one of our institutions?

MS. LeWINN: It will reduce the ---

SENATOR SCARDINO: I didn't ask that. That isn't the way it is being conveyed though because the way I am getting it is that Jim and I are going together in one direction in terms of keeping the detainer patient out of that institution, without mixing them; but where we differ is that he believes in what you said, that this bill is going to do that. I am saying that I respectfully disagree. It is not going to do that.

MS. LeWINN: This bill is not going to keep every detainer patient out of the civil hospitals. The only way you can do that is to introduce a bill that says no detainer patients can be transferred to State psychiatric hospitals. It is going to make it very hard for the Department of Corrections to dump all their uncooperatives or "nuisance" prisoners at Marlboro or even at the Vroom Building or at Greystone.

SENATOR HAGEDORN: In other words, Tony, are you eager to minimize the problem? That is what this bill will do; it will help to do that.

SENATOR SCARDINO: I am not convinced at all.

SENATOR HAGEDORN: Would the court decision amend it in Section 4?

MS. LeWINN: I think it distorts or it detracts from some of the real merits of this bill to focus on the detainer issue, because this is not a detainer

patient bill; this is a civil commitment bill.

SENATOR SCARDINO: No, but it has a lot to do with the detainer patients. There was a point raised before - and I still feel that we are going to need a lot of discussion on it - and it had to do with the definition of dangerousness. I see it as meaning what you are going to do is depopulate the mentally-ill patient, rather than the detainer patient.

SENATOR HAGEDORN: No way.

SENATOR SCARDINO: You know, Gary, either I am listening to something entirely different from the rest of this Committee here this morning - and I am going to have to look at the transcript again - but I thought that Laura said something to that effect in the course of her comments. The premise is this: There are people going into the institutions that don't belong there, okay? If that holds, then the premise also has to hold that there are people there now that shouldn't be there.

SENATOR HAGEDORN: We agree with that.

SENATOR SCARDINO: If you agree with that, then how can you disagree with me when I say that it will depopulate the institutions at this point because we agree there are people there that don't belong there.

SENATOR HAGEDORN: It is an entirely different process.

SENATOR SCARDINO: It is not.

MS. LeWINN: Excuse me, Senator. I think ---

SENATOR SCARDINO: It is not though. You have to look at the people who are there and give them the availability of what this process is all about and say, "you really don't belong here now. You should be someplace else." Where, you are going to have to spell out for us.

SENATOR VREELAND: But I think Tony made that point. He said it may take three months or it may take six months, but these hearing go on and eventually maybe the person will be out.

SENATOR SCARDINO: But it goes back to the point that I made. It should, indeed, depopulate. It should, indeed, relieve the institution of people that are there now other than detainer patients.

MS. LeWINN: Down the line, it should have that effect because right now ---

SENATOR HAGEDORN: Isn't that the very policy we are following right now?

SENATOR SCARDINO: That's why I say: Why do we need the bill then if we are doing it right now?

SENATOR HAGEDORN: Not to get them in there in the first place.

SENATOR RUSSO: Incidentally, will this bill apply to the retarded children also?

MS. LeWINN: No, that is a totally different subject.

SENATOR SCARDINO: Follow the logic then. If what Senator Hagedorn is saying is true that you don't want people in an institution that don't belong there and the process will now see to it that they don't end up in an institution by virtue of the screening process and the combination of professional people who are going to be making evaluation, and, hopefully, you are going to have alternative settings for these people -- and that is something that I want to have clearly defined as to what the alternatives are going to be — and then simultaneously you are going to be removing people from the institution because we agree that there are people there that shouldn't have been there in the first place ---

MS. LeWINN: This bill would not have that immediate impact on the already

institutionalized. The scenario you are drawing is true, but it would be down the line because what we are talking about is from here on in.

SENATOR SCARDINO: Let's look down the line then. You are dealing ideally and I am dealing ideally in terms of my question. You are obviously looking at the ideal approach. You want this thing to be the remedy to a very serious situation from your own point of view. I want it to be the remedy too. But I don't quite see it the same way you do. I don't see it as a remedy. I see it, quite frankly, as making it a lot worse than what we have right now. This is what I am trying, hopefully, to get you to convince me otherwise. So, if you depopulate, whether it is now or down the line, and you have fewer persons in the institutions, with your definition of the term "dangerousness" that is incorporated in the bill, what I said earlier this morning at the outset I am going to repeat again, I actually see a shift in terms of increasing the population of detainer patients at the mental institutions. The question then arises: What do you do with those people that you are moving out? You are not doing enough to prove to me that you have an alternative setting for them.

I am not convinced that I want to see the shift of detainer patients over to the mental institutions. But that is the way I see it.

SENATOR HAGEDORN: That is a matter of opinion. I see it otherwise.

MS. LeWINN: Senator, the concerns, as you have just expressed them, are about the most succinct and all-encompassing wrap-up of all of the issues and the problems that face the mental health commitment system as it operates today. I think that it doesn't do credit or that it is not fair to this bill to try and get too cosmic. If you think about it long enough, everything starts looking hopeless and you think you are never going to make any progress anywhere. If you look at what this bill is intended to do, which is to make some sense out of and to codify and to make efficient and make effective the civil commitment process as it now exists, this bill goes a long way toward doing that. This bill consolidates statute, court rule and administrative directives into one legislated procedure.

If you have problems with some of the substance of those procedures in the bill, that is something else. But I don't think that it is fair to this bill to start bringing in scenarios of detainer patients taking over the State hospitals and the non-detainer, mentally-ill walking the streets with no place to go. I think we do have some givens: One, the State hospitals are not providing the best adequate therapeutic treatment that is available in conformity with accepted medical and psychological practice. Two, there are inadequate alternative facilities for mental health services in less restrictive community or non-hospital settings. And, three, what I referred to before, the civil commitment process as it now exists provides opportunities for abuse and arbitrary deprivations of liberty that are not justified by what is coming out on the other end, by the quality of treatment that is coming out on the other end.

Given, the quality of treatment issue, you have to go back and look at the deprivations of liberty and the abuses that exist in the current system. That is what this bill is meant to address. This isn't an after-care bill. This isn't a detainer patient bill. This isn't a community mental health center funding bill. Those are all issues that have to be addressed, yes; and they have some bearing on what we are talking about today. But they are not addressed by this bill and I don't think that they necessarily come into existence because of this bill.

SENATOR SCARDINO: They are addressed by the bill. If not directly, indirectly they are addressed by the bill. It has an impact on all of the areas

that you cited. And you are not going to convince me otherwise. Let me rephrase that. I would appreciate it if you could convince me otherwise so that I could agree with you because I happen to share your ideal. But I don't see it that way. I sit here and listen to you speak. And I am just wondering, really, what we are doing. I don't want to see people falling through the cracks again. I don't want us losing people in the system. I don't want people to be removed from our mental institutions that cannot be provided with an alternative and "better" - quote, unquote - setting than they have available to them now. And I am telling you that I see this as a possibility of happening.

SENATOR HAGEDORN: I don't see in this bill, Tony, where this is going to make any change in what we have at the present time, as far as release is concerned. I would like to know where it is.

MS. LeWINN: If this bill were implemented tomorrow, it wouldn't mean that anybody now in the hospital is going to get out that day because of this bill.

SENATOR RUSSO: They may not get in.

MS. LeWINN: That is the other end of the spectrum.

SENATOR SCARDINO: With your concern for the liberty and rights of all these people, how can you make a distinction between the person that is in the institution and the person that is in the screening center? If you are concerned with their liberties, how can you do that and not be contradictory?

MS. LeWINN: I don't make a distinction.

SENATOR HAGEDORN: Have them all rescreened.

SENATOR SCARDINO: Thank you, Gary. But I want to hear the young lady say that.

MS. LeWINN: What did he say?

SENATOR HAGEDORN: I said have them all rescreened. There is nothing wrong with that. Have the Governor sign the bill to provide the money.

MS. LeWINN: I don't make that distinction, but this bill does in that it doesn't address one of those groups you mentioned. It doesn't address the currently hospitalized. It addresses what Senator Russo mentioned. It addresses the people who the day after this bill is implemented are coming up for admission to a hospital.

SENATOR RUSSO: With respect to hearings generally, what role does the Public Advocate play? You represent, do you not, the patient at the hearing?

MS. LeWINN: Yes.

SENATOR RUSSO: You attempt to have the patient released? Your role is to convince the judge that he is cured or that he doesn't belong there in the first place - your Honor, will you consider releasing him?

MS. LeWINN: Our role is to present to the court the client's position in the proceeding. If it is a commitment hearing, generally the client's position is to resist commitment and we argue that position.

SENATOR RUSSO: And that is the allegedly sick person, the client?

MS. LeWINN: That is the person against whom an application for commitment has been filed, yes.

SENATOR RUSSO: So your battle is to get him out?

MS. LeWINN: To prevent him from being kept in.

SENATOR RUSSO: At the review hearings, the role played by the Public Advocate is to do whatever possible to have the allegedly sick person released from the institution?

SENATOR HAGEDORN: Not necessarily, Tony. I think it also includes one other area and that is, if he is not getting or she is not getting the proper treatment,

to help get the proper treatment. I think that is one area where the Public Advocate has certainly been very helpful.

MS. LeWINN: We also have a class-action component within the division that does focus on right-to-treatment issues. In fact, Greystone was our first defendant.

SENATOR HAGEDORN: I might say I have never been the greatest advocate of the Public Advocate's Office, but I can tell you right now that I think this group has done more to improve mental health care than any other activity I have seen.

SENATOR RUSSO: I would suggest in all sincerity that in order that the members of this Committee can get a better grip on this whole program in its entirety we visit the State institutions ---

SENATOR HAGEDORN: I have done that.

SENATOR RUSSO: (Continuing) --- specifically to attend the hearings,not to visit the institutions.

SENATOR HAGEDORN: Let me know when there is a hearing, I will be there.

SENATOR RUSSO: --- attend the hearings at the institutions, so you can fully understand what is transpiring in the State of New Jersey and in many other states. You will appreciate what I said earlier that we are hurting people to a degree. People who need our attention, our help, our care, our compassion, our kindness, we are releasing to the streets.

I think what we are doing here this morning, should we implement this bill, is enlarge what has already happened to a much greater degree. That is my personal opinion now. I say that to you from experience I have derived from attending all of these hearings.

SENATOR HAGEDORN: There was one other thing I would like to inquire about and that is the question about examples of people getting into institutions that shouldn't be there. I think you asked that question and Laura is supposed to be getting us some facts and figures. I would just call to Laura's attention that one area that she might investigate is the very institution that we mentioned here this morning, Marlboro, where on weekends the law enforcement agencies are dumping every intoxicated person in Marlboro. That is just one area alone that I think the bill could help to correct.

SENATOR RUSSO: You are going to give us that information by name. You are going to name each case. Don't be general in your comments; be specific, Laura.

MS. LeWINN: I will give you the most specific statistics I can.

SENATOR RUSSO: The name of the institution, the date, and the party involved.

MS. LeWINN: I may have some problem with the names of the patients, but I will give you what we can.

SENATOR HAGEDORN: Is that fair though to release the names?

SENATOR SCARDINO: Confidentiality may prevent her from doing that.

SENATOR VREELAND: That's right. You can't have that.

SENATOR RUSSO: Give us the other things.

MS. LeWINN: I still think the fact that I can come before you and say that in the cases that we do represent people, 75 percent of the time they are either released or the commitment is denied - these are people who have already been in the system and a judge has found that they are not appropriate subjects for commitment - is very compelling evidence of the inappropriateness of some of the people who do get caught up in the system.

SENATOR VREELAND: Are you saying some of these people who make the decisions that these patients should go in are making the wrong decision until you come along and give the reason why they shouldn't be there?

SENATOR HAGEDORN: It is a question of how some of them got in there in the first place.

MS. LeWINN: Right now, the person who makes the decision that someone should be in can be a family member or a police official who just has to file an application for commitment. That in itself is enough to detain a person until the court mechanism or the hearing mechanism is set in order.

SENATOR VREELAND: It could be, as Tony points out, six months after they are in there.

MS. LeWINN: It could be. It should be 20 days, but it very often isn't.

SENATOR RUSSO: The first hearing should be 20 days.

SENATOR VREELAND: But as she pointed out that doesn't always happen. You say it does. Does it?

SENATOR RUSSO: Well, it should happen. It doesn't always happen. But there is a second hearing within 3 months and another hearing 3 months after that, then 6 months after that, then yearly thereafter. So, what I am trying to say is that that particular patient gets a lot of judicial attention. If there is some oversight at the first hearing, it will be picked up at the second. And the psychiatrists are there to testify.

MS. LeWINN: This is to reduce the oversight.

SENATOR HAGEDORN: We are trying to avoid the oversight in the first place.

SENATOR RUSSO: Then there may be something wrong with our institutions. Our medical people down there maybe should be dismissed. Maybe they are incompetent. Maybe that is where we should focus attention if people are being admitted improperly who don't belong there.

SENATOR HAGEDORN: That's the reason for the bill, Tony.

MS. LeWINN: That is exactly what the bill addresses.

SENATOR RUSSO: If the bill is enlarging something we already have and what we have isn't working properly, let's take another look at it.

SENATOR HAGEDORN: That is the very reason I have asked for another public hearing. I know there are deficiencies in the bill. I think we want to improve the bill. That is the very reason we are getting testimony from people who have had practical experience dealing with this.

SENATOR SCARDINO: Laura, I thank you for your testimony. I am not trying to cut you off because I am sure we have a lot of questions we still want to ask you. We are going to continue the public hearing on this bill at a later date. I would like you to come back to the Committee. At that time, I would like you to be very specific with case examples of what you are talking about and give us a "walk through," so to speak, as to what is happening now and what would happen under this bill to help these people.

We are all of the same mind here today, even though we have some basic differences of opinion as to the direction this law should go. I sincerely believe that some of the apprehensions that I have will occur and I would like to be convinced otherwise. You certainly have the charge to do that if you like. So, I would appreciate your being back with us at the next meeting.

MS. LeWINN: I would be happy to, Senator.

SENATOR SCARDINO: I would also ask those of you who have requested to

testify on this bill to join us again at the next meeting. We will continue the list we have today and you will be the first people listed. In the event there may be others who will come forward and want to testify, they will be put after you on the list of participants.

We will now conclude today's hearing on Senate Bill 352 and resume at a time and place to be announced. Thank you very much.

- - - - - -

STATEMENT ON BEHALF OF THE PUBLIC ADVOCATE ON S. 352

Submitted by,

Laura M. LeWinn, Esq.
Deputy Director
Department of the Public
Advocate
Division of Mental Health
Advocacy
428 East State Street
Trenton, New Jersey 08625

June 26, 1980

Mr. Chairman, and members of the Committee, on behalf of Public Advocate Stanley C. Van Ness, I would like to thank you for this opportunity to appear before you today, and address you concerning S. 352. The legislative effort to revise the current statutory morass of civil commitment procedures has been a long and valiant one. This bill represents considerable progress in that regard, both in terms of rendering the various components of the civil commitment process more efficient and effective, as well as in terms of according significant deference to the rights of those individuals who find themselves subjected to that process. In the experience of the Division of Mental Health Advocacy in the Department of the Public Advocate, currently existing laws are woefully inadequate in achieving either of these goals. The time is long overdue for updating these laws to bring them into conformity with developing judicial case law and mental health lore.

To the extent that S. 352 moves in this direction, we applaud it. We do feel constrained, however, to point out several areas in which we feel the bill, as currently drafted, does not go quite far enough.

1. In general, the screening service concept is a promising one and we welcome the codification of that concept in this bill. However, we would like to see the definition of "screening service" expanded to emphasize its function, not only as providing "examination, diagnosis, evaluation and emergency treatment" to persons facing involuntary civil commitment, but also as a referral service to other, less restrictive alternative mental health services. This would help insure that screening services perform a true "screening" function, and would help reduce the possibility of such services becoming merely an additional -- albeit threshold -- step in the civil commitment process. We suggest adding something like the following language to the definition of screening service currently in the bill:

> . . . for the purpose of ensuring that persons needing mental health services are referred to the most appropriate and least restrictive available mental health service."

2. We would like to see the definition of "dangerous" tightened up by inserting the word "immediately" before "foreseeable" in line 111, "recent" before "behavior" in line 114 and again in line 116, and "seriously" before "impairing" in line 117. This language would render the statutory definition of dangerousness consistent with the standards mandated by the United States Supreme Court in O'Connor v. Donaldson, 422 U.S. 563 (1975) and our own Supreme Court in State v. Krol, 68 N.J. 236 (1976).

3. Section 3(4) (p. 5, lines 24-28) should be expanded to comport with the recent decision of the United States Supreme Court in Vitek v. Jones, 100 S. Ct. 1254 (1980). In this regard, please refer to the attached letter addressed to the Honorable George Y. Schoch, Assignment Judge of Mercer, Hunterdon and Somerset Counties, which sets forth the position of the Department of the Public Advocate concerning the impact of implementing the Vitek decision upon the laws of New Jersey. Persons in confinement in correctional institutions are now expressly entitled to certain due process protections when facing transfer to a mental health facility. This bill should reflect the judicial mandate, as indicated in the attached letter.

4. In section 8, we would like to see "county medical examiner, . . . [and] county or municipal welfare director" eliminated from the list of parties who may apply for the psychiatric examination of an individual believed to be dangerous. We feel that those who hold these positions are likely to bear too attenuated a relationship to the individual in question to adequately (and personally) assess the need for detention and examination in a given case. There is no logical basis on which to assume that such parties, merely by virtue of their positions, are particularly qualified to make the judgment called

for in this section. In addition, we would like to see precise and meaningful definitions for "nurse," "social worker," and "police official," to ensure that these parties are qualified by virtue of their training and background -- not simply by their title -- to exercise the requisite judgment.

5. In section 9a, we would like to see the phrase "other appropriate means" (lines 2-3) qualified to require personal observation under any circumstances by the director of the individual named in the application before accepting that individual into the screening service.

6. The provisions in section 9a and 9b, permitting a police official to bring an individual to a screening service for admission should be mod fied to require the screening service in the first instance to perform an outreach function and make every good faith effort to examine an otherwise unwilling subject at the place where he/she can be found. Only after this effort has failed should a police official be authorized to detain and transport a person involuntarily to a screening service.

7. We would like to see either the 72-hour limit in section 10a, or the 48-hour limit in section 13/ (or both) reduced to insure that the total time detained in a screening center before a commitment application is filed is no more than 3 days. We think this can be reasonably accomplished by reducing to 48 hours the limit on the initial detention contemplated by section 10a, and reducing to 24 hours the time within which the director must file a court application for commitment, once a determination of dangerousness has been made. Support for this recommendation can be found in: Lessard v. Schmidt, 349 F. Supp. 1078, 1091 (E.D. Wis. 1972); Bell v. Wayne County, 384 F. Supp. 1085, 1098 (E.D. Mich. 1974); Kendall v. True, 391 F. Supp. 413, 419 (W.D. Ky. 1975); and Lynch v. Baxley, 386 F. Supp. 378, 388 (M.D. Ala. 1974).

8. We would like to see section 11d. expanded to provide that the right to receive services includes the right to refuse certain forms of treatment, such as the administration of psychotropic medication. The following language is suggested:

> d. The right to participate in the planning of treatment and services that may be provided to him/her, the right not to be denied one form of treatment because of refusal to accept another form of treatment, and the right to refuse to participate in experimentation.

Such language would render this section in compliance with currently existing New Jersey law, to wit N.J.S.A. 30:4-24.2, as well as pertinent case law, Rennie v. Klein, 462 F. Supp. 1131 (D. N.J. 1978), further proceedings at 476 F. Supp. 1294 (D. N.J. 1979). This language also appears in the proposed Bill of Rights amendment to Title VII of the Federal Mental Health Systems Act (S. 1177).

9. In section 14a, we would again like to see the phrase "other appropriate means" qualified to require personal observation by the examiner before the application in question is made. Also, as discussed earlier, we would like to see this section modified to require reasonable efforts at "outreach" services by the examiner before resorting to police intervention.

10. Section 17 should be expanded to require that the provisions of N.J.S.A. 30:4-24.1 and 24.2 apply in toto. These statutes as currently written already apply to "every individual who is mentally ill" and "every patient in treatment." Individuals subject to section 17 of this bill fall within these existing categories; therefore, there is no justification for restricting the rights available to them under this bill.

11. In section 18, "immediately" (line 3) should be qualified to require probable cause review within a maximum of 48 hours. In section 18a(1), the time for holding the final commitment hearing should be reduced from "10 days" to "7 calendar days," and the continuance should be reduced from "an

additional 15 days" to "an additional 5 calendar days." Support for these time limits can be found in those cases cited above in paragraph 7 of this statement.

12. The implication of section 18a(2) is that the attorney has no right to inspect and copy patients' records prior to the issuance of the temporary order. This right should come into existence as of the moment an individual is admitted to a screening center, or brought to an examiner, for evaluation. It is not unlikely that an individual facing the possibility of involuntary civil commitment may wish to avail himself of the services of an attorney at some point prior to the issuance of the temporary order. Legal counsel's right to access to records should be coterminous with his retention for services by the individual in question, whether or not such services begin prior to the temporary order.

13. Finally, we would like to see section 21 amended to provide periodic review 3 months, 6 months, and 9 months from the date of the initial order, and annually thereafter. This additional review will help further reduce unnecessary and/or inappropriate commitments. In any event, this section should be amended to require that the commitments of minors be reviewed "every three months from the date of its entry until the minor is discharged or reaches his majority." The quoted language is from R. 4:74-7(f) of the New Jersey Court Rules, and should be codified in the statutory scheme.

In closing, we would like to reiterate that we applaud the efforts, represented by S. 352, to render the civil commitment process (and related procedures) more humane and effective. The screening service concept must be given legislative recognition, along with the concept of the least restrictive alternative approach which is also embodied in this bill. Subject to the reservations discussed above in this statement, we feel S. 352 goes a long way toward addressing the confusion and inequities inherent in the current statutory scheme.

State of New Jersey

DEPARTMENT OF THE PUBLIC ADVOCATE
DIVISION OF MENTAL HEALTH ADVOCACY
P. O. BOX 141
TRENTON, NEW JERSEY 08625

MICHAEL L. PERLIN
DIRECTOR

LAURA M. LE WINN
DEPUTY DIRECTOR
TEL. 609-292-1780

STANLEY C. VAN NESS
PUBLIC ADVOCATE

June 20, 1980

Honorable George Y. Schoch, A.J.S.C.
Mercer County Courthouse
Trenton, New Jersey 08607

Re: Implementation in New Jersey of
Vitek v. Jones, 100 S. Ct. 1254 (1980)

Dear Judge Schoch:

In response to your request at our meeting on June 3, 1980, I am writing to advise you of the position of the Department of the Public Advocate concerning compliance in New Jersey with the recent United States Supreme Court decision in Vitek v. Jones, 100 S. Ct. 1254 (1980).

In Vitek, the Court found that the involuntary transfer of a prisoner to a mental health facility for the purpose of subjecting him to psychiatric treatment "implicated a liberty interest protected by the Due Process Clause," 100 S. Ct. at 1264; certain pre-transfer procedures were mandated to comply with due process requirements, including written notice, a hearing, the opportunity to present witnesses, an independent factfinder, a written statement of findings and reasons, "qualified and independent assistance," (100 S. Ct. at 1267)[1] and timely notice of these rights.

---

[1]This is the language found in the concurring opinion of Justice Powell. A majority of the Court concurred in the constitutional necessity of all the above-enumerated rights with the exception of the nature of independent assistance to the inmate. On this issue, four Justices felt that the assistance of a licensed attorney was mandated. Justice Powell, who voted with these four Justices in favor of every other pre-transfer right, differed on this issue of counsel. He stated:

> [A]lthough the State is free to appoint a licensed attorney to represent an inmate, it is not constitutionally required to do so. Due process will be satisfied so long as an inmate facing involuntary transfer to a mental hospital is provided qualified and independent assistance. 100 S. Ct. at 1267.

The implications of the Vitek decision for New Jersey practice are significant. It is the position of our office that Vitek must be read to require a pre-transfer hearing for prison inmates facing psychiatric hospitalization, in every instance, with one possible, very limited exception for true emergency situations as will be discussed below.

Current New Jersey statutes and court rules comply with Vitek to a considerable degree. N.J.S.A. 30:4-82 can, in part, be read consistently with Vitek to require pre-transfer hearings. However, the provision in that statute that "[p]ending the [court] action such person may be temporarily confined in an appropriate public institution in this State, upon an order of the court," is inconsistent with Vitek and, therefore, should no longer be considered valid. Likewise, N.J.S.A. 30:4-84 (allowing administrative transfers, on the commissioner's authority for up to 30 days) is no longer valid in light of Vitek.

In short, Vitek should be read to require that -- with a very narrow and limited exception for true emergencies -- transfers of prison inmates to psychiatric hospitals shall be regarded as Class A commitments, under N.J.S.A. 30:4-25, and 4-36, thus requiring the entry of a final commitment order prior to the transfer. This designation as Class A proceedings, in turn, invokes the applicable provisions of R. 4:74-7.

The New Jersey statutes and court rule contemplate judicial hearings in these matters. Therefore, even though the Vitek opinion speaks in terms only of an independent decisionmaker, application of the Vitek mandate in this State should place such hearings within the purview of the judicial branch. The judicial mechanism is currently in operation; judges have been hearing commitment matters on a regularized, plenary basis since 1974 (see attached Memorandum of Chief Justice Hughes, #74-7, dated November 12, 1974). No alternative decisionmaking mechanism currently exists which could effectively assume responsibility for these hearings; thus, but for the invocation of the judiciary in this regard, a new hearing and decisionmaking authority would have to be created. Unlike the situations in Morrissey v. Brewer, 408 U.S. 471 (1972), and Gagnon v. Scarpelli, 411 U.S. 778 (1973), there is no analogue to either the Parole Board or the county probation departments, which were charged with the respective decisionmaking functions in those cases, currently in existence in New Jersey to perform the decisionmaking function required by Vitek. The judicial system can absorb this function in a more efficient and effective manner than any prospectively created administrative agency.

We also feel that legal counsel should be available to inmates at their transfer hearings, for the reasons expressed by four Supreme Court Justices in Vitek:

> A prisoner thought to be suffering from a mental disease or defect requiring involuntary treatment probably has an even greater need for legal assistance for such a prisoner is more likely to be unable to understand or exercise his rights. 100 S. Ct. 1265.

Legal counsel is currently available to all other New Jersey citizens facing civil commitment to psychiatric hospitals, R. 4:74-7(c)2. Given the similarity in nature of the issues in transfer/commitment hearings and civil commitment hearings, as well as the added factor of the special vulnerability of prison inmates facing transfer as noted in Vitek above, the availability of legal counsel is particularly appropriate in "Vitek hearings;" this becomes even more evident when viewed in conjunction with the proposition that the judiciary is the proper mechanism to conduct such hearings, as discussed above.

As indicated earlier, we feel one limited exception may be appropriate to our over-all position that Vitek requires pre-transfer hearings (and related rights) for prison inmates facing psychiatric hospitalization. This would be in the case of a true emergency, where an inmate is actively demonstrating behavior which constitutes an immediate peril to himself or another, and no means is available within the prison to defuse the crisis. However, a clear responsibility should be placed upon prison officials to take as constructive and effective steps as possible to avoid the onset of such emergencies, and to control and subdue them when they occur, with means other than peremptory transfer to a psychiatric hospital. We urge very strongly that the exception not become the rule, and that the Department of Corrections take reasonable measures to effectively treat disturbed inmates within the confines of the prison or reformatory, rather than rely too easily on the availability of the state hospitals. True compliance with Vitek v. Jones requires as much; basic human decency and compassion dictate no less.

Thank you for the opportunity to share these thoughts with you. I would be happy to discuss these matters with you further if you so desire.

Respectfully yours,

Laura M. LeWinn
Deputy Director

LML/bjm
Encl.
cc: John Shoosmith
Ed Stern
Joseph Maloney
Frances Boronski
Jean Ross

9X