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

before

ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE

To examine problems and prospects for the
mental health care system in New Jersey

March 24, 1988
Room 341
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Harold L. Colburn, Jr., Chairman
Assemblyman Nicholas R. Felice, Vice Chairman
Assemblyman Rodney P. Frelinghuysen

ALSO PRESENT:

Assemblyman Frank A. LoBiondo
District 1

David Price
Office of Legislative Services
Aide, Assembly Health and Human Resources Committee

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March 1, 1988

NOTICE OF A PUBLIC HEARING

THE ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE ANNOUNCES A PUBLIC HEARING TO EXAMINE MENTAL HEALTH PROGRAMS AND ISSUES

Thursday, March 24, 1988
Beginning at 12:30 P.M.
Room 341 of the State House Annex
Trenton, New Jersey

The Assembly Health and Human Resources Committee will hold a public hearing on Thursday, March 24, 1988, beginning at 12:30 P.M., in Room 341 of the State House Annex, Trenton, New Jersey, to examine problems and prospects for the mental health care system in New Jersey. The committee intends to hear testimony from individuals, agencies and organizations reflecting a wide variety of perspectives on institutional and community mental health programs and issues, for the purpose of obtaining information and assessing the need for administrative and legislative initiatives.

The scope of this public hearing will include, but not necessarily be limited to, public and private inpatient and outpatient services for adults and children, screening and commitment procedures, community-based residential programs, services for the dually diagnosed, mental health staffing problems, mental illness and substance abuse and insurance coverage for mental health care.

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ASSEMBLYMAN HAROLD L. COLBURN, JR. (Chairman): We are going to open our public hearing now. Although not all of our people are here, it is about five minutes after the time and we do have limited time. I'm going to try to wind it up by four o'clock this afternoon.

As many of you probably know, we've asked that you try to summarize your testimony. You're certainly welcome to hand in more material than you're able to present here today. We're going to go over all of that, and from this we're hoping to come up with help from the legislative point of view, on the subject of mental health.

As Frank Bosworth over here -- who's the Chairman of our Burlington County Health Board -- knows, I think I've been interested in mental health for at least 20 years, as a physician and a freeholder, and now up here. I've been frustrated on a lot of occasions by what has happened in the field and what doesn't happen. I was an early questioner of deinstitutionalization, and still feel that it hasn't been handled the way it should be. So I am quite sympathetic to this.

All of the members of our Committee are also sympathetic. Mr. Otlowski -- who we hope will come later -- has introduced quite a lot of legislation in the past in the field of mental health. Mr. Deverin -- who is on vacation -- is interested of course. Mr. Frelinghuysen is probably our number one expert on this subject on the Committee. Mr. Felice -- who will be here in a few minutes -- is also very interested, and has introduced quite a bit of legislation having to do with institutions in general. So we're all aware of the problem. There's lots of hurdles to overcome.

I would like to introduce not only Mr. Bosworth, but Mr. Frelinghuysen, our staff member Bill Naulty -- he's from our district staff -- Suzanne Ulivi from the Republican Majority staff here -- John Kohler is expected later -- David

Price the nonpartisan member, and Mary Messenger who represents the Democratic Minority, and has thus far been mostly under control at this hearings; thus far. (laughter) I'm Harold Colburn.

We're going to call the first witness, Mr. Nicholas, who is Deputy Commissioner, Department of Human Services. Do you want to come up and sit down, Mr. Nicholas?

D E P U T Y C O M M. R O B E R T N I C H O L A S: Yes. We are going to try to be brief. The first three are all Department officials. We won't take up a lot of time.

ASSEMBLYMAN COLBURN: Okay, fine.

DEPUTY COMMISSIONER NICHOLAS: Thank you, Mr. Chairperson. My name is Bob Nicholas. I am a Deputy Commissioner at the State Department of Human Services. One of the areas that I'm responsible for is the Division of Mental Health and Hospitals. We have today also Steve Pelovitz, who is the Department's Chief of Staff, and Alan Kaufman, who is the Director of the Division of Mental Health and Hospitals. We have some brief remarks, and then we'll obviously be willing to answer any questions that the Committee might have.

We'd like to say in opening that we are grateful for the interest of the Committee in the mental health system. It has been an area of considerable concern to us during the last year. There's probably no area of the Department that has had more attention to it in the last year, and it's an area with tremendous needs.

So we'd like to open if we could with some brief remarks by Alan Kaufman, just to let you know the Division's perspective on the mental health system at the present time.

ASSEMBLYMAN COLBURN: Okay.

A L A N G. K A U F M A N: Mr. Chairman and Committee members, as you're aware I'm new to the Division of Mental Health and Hospitals as the Director, but I am not new to the State of New Jersey, or the mental health system that we provide here.

I want to take some moments to share with you some observations that I've made of our mental health system in the last six months of tenure as the new Director.

First I guess is to tell you how pleased I was to be able to confirm an impression that I had as a provider across the State of mental health services itself. And that impression was that we have in New Jersey some outstanding expertise in terms of the community agency providers -- over 120 of them in New Jersey -- who are providing services to our severely mentally ill, most of our most vulnerable population in terms of mental health needs. That expertise basically tells us that we have the technology, the knowledge, the skills, and the willingness, to be able to provide what has become some of the most creative and innovative services provided to our population and community. And we continue to be a leader in our nation in terms of using that expertise and technology. It's nice to have that confirmed, particularly from having the vantage point in the last six months of being able to view that from an oversight position and have that kind of perception confirmed.

The community providers, however, are constrained. They are basically trying to move on a system that is being stretched to its limits. But it is not an issue of technology, ability, willingness, knowledge, or capability, to provide the services that are effective, innovative, and creative, that our population needs in our community.

I've also observed from the institutional system -- and had the opportunity to become very involved in that in the last six months -- that certainly and admittedly we have problems in our institutions, and we need to improve in the seven institutions the quality of care. But on the other hand, I'm here to tell you, and very proudly, that I'm very impressed with the level of commitment, dedication, talent, knowledge, and skills, of most of our staff who are working in the

institutions. We are struggling with problems of recruitment and retention of sufficient numbers of nurses, physicians, psychiatrists, other professional staff, and it's placing us in a surrounding and situation that is difficult to deal with. But we have a great deal of talent. We have made tremendous strides in the mental health system, in terms of our seven institutions.

But overall, the observation I really want to convey this afternoon to you, is that I've identified and basically become astounded at just how delicately balanced and fragile our mental health system is in our State. The best example of that is sort of an analogy to me. It appears that our mental health system in this State is like a very overfilled balloon with an extremely taut skin. And we have to be very careful to stay away from sharp objects and sudden jolts, because we run the risk when anything in this delicately balanced system moves, it not only punctures that balloon, but basically has the potential of collapsing the system.

The best example I can give is one that you may be familiar with already. In June of 1987 the County of Hudson needed to close down half of its psychiatric unit beds in Meadowview Hospital. It's only 70 beds total. They closed down 35 in June of '87. You would have to ask yourself, as I did, what impact could 35 beds have? If you have adult hospitals and three specialized hospitals run by the State that accounts for just under 3000 beds, and you have five county psychiatric institutions that accounts for 1200, how many, and what kind of impact, can 35 beds have on our system based on 4200 other beds, not mentioning the community mechanism?

The reality is astounding. By closing those 35 beds -- and an indication of how fragile our mechanism and system is -- it caused today over 120 additional Hudson County patients at Greystone Psychiatric Hospital. The increase of 120 people from those 35 beds over the last ten months, has basically

caused the delay in the removal through attrition and moving of positions out of the Greystone phase-down plan. We have not been able to move and would not -- we did not want to compromise quality of care -- would not move the positions out of Greystone because of the increased overcrowding due to these 35 beds, basically.

The domino effect and how fragile we are-- By not being able to remove the positions, we are not able yet to staff the second admissions unit that is ready and able to begin at Marlboro Psychiatric Hospital. This is essentially an initiative to recognize by the management team, and very important. So without the ability to transfer the positions, we can't open the second admissions unit at Marlboro.

Following that, because of difficulties at Marlboro over the last year, about a year ago we diverted admissions from Ocean County that normally would have gone to Marlboro Psychiatric Hospital, into Ancora. By an inability now, or a delay in opening the second admissions unit at Marlboro, we are unable to remove or relocate back the Ocean County referrals out of Ancora.

So as an example of fragility and delicate balance, we have basically 35 beds closed in Hudson County, that within a 10 month period of time has caused 120 more people sitting at Greystone Psychiatric Hospital, an inability to open up an admission unit at Marlboro, and a subsequent inability to relocate admissions out of Ancora. So we have 35 beds affecting three out of four adult psychiatric hospitals. It is a very fragile and delicately balanced system. It's stretched to its limits.

In terms of the future, very briefly, I think one of the strong things that we have to do in the Division of Mental Health and Hospitals -- besides continuing the emphasis for improving quality of care and others -- is basically to organize better into some of our planning mechanisms.

We have started about five months ago to initiate a county planning mechanism, so that each of the 21 counties, with local input from a variety of different interest groups and experts, are developing right now county mental health plans. We need to move on that.

We intend to imminently appoint the Governor's Advisory Council on Mental Health Planning, which we hope will begin in the very near future, and basically use a lot of the information that has been gathered by staff over the past year. We need to put planning into effect.

I want to thank you.

ASSEMBLYMAN COLBURN: Thanks. Could I ask a question before you go on? It was my understanding that we've had county mental health plans for a long time.

MR. KAUFMAN: Yes.

ASSEMBLYMAN COLBURN: Are these revised ones, or new ones, or different ones?

MR. KAUFMAN: Unfortunately, the county mental health planning process of the county mental health plans have not really been redone in a comprehensive fashion since 1981. They've had some updates, and we basically re-energized that process, and to also assure some very wide representation on the plan development committee.

ASSEMBLYMAN COLBURN: And when was the Governor's Advisory Council authorized or announced? Has it been a long time in the appointing process?

MR. KAUFMAN: I believe that the-- I'm not sure. Bob may have to help me in terms of the history of when it was announced.

DEPUTY COMMISSIONER NICHOLAS: It's been a long time. It's been since last summer that we announced it. In terms of getting the proper balance of membership and leadership for that Committee, it has been a long time coming together, but we think we're ready.

ASSEMBLYMAN COLBURN: Okay. I just wanted to ask you that. Thank you. Any other questions? (no response) Thanks.

DEPUTY COMMISSIONER NICHOLAS: I'd like to just briefly update you on the Department's overall perspective and conceptual framework for our actions in mental health. I'll give you an update on two things which we've done in the last year which we think will make considerable improvement in the mental health system.

A policy approach that we have taken, which is somewhat different from the previous leadership of the Department, is that we are seeking to downsize the four regional and three specialized hospitals in the Division. We think that this will have two primary benefits. The first being that smaller hospitals are easier to manage. They provide the ability to provide increased quality of services and more individualized attention to patients, and third, and very importantly, increased client safety in terms of the ability to supervise, and the overall operation of the hospitals.

The other benefit of that, which is really our primary goal -- and has been the primary goal, I think, of the Division for many years -- is to increase community based mental health services by transferring the savings out of institutional units into community programing, and placing people from the hospital who need alternative programing into those specialized programs, both in the community and elsewhere, in order to more appropriately meet their needs.

So we're talking about downsizing and looking at the institutions for the resources necessary to create community mental health programing. To accomplish this we have followed basically two primary principles:

The first is that the funding for new programs needs to precede clients into the community. I think, as you referenced before, Mr. Chairperson, the ills of the past and

how deinstitutionalization may not have been handled appropriately before. One of the things was not having the programs in place ready to take people who were coming out of hospitals before they needed to be discharged. We see that as an absolute necessity in our planning.

Secondly, we want to involve mental health professionals, advocates, consumers, and their families, in the planning for the alternative programs that need to be created at the community level. This is done both through the routine use of the county mental health boards, but also through special project advisory committees, and to as great an extent as possible.

Using these two principles, and using that overall conceptual framework, we developed within the last 12 to 14 months the two primary plans throughout the State.

The first is one that Alan mentioned earlier, which is the Northern Regional Expansion Program. We were confronted a little more than a year ago with the need to make a significant investment in Greystone Psychiatric Hospital, which is an 835 bed facility. In assessing the need to do that we looked at who the clients are that we were serving there, and confirmed that it was a significant number of people who needed other kinds of alternatives, either in the community or in other kinds of specialized residential facilities.

We decided that rather than invest in the hospital, we would invest in the community, and to develop a plan which calls for the phase-down of 335 beds to a 500 bed hospital. We made available $12 million to the community for start-up costs -- capital start-up costs -- for alternative programs, which otherwise would have gone into the building or renovation of buildings that are on the hospital grounds, and saved $11 million in ongoing operational costs which are going to be used to fund the programs in the community, in the six northern counties that are served by Greystone. So through this plan,

which is a three-year plan, and other than the problems with Meadowview that we've talked about before, the community development is going very well. We have set up a process by where money that was already there, money that's in Greystone Hospital, will be used as the funding for community programs, for a better approach to provide more appropriate alternative services for the clients there.

We have been using the mental health boards in each county to do the plans for their share of the Greystone savings, and to come up with a strategy on what their priorities are within their county. We also, however, have northern regional committees which are helping us on such issues as overseeing the overall project, and doing planning for the use of resources at Greystone -- the vacant buildings, the land -- and what Greystone Hospital should be in a new, more community based mental health system in the north.

So this project is going well, and we think it's the kind of thing we can do more of in the future.

Secondly, we have the Trenton Adolescent Unit Plan. Once again most of you know that we had significant problems in the Adolescent Unit two years ago -- or going on two years ago -- and as a result of those concerns, once again it was where do we invest our money in terms of corrective action? And in looking and assessing the clients who we were serving at the Adolescent Unit, we found that once again we had clients that really needed alternative services; things like short-term crisis intervention, things like transitional living community based residences for younger kids especially, and outreach services -- getting mental health services out to detention centers, shelters, other kinds of programs in kids' own homes, to be able to avoid kids coming in inappropriately into a psychiatric hospital.

And again we decided that the money ought to be invested in the community. So a plan was developed which will phase out the Trenton Adolescent Unit and its 70 beds entirely, and phase down the Arthur Brisbane Child Treatment Center from 70 beds to 40 beds, for a total decrease of 100 beds in the children's system; and develop a whole network at the regional level of more appropriate residential programs for kids. They include 40 additional CCIS beds -- or crisis intervention beds -- 32 in transitional residences which will be located in each region, four programs for five to ten year old clients that will be throughout the State, treatment teams that will do outreach services to a variety of different kinds of community facilities, increased DYFS residential programs to provide the alternatives to the Adolescent Unit, and most importantly, a case management system that will get the kids through this maze of resources that we have that are yet uncoordinated, and which I think is a very important management aspect to the system.

So that is another plan that we are quite proud of. It is working well. We've got one cottage at the Adolescent Unit already closed. We have the population down in both of the psychiatric units, and it's proceeding nicely at this point.

Once again, we have had public input into that process. The Commissioner had a panel of experts that was appointed to work with us, of leaders in the mental health community throughout the State, and who were very helpful in molding the plan. We have an ongoing statewide advisory committee that meets with us on a monthly basis to give us input on how things should go and decisions that need to be made. And finally we have regional advisory committees who actually mold the plans for the alternative services; telling us where they should be, what the providers should be, where they should be located to maximize their accessibility in their regions. So we have a lot of people that are working with us on this, and we feel real good about that particular plan as well.

So I think that is an indication to you of where we would like to go, the kinds of things that we're trying to do, and the conceptual framework from which we're operating. Obviously there are great needs out there, and we see them as well as anyone. We are trying to use our resources in as efficient a manner as we can.

I'd like to turn it over to conclude to Steve Pelovitz, our Chief of Staff, for some concluding remarks on our budget situation at this point.

ASSEMBLYMAN COLBURN: Before you do, Rod, do you have any questions?

ASSEMBLYMAN FRELINGHUYSEN: No.

ASSEMBLYMAN COLBURN: I wanted to ask-- Have you heard from any people who feel that people who are not going to be in the Trenton Psychiatric Unit are going to be able to go to appropriate places?

DEPUTY COMMISSIONER NICHOLAS: Well we are maintaining a 40 bed unit, which will be a backup to our regional system, for those kids who can't go to other places. However, as I said, we did an assessment, and there were a lot of kids in Trenton who really didn't need to be there. We feel--

ASSEMBLYMAN COLBURN: Who determines that?

DEPUTY COMMISSIONER NICHOLAS: Well, there are obviously clinicians involved in determining that, as well as our panel of experts that helped mold the plan. The way the system is set up right now, the first 28 days of care ought to be provided at the regional level in some contract agencies which we've had for the last 10 years in New Jersey that have worked very well. What we found two years ago was those agencies were overcrowded and frequently didn't have a bed for a child. The kids then were being by-passed and going right to the longer term facility at Trenton, which really wasn't set up to deal with kids in crisis. We felt that there were so many of those kids going to Trenton, that we could use the money

going to Trenton to increase the regional beds that were available to serve those kinds of kids.

So, there are additional psychiatric beds being created. They're being created in the private sector. They're being prepared to be more accessible to families and kids, to be done at the regional level. We're certainly not leaving the-- Not only are we not leaving, we're expanding the resources that we have throughout the State. We'll be able to serve more kids with this fairly large amount of money.

ASSEMBLYMAN COLBURN: Okay. Well, we just have to rely on each year's appropriations to see to it that the money that comes from something that's closed down gets to the right place, because we can't designate it forever, I guess, that way.

DEPUTY COMMISSIONER NICHOLAS: That's true. We've heard over the last two weeks something that is totally erroneous at this point which needs to be clarified. The $8 million which is being saved as we phase out the Adolescent Unit, is indeed in our budget for next year, and will be transitioned into the community accounts of the MH&H. There was some rumor around that that had been cut, and therefore we were going to leave the State without the resources that we had promised. We are going to fulfill the promise in terms of the alternative resources, and we do have that money on an ongoing basis.

ASSEMBLYMAN COLBURN: Okay. Well just as a-- The way I've looked at things for a long time, I'm always -- I hope I shouldn't use the word "paranoid" -- but I'm always concerned that when they say that a person is in the right place, that they're in the right place. Now, you know it's a matter of judgment, and maybe sometime one expert would disagree with another. So I think you get into that sometimes.

DEPUTY COMMISSIONER NICHOLAS: Yes. Well, as people who are here know, one of my pet peeves is that particular point. That is that as a State, and a discipline nationwide,

there is not a commonly accepted classification system for matching a child to an appropriate program.

ASSEMBLYMAN COLBURN: I sure understand that.

DEPUTY COMMISSIONER NICHOLAS: So we have, between DYFS, and Mental Health, and courts, and all the different people who get involved with troubled children, great disagreements of who ought to be where.

ASSEMBLYMAN COLBURN: Yeah.

DEPUTY COMMISSIONER NICHOLAS: You'll be hearing later from the Governor's Committee on Children's Services Planning on their mental health forum report, which is about to come out and which I think will be a great resource as we look to doing planning for children's mental health in New Jersey. One chapter of that proposes a classification system that hopefully all the different disciplines could buy into, which would certainly help in terms of getting rid of the disagreements that we have day-to-day in the system.

ASSEMBLYMAN COLBURN: Okay, fine. Thanks. You're on.

S T E V E N A. P E L O V I T Z: Mr. Chairman, Assemblyman Frelinghuysen, I'd just like to take a moment or two to reflect on the Department's proposed budget for FY '89, and its impact on the mental health system and our mental health budget.

The recommended increase in FY '89 is $250 million. That's the largest increase that has ever been recommended for the Department, and is $50 million higher than the next largest increase. A portion of that -- and in fact, a very large portion, $75 million worth -- is an increase in the Medicaid budget, which really was not expected at the time we started our budget negotiations. During the course of this fall, new statistics arrived concerning Medicaid, both on hospital rates, and on nursing home utilization -- number of beds available and the rates we were paying -- that increased the needs for Medicaid just to maintain its current level of services to current beneficiaries by almost $150 million. That was over an

expected level of about $75 million. So there was an extra $75 million that needed to be accommodated in our budget in order just to maintain the same levels of services to the same numbers of people.

Given that, there were a number of important things the Department would like to have done that just needed to be put over for another year. Our first priority has to be maintaining services to our current clients that we're serving. The $250 million increase does include full funding for the second year of both the Greystone initiative and the Trenton Psychiatric Adolescent Unit initiative, and that's something we need to be very clear about. I know there have been concerns about whether or not those funds are available. They are there. It is our intent to proceed, as we have been saying right along, with those initiatives.

There's also money available to begin implementation of the screening bill that the Legislature passed, and the establishment of a training academy to help better prepare the people we hire to work within our institutions. In addition, there is full funding, including inflationary increases, for the services we're currently providing, both in the community and in the hospital setting.

Again, we have a very very significant increase to our budget this year that largely has focused on maintaining the level of services we have been providing to our current clients, both in Mental Health and in our other Divisions.

ASSEMBLYMAN COLBURN: Thank you. Rod?

ASSEMBLYMAN FRELINGHUYSEN: I'll resist asking any questions at this point, Mr. Chairman.

ASSEMBLYMAN COLBURN: Okay. Thanks a lot. I'm going to ask Dr. Rubin to come up, Kenneth Rubin, President of the New Jersey Psychiatric Association. Good morning, or a good afternoon, I should say. Thanks.

D R. K E N N E T H J. R U B I N: Thank you. I'd like to thank the Committee for the opportunity to testify before it. I'm Kenneth J. Rubin, M.D., President of the New Jersey Psychiatric Association. I am also the Medical Director of the inpatient unit of Monmouth Medical Center and in private practice in Long Branch. There are four areas that I would like to cover, and reserve it to that because of the short time.

I. The Commitment and Screening Bill: As you are aware, the new Commitment Law, Public Law 1987, Chapter 116, is to take effect on November 1, 1988. There are significant improvements in the law. For example, including the concept of gravely disabled in the criteria for admission to the hospital and the maintaining of physicians as the only ones to complete this certificate. It also establishes the concept of screening centers and short-term care facilities.

The New Jersey Psychiatric Association has been involved in the Screening Rules and Regulations Advisory Committee chaired by the Department of Human Services, since December of 1987, to review in great detail the proposed regulations for screening, and screening outreach programs. We have had active input, and the final draft should be available on April 8. We feel to be effective the law will require adequate fiscal support, the cooperation of the Department of Health and the Department of Human Services, and the commitment by mental health professionals to quality programs.

ASSEMBLYMAN COLBURN: Dr. Rubin, I want to stop you right here for a moment. We only have about six minutes.

DR. RUBIN: Yeah, I abbreviate this.

ASSEMBLYMAN COLBURN: You're not going to read all these ten pages?

DR. RUBIN: No, no.

ASSEMBLYMAN COLBURN: Okay. Thanks a lot. I'm sorry to interrupt you.

DR. RUBIN: I'm going to abbreviate. I know that. But there were certain areas that I did want to read.

ASSEMBLYMAN COLBURN: Of course.

DR. RUBIN: We feel that the Department of Health should develop an intensive treatment unit concept, distinct from the regular psychiatric units.

The Department of Health and the Division of Mental Health and Hospitals must acknowledge that not all patients can or should be treated in a community hospital, and there a substantial number of patients that need asylum in the State hospital system.

The leadership role of psychiatry must be recognized, with the screening centers and short-term care facilities under the direction of a psychiatrist. The screening center should be hospital based and administered by the Department of Psychiatry. The existing emergency room staff should be incorporated into the screening system.

The psychiatrists involved should not be expected to provide the service in these components as part of their on call or service obligations to the hospital. But funds must be provided so that programs will be able to recruit and obtain competent psychiatrists to do the necessary work.

The screening centers and hospital emergency rooms must work together, and all patients must be medically screened first.

As can be seen, for the screening centers and the commitment process to function adequately, and to provide the high quality of care and treatment that the mentally ill in New Jersey require, there must be adequate funding to the program. In Governor Kean's budget there is proposed $1.8 million for this whole project, and about $23 million for the whole Mental Health budget. Both items are inadequate and the former amount of $1.8 million is probably closer to providing funds for one screening center and its various components, than for the whole system. Obviously much more money is needed by the Legislature.

II. DRGs: New Jersey, as you are aware, is the only state in the country where general psychiatric units are reimbursed under the DRG system. Even the Federal government has exempted psychiatry from the DRG system. There are many problems with the DRGs in psychiatry. For example:

- The clinical treatment of patients is compromised by the length of stay constraints placed on the physician.

- They discriminate against the mentally ill because co-morbid conditions -- for example, diabetes, hypertension extension, are not reimbursed or included in the reimbursement to the hospital.

- The DRGs are not indicative of the intensity of the treatment required or the allocation of resources which are needed.

- DRGs for psychiatric diagnoses do not have lengths of stay which approximate a normal curve, which is the statistical model upon which the DRGs are based.

- The DRGs were not applied to all or most psychiatric providers as they were with the medical/surgical illnesses.

- The implementation has caused psychiatric departments in general hospitals to cut back services.

- And also the Department of Health is pressuring for decreased lengths of stay and decreased costs while Department of Human Services is pressuring the opposite way for the general hospitals to care for deinstitutionalized chronic patients.

The New Jersey Psychiatric Association has proposed the following solutions for the deleterious effects of the New Jersey DRG reimbursement system for the mentally ill:

1) Exclude services rendered to psychiatric patients in general hospital psychiatric units until the methodology can be developed which would adequately deal with these diagnoses, or

2) Extend a modified DRG reimbursement system to all psychiatric units of hospitals treating mentally ill patients,

excluding Federal, State, or county sponsored units or hospitals, unless they request to do so.

Modifications should include: Reimbursement acknowledgement of co-morbid conditions; reimbursement should make allowance for stay on medical/surgical units which are not done now; the chronicity of illness must be considered; the number of prior hospitalizations and the durations of hospitalizations in the past; the severity of functional disability, and the severity of psychosocial illness, must also be considered.

We presented these issues to the State of New Jersey General Assembly Health and Human Resources Committee on June 5, 1985, and also on July 14, 1986, and were told that Ms. Faith Goldschmidt from the Department of Health would meet with us in a task force to develop alternatives. However, to this date we have not been contacted or approached. But as an organization we are prepared to discuss DRGs with anyone and work to develop a reasonable plan for them for psychiatry, especially if psychiatry continues to be included in the DRGs.

III. Children and Adolescents: We are requesting that the moratorium on child and adolescent beds be lifted immediately. The SHCC Task Force met initially to formulate rules and regulations for special and intermediate beds, and then did acute bed -- specialty beds and intermediate had not been completed. All counties need to have additional beds.

For example, it was determined that Monmouth-Ocean County needs only seven children and adolescent beds. Yet in the last 15 months in my hospital, 86 children were presented with either depression, overdoses, or abuse. Twelve of them had to be sent to Pennsylvania for further care. This is the experience in only one hospital in the two county area where there are nine other emergency rooms seeing other patients. Obviously we need more than seven beds.

Secondly, the State has decided to phase out and eventually close the Children and Adolescent Units at Arthur Brisbane and Trenton Psychiatric Center, but they have not made beds available in the community to replace them. Also, the alternative programs should be functional before the facilities decrease their beds. For example, there is a backlog of patients into Rutgers, and when you call to get the patient into Rutgers they say, "We can't take him." They don't want to screen him for Trenton, and they tell you to keep him in your general hospital. We are ill-equipped to do that. We don't have an adolescent unit. We're not a children unit.

There is a need for appropriate funding methods for intermediate and specialty beds. And we ask for beds for patients with dual diagnoses, substance abuse and psychiatric disorders, physically abused, violent, neurological impaired, long-term children, as well as not to mix the violent patients in the juvenile system with the general psychiatric population.

IV. Lastly, the non-discriminatory mental health benefits: Another area that needs to be changed is the increasing of mental health benefits with the ultimate goal being, making mental health benefits on a par with medical/surgical benefits.

The New Jersey Psychiatric Association has conducted an analysis of research into mental health benefits entitled, "Psychiatric Care: A Look at Benefits and Costs," a copy of which is attached to my testimony, and you can read it in further detail. But to summarize, after reviewing the evidence concerning the costs, benefits, utilization rate and access levels for psychiatric care, shows that everyone stands to benefit when people with mental illness or emotional illness are given access to timely, adequate psychiatric treatment.

The United States economy loses an estimated $185 billion in foregone productivity, accidents, absenteeism, health care expenditures, and other factors due to mental health problems, including those that go undiagnosed.

We summarized many studies that showed adequate mental health coverages produce utilization costs and rates no higher and sometimes lower than coverage for other illnesses. It also demonstrates that access to psychiatric care actually can reduce expenditures for the treatment of physical illnesses.

With this analysis in mind, we ask that you strongly consider the nondiscriminatory mental health benefits bills which have been re-introduced into the Legislature by Assemblywoman Maureen Ogden and Senator Dick Codey, because not to do so would continue to deny adequate access to treatment to a significant part of the population. This is a tragedy because care can lead to restored mental health and renewed productivity for employers, employees, families, and society.

I would like to thank you once again for the opportunity to give the New Jersey Psychiatric Association's views on these issues, and reiterate that we are ready and eager to work with the Department of Health, Human Services, and other agencies, or any other committee or task force that deals with issues of mental health. Thank you.

ASSEMBLYMAN COLBURN: Thank you. Well, you had me scared with all these pages, but you sure did very well. I was going to ask-- I guess you appeared before our DRG hearing in '85--

DR. RUBIN: Yes.

ASSEMBLYMAN COLBURN: --and that's where you understood you would be contacted by the Department of Health.

DR. RUBIN: Yes.

ASSEMBLYMAN COLBURN: Well, I would ask now that if you don't hear anything, that we get -- as Mr. Martin will kind of bird dog that particular problem-- Frankly, I did personally forget all about it. So, please keep after us, and you can do it through him. That's an interesting concept, and it certainly deserves some special consideration. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: I sort of remember that discussion as well, and I questioned whether in fact psychiatrists were using the DRG system as well as they could, even though there weren't the specific categories covering certain diagnoses. Isn't that correct? I remember I had a -- I'm not sure whether it was a confrontation or a clash -- with you or some of your other representatives, and it was my feeling as a layperson that in fact psychiatrists are using the DRG system to get patients admitted and cared for, but they're quite unhappy with the lack of DRG categories. Isn't that--

DR. RUBIN: Well they're not using the DRGs to get them admitted. The problem is we are-- Our manual, the DSM-3 -- now it's R, at that time it was three -- their criteria and their differentiation of the patients is much different than what's the DRGs at this point. In other words, they lump something like bipolar illness, which is manic depressive illness--

ASSEMBLYMAN FRELINGHUYSEN: They being?

DR. RUBIN: Whoever made up the DRGs, the Department of Health and the model. There's eight DRGs, and I think it's 430. It covers psychosis non medical, and it covers things like bipolar illness -- which is manic depressive illness -- schizophrenia, schizo-affective disorder; which have all different kinds of conditions, lengths of stay, different types of treatment, and different type of, obviously schizophrenias. So our concern is that you are lumping together different categories of patients that shouldn't be, and the different resources that are needed--

ASSEMBLYMAN FRELINGHUYSEN: How many psychiatrists are there in the State of New Jersey, that are active with your Association?

DR. RUBIN: We have about 850 members.

ASSEMBLYMAN FRELINGHUYSEN: I'm not excusing, as you mentioned here, the inability of the Legislature to put you in touch with representatives of the Department of Health. I can't believe for the life of me, knowing how the system works down here, that a viable group of psychiatrists, perhaps led by you, couldn't influence the system.

DR. RUBIN: We've tried.

ASSEMBLYMAN FRELINGHUYSEN: I just can't believe it. I can't believe that you've tried and it--

DR. RUBIN: What happened, when it was first happening, the other person who was here a couple of years ago, Dr. Nadel -- that was who you were talking with -- he was involved in that, and they originally showed the Commissioner at that time, the nonstatistical model and so on. And there was enough evidence shown at the initial hearings in '81, '82, and '83, and she dismissed it and said that wasn't so. There's been evidence shown along the way--

ASSEMBLYMAN FRELINGHUYSEN: Well, let's see if we can work on her. We certainly want to--

DR. RUBIN: We'd love to, but there's a lot of things that need to be changed in it.

ASSEMBLYMAN FRELINGHUYSEN: Thank you. Thank you, Mr. Chairman.

ASSEMBLYMAN COLBURN: Thank you. And I might also-- Mr. Felice, do you want to ask any--

ASSEMBLYMAN FELICE: No, no. I agree that there should be much more involvement and some interface, so that some of these programs can be worked out under the DRG.

ASSEMBLYMAN COLBURN: Once again, I want to tell you all that although we may not hear every word that you hand to us, we are going to go over this very thoroughly. So, what you give to us will be not only what you say here today. Thanks a lot.

DR. RUBIN: Okay. Thank you.

ASSEMBLYMAN COLBURN: Let's see. Mrs. Skerritt? Where is Mrs. Skerritt of FACE? There she is. Can you find a way out of that? (witness makes her way down to the front) Don't be scared by this group. This group is all right.

D O L O R E S S K E R R I T T: Good morning, Dr. Colburn.

ASSEMBLYMAN COLBURN: Good morning. Good morning.

MS. SKERRITT: I know you from Burlington County.

ASSEMBLYMAN COLBURN: Right.

MS. SKERRITT: I'm Dolores Skerritt, and I am the President of a local support group which organized in 1981 out of our sheer frustration with the mental health system, and the problems as family members, we were faced with in getting adequate care for our loved ones. We meet twice monthly, and we have been successful in getting our members on the mental health board in Burlington County.

A committee of our members meets four times a year with the directors of the mental health agencies in the county. Today that committee, which formerly met four times a year, is now meeting more frequently. We've expanded it to become a real professional resource, a professional advisory committee, within the county. We've added adult professional services from our local welfare board, a DDD representative, a DYFS representative, and our mental health board also meets with us. We're working on Kaufman's plan for the needs in our county, which he requested all counties to do.

We also meet quarterly with the administrative staff at Ancora Hospital, and we find that very valuable in getting the proper services for our young people. We also serve -- I told you -- on the mental health board, and on the New Jersey Human Services Advisory Committee.

In Burlington County our FACE members work closely with our mental health agencies, our board, our southern regional office of community services, and the Human Services Advisory Committee; never compromising our position of advocacy for the needs of our ill family members.

A few months ago we went through our membership list to determine how many of our families were receiving services for their ill family members. We were able to identify 46 members. We have many more, but there were 46 that still come regularly, and that I could identify. The ill family members in half of these families are receiving no community services at all; for many reasons: because they're program resistant, because there's no outreach, there's no way to reach some of these people. So the families anguish at home with their problem as best they can.

Despite hospitalization, despite psychotic episodes, despite displaying bizarre behavior, these families are getting no help. We have one member whose son is suicidal. He's slit his wrists a number of times. We have another member, who, their son disappeared from college and they ended up getting a phone call from the son in California. The mother and father took a plane to California, to L.A., roamed the streets until they found this young man and brought him home. He is at home now receiving no services, because he doesn't recognize the nature of his illness. I hope we were able to support the family enough to help them to cope. Okay?

Ten percent of our members are residing in institutions in other states. About five percent reside out of county. One of our members-- They're an elderly couple. Their daughter is in Freehold because there's no boarding homes available to her in Burlington County. The ill family member is soon to become a grandmother, and she's 50 miles away from her family. These two old people are roaming, trying to find a boarding home for her closer to the area where they live. And 35% of our members are receiving services in outpatient and partial care programs, and privately.

From a population profile of the seriously mentally ill for the 1987 Fiscal Year, we find that approximately 5000 Burlington County residents were enrolled in community mental

health services. Now, if half of our people aren't even enrolled in services, I would say there's probably about 10,000 out there who could use our services if we had them. Okay? Among those served were 40% with effective disorders, 32% with thought disorders and bizarre behavior -- I'm getting very thirsty now, I can't even talk -- and almost 18% of them were suicidal. Now, this shows I think a little bit that we are meeting the needs of the seriously mentally ill, when that many people are being served, and yet a great percentage of them are seriously mentally ill, with our limited resources.

In 1983, 104 Burlington County residents were admitted to the State mental institution, Ancora. In '87, 108 were admitted, an increase of 71%.

I'm going to interject here now. I wrote it on a piece of paper. As family members, we supported the screening and commitment bill. We were educated on it. We did what we could with our legislators to get the bill passed. And it's very discouraging to us now to find that there is little money to have the programs implemented. As family members, we supported the Federal program for vocational rehab in our State, which included Federal monies for supported employment. We were very disappointed to find that in our county not one agency submitted a proposal to make use of this money.

As a family member trying to get my son to be more independent, I took him out of private psychiatric care, and had him get the psychiatric care of the psychiatrist in the partial care program he was in. I find now that the psychiatrists keep changing. I don't know how much time he has. I don't know how much quality time he has. He was hospitalized in November, and again in February. He walked across the street and admitted himself to the hospital. This is on the psychiatric care he is receiving in the partial care program. He had not be in the hospital for years prior to that under private care.

As family members, we have been trying to bring to the attention of Ancora, making better use of the buildings they have on the grounds as transitional residences, or for the use of the psychiatric patients. I'm in complete burnout the past two weeks, talking to members of my church, talking to members of the community, about what happened at Ancora when a private organization requested use of those buildings. I had to educate people about the needs of the mentally ill. Okay? You can get people's support on one subject, and they don't recognize the needs of other members of our society. Okay? I'm glad to see a lot of our mentally ill coming out and coming to our meetings. It encourages me, and I'm saddened by it, because every meeting we have more people.

As family members we also press for more housing. And I'm telling you right now, if we don't have the housing we are finding our mentally ill in other service areas, like welfare -- in motels -- homeless mentally ill, in the criminal justice system, okay? So, money that we don't spend on adequate community care, will somewhere down the line be needed for emergency care.

I'll go back to my paper now.

Our most pressing needs are housing in the community, supervised homes -- not beds -- boarding homes when needed, affordable apartments, affordable homes for all our ill family members.

We desperately need clinical case management with outreach. Half of our members can attest to that. They need outreach, and it is not available.

We need crisis centers in every county. We have a much used crisis center in Burlington County. But our crisis center, our outpatient and partial care programs, are desperately in need of adequate psychiatric coverage. You need the medical and psychiatric coverage. That's part of the program.

It is known that people with mental illness can benefit greatly from the community support network provided by drop-in centers, yet we don't have one in Burlington County. As Joe Rogers, a diagnosed paranoid schizophrenic, said in a recent magazine article that I read, "People affected by psychiatric disorders are a great untapped resource," themselves, I'm adding, "and they should be helping themselves and others to recover." That's what I see the need of drop-in centers as being. Thank you.

ASSEMBLYMAN COLBURN: Thanks a lot, Mrs. Skerritt. To me that outlines most of what we need, and it comes from somebody who certainly had the experience and knows. Do you have any copies for us? (affirmative response) Okay. Just bring them up here.

MS. SKERRITT: I had given them to you.

ASSEMBLYMAN COLBURN: That's all right. We're going to put them into our collection.

MS. SKERRITT: I digressed. I should have given it to you.

ASSEMBLYMAN COLBURN: Oh, that's all right. Thanks a lot.

MS. SKERRITT: Thank you.

ASSEMBLYMAN COLBURN: Any questions? I think you said it pretty well.

MS. SKERRITT: Are there any questions?

ASSEMBLYMAN COLBURN: No. We think you said it very well. You raised a lot of questions, and I've got almost 10 or 12 points here. Thanks a lot.

MS. SKERRITT: Thank you.

ASSEMBLYMAN COLBURN: Let's see. Mr. Bucher? Is it Bucher or Bucher? (pronounces it two separate ways)

J A C O B P. B U C H E R: Good afternoon.

ASSEMBLYMAN COLBURN: Good afternoon. Did I pronounce your name--

MR. BUCHER: Bucher.

ASSEMBLYMAN COLBURN: Bucher, okay.

MR. BUCHER: Good afternoon. We have a lot of reference material here to try to acknowledge, but we're going to try to say it here. Okay?

ASSEMBLYMAN COLBURN: You're with a New Jersey Consumer Operated Self-Help and Advocacy Group.

MR. BUCHER: Yes, Mr. Chairman.

ASSEMBLYMAN COLBURN: Is that the name, or is there another name?

MR. BUCHER: No, that's the name.

ASSEMBLYMAN COLBURN: That's it. Okay. Just to identify you.

MR. BUCHER: Our theme is "Working Together for New Jersey's Mental Health Self-Help Consumers." Mental health consumerism in New Jersey is having a growing impact, not only within the mental health system, but also within the community of disabled and on the quality of life of participants in the movement. COSHAP -- that's an acronym, Consumer Operated Self-Help and Advocacy Program -- and COMHCO -- another acronym -- Coalition of Mental Health Consumer Organizations -- have become fully established within the system.

With the support of the Division of Mental Health and Hospitals, mental health self-help consumerism is now established on a solid foundation. COSHAP is well into its second year, and is becoming well-known throughout the State. We have begun to see suitable changes in the community, and, as consumers, are now voicing our concerns through COSHAP and COMHCO.

We now have in place a system in which a number of consumers feel comfortable in becoming more involved in advocacy and the future expansion of services that include them as providers. We have a few examples.

1) Consumer Representatives: The reaction of mental health consumer representative positions with the State hospital system could be the focal point for altering and expanding consumers who are full-time staff, could promote the patient government system within the hospitals, and represent hospital patients to community service providers.

2) Consumer Run Drop-In Centers: Drop-in centers are an important community base peer support system for consumers with serious mental illness who are residing in the community. The long-range goal is for there to be a consumer run drop-in center in all 21 counties.

3) Representatives on State and local mental health boards: Consumer involvement in services is particularly important in a system of community based supports. Consumer involvement reinforces values of independence, and ensures that the more varied needs of persons living in the community are addressed.

Those are basically from the "Unalienable Right" of '87, if you're familiar with that.

4) Consumer initiatives and drop-in centers that are developing in the following counties:

a - We have Bergen with the assistance of the "On Our Own" group and the Mental Health Advocacy Group -- these are proposals;

b - Somerset, with the support of consumer self-help group HUGS and the Mental Health Association;

c - Proposals for drop-in centers have been submitted for Morris, Union, and other counties;

d - Creation of two full-time positions, one in the northern region -- possibly in Passaic -- and another in the southern region -- and that's Cumberland County; with the creation of these positions COSHAP could regionalize and be more effective in coordinating the growth of self-help and consumerism on a regional and local level.

5) Mental Health Stigma: Contributing to public awareness, support and improving the system of mental health care with the Public Education Committee of the State Community Mental Health Board.

We have attachments for a lot of this to give you a little more in-depth of what we're trying to state here.

Consumers unanimously agree that the number one overall long-range priority is for the development of a system of housing, that would give mental health consumers and former patients the same options that are currently available to the rest of the community of the disabled. This system would include supervised housing, group homes, apartments and other congregate living situations, as well as independent living options with State subsidies.

In conclusion, we hope that the developing coalition between the mental health system and the self-help movement, will foster greatly improved services for our State's mental health consumers, with the ultimate goal of improvement in the quality of life for those individuals.

Yours and our struggle, thank you.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: No questions.

ASSEMBLYMAN COLBURN: Mr. Felice?

ASSEMBLYMAN FELICE: Just briefly. I think of the many important issues that you raise here, number five, the mental health stigma and the public awareness, I think that's a factor. I've been involved for 25 years in a mental health board on a local level, and also founded a center for those young adults that are beyond school programs. One of the things that we found most encouraging was to get the local municipal government to contribute a certain percentage, and the board of education, for each student, so that those centers and those facilities would be available with help both on the local government level and also from the board of education.

That was an important factor in anything else that we did in the community, besides the local mental health center.

I think I'm being made aware, as many of us are, that some of the areas in the State do not have the facilities that we have in Bergen, for instance in Passaic. And one of the factors that we feel was very helpful to us in our work with the centers, was to make sure that we got the educational factor, and the local government involved in the situation; whether it was originally not only helping some sort of REACH Program or a crisis phone system, but also getting the seniors into the picture. So we coordinated a lot of things that the community needed, and put them in working with the mental health centers, which were a great factor to make the people aware of, when we wanted to expand either community housing, or even to buy a piece of property to use for the young adults. I think that was a very important point that you brought up there.

MR. BUCHER: Thank you.

ASSEMBLYMAN FELICE: I commend you.

ASSEMBLYMAN COLBURN: Thank you. Are you on our list too, or would you like to say something?

T H O M A S G R I F F I T H: I'm a consumer, but I could just briefly say something?

ASSEMBLYMAN COLBURN: Sure.

MR. GRIFFITH: We are socially and economically depressed by the system, not to mention having overwhelming health problems. Like everybody else, we just want to live, and like everybody else, we deserve the help to do so. I think the work done by empowered consumers is a true sign of what we can do. We have no idea what impact consumers could make on society because only five percent of us make it through the mental health system in good enough shape to work in the community.

And just in conclusion, everywhere we look, we see that obviously we need more help in the system. It's just obvious.

ASSEMBLYMAN COLBURN: That's true. I agree with you. It certainly is. Thanks a lot.

MR. BUCHER: Thank you for your time.

ASSEMBLYMAN COLBURN: Charlotte Bednarsh, Parents Helping Parents. Good afternoon.

C H A R L O T T E B E D N A R S H: Good afternoon.

ASSEMBLYMAN COLBURN: I keep saying good morning.

MS. BEDNARSH: My name is Charlotte Bednarsh, and one year ago that past month, my 11-year-old son, who was at the time 10, attempted suicide. The journey over the past year of my son's recovery to emotional health and stability, is a tribute not only to his phenomenal courage, but also to a group of skilled, caring professionals and administrators in a preteen unit of a private psychiatric hospital in Pennsylvania, without whom his recovery would not have been possible. If I had to rely on the public system in this State of New Jersey to provide mental health services for my son, he would have been sentenced to a slow, painful, emotional death of physical destruction by his own hands.

For months prior to his suicide attempt last year, I had spent enormous time, energy, and money in attempting to secure quality services in this State for my little boy. However, to my frustration, anger, and disappointment, I discovered there was no agency in the State of New Jersey that could offer me any assistance when my young son became potentially suicidal. I spent months sleeping by his bedroom door so he wouldn't kill himself, and lost weeks of time from work because there was no affordable skilled day care available to watch my child when he couldn't safely attend school. To compound the situation, I am a single parent, the sole support of two children, and losing my employment would have represented a total loss of income and health insurance benefits.

As a member of Parents Helping Parents, a support group sponsored by the Mental Health Association of Monmouth County for parents of severely emotionally disturbed children, I hear stories about the abuse or lack of adequate treatment being offered to other emotionally disturbed children when their parents are forced to rely on the public system in the State to provide mental health services. I've heard of sexual and physical abuse in State inpatient psychiatric treatment facilities for children, and of parents like myself trapped in their homes for months and years because there was nowhere in this State to get assistance. While in our public psychiatric hospitals, one woman's son was sexually abused and physically assaulted by underpaid and undertrained staff. Another parent's son, whose behavior is both homicidal and suicidal, has had no educational services for months, is receiving minimal clinical services due to limitations on their insurance benefits; and spends his days unsupervised, sleeping, or hanging out at the mall, because his mother -- who is a school nurse -- must work to support him. She is a single parent.

It is impossible for anyone to even speculate what it is like to be the parent or sibling of a mentally ill child. As parents, we suffer because society feels we have somehow created our children's disturbances, rather than viewing their mental illness as a sickness that requires skilled, professional treatment. Their siblings suffer from never knowing when there is going to be an outburst of uncontrollable behavior, and refuse to allow their friends to visit or play for fear their terrible secret will be revealed.

My son's success story was made possible because I had health insurance, which facilitated initial admission into the preteen unit at the Horsham Clinic, a private psychiatric hospital in Pennsylvania. There were no adequate inpatient psychiatric children's beds available at the time of his suicide attempt in this State, in either the public or private

sector. Approximately six weeks into his hospitalization at the Horsham Clinic, my son has exhausted all of his inpatient psychiatric insurance benefits. His attending psychiatrist felt he would require another three to four months of hospitalization, and at that point, Horsham offered to accept New Jersey Medicaid payments in order to maintain him. The State of New Jersey refused to so, stating there were sufficient children's services within this State. At that point, I offered to second mortgage my house in order to pay for his treatment at Horsham. However, the hospital continued his care without requiring any additional payments from me. We all knew that any attempt at transferring him to receive nonexistent services in this State would have been sentencing him to a death as certain as untreated cancer.

Five months after his admission to the preteen unit at Horsham, my son was discharged. He walked out with his head held high, demonstrating more courage, wisdom, and strength, than one would have thought possible for an 11-year-old child. He had fought the hardest battle of his young life and my child emerged the victor, with a sense of dignity, self-esteem, and most important of all, the will to live. I overheard some of his friends asking him what it was like to be in a mental institution, and his response was the following. I will quote him. "My mommy took me to a place that doesn't have bars on the windows like you see on television. Instead, I went to a hospital where there were doctors and nurses who really cared about me. They help kids like me feel better. I know I'm better because my doctor said that if I worked really hard, after sad comes glad, and now I feel glad. That's nothing to be ashamed of."

My son is currently at the Somerset Hills School, an excellent residential treatment facility for young boys in Warren, New Jersey. His treatment is funded by the Marlboro Board of Education and DYFS. His continued progress has been

remarkable. However, it is my understanding that given the current budgetary constraints and cutbacks in children's mental health services, placements such as these will become more and more scarce. With fewer and fewer residential placements available, as well as acute inpatient psychiatric beds for children on the decline in this State, mentally ill youngsters and their families will be sentenced to a life of agony and frustration in their attempt to secure nonexistent support services in their community.

If I had to rely on the public system in this State to provide adequate mental health services for my son, he would have been doomed to a slow painful death. I beg of you, do not abandon our mentally ill children, no more than you would refuse services to a youngster suffering from leukemia or juvenile diabetes. For those mentally ill children who can lead normal, productive lives, give them that opportunity. And for those whose illness renders them more severely dysfunctional, guarantee that they be treated with dignity, compassion, and protected from abuse. Open your hearts to our pleas, the parents, and the State's treasury to pay for the quality of mental health services our children so desperately need. If you deny them these services, you are sentencing them to a lifetime imprisoned by their own tortured, sad thoughts and self-destructive behavior.

I thank you for this opportunity, and if you have any questions--

ASSEMBLYMAN COLBURN: Thank you. Rod?

ASSEMBLYMAN FRELINGHUYSEN: I wouldn't want to, Mr. Chairman, to prejudge the testimony to follow this, but I think of all the testimony we may hear this is perhaps in some ways the most eloquent and disturbing. You have to be made of rock not to have a very emotional feeling about hearing it. At times hearing about his just makes my blood boil, and you always have the feeling you'd like to get your hands on some of

the people who perhaps were initially responsible for handling your case that worked within the system, that didn't work effectively enough perhaps on your behalf and others to be of assistance.

MS. BEDNARSH: If I may say something? As a member of a group who have severely emotionally disturbed children, the reason I feel so strongly is I am far from alone. My outcome was better because I figured out somehow how to negotiate the system, and because Horsham in particular picked up the funding of close to $100,000. There is an outstanding bill. Most people are not that lucky.

ASSEMBLYMAN COLBURN: Mr. Felice?

ASSEMBLYMAN FELICE: Besides the courage and the great maturity of a 10-, 11-year-old, I commend your courage as a parent. I know, having been involved with many cases both personal and otherwise, how difficult it is.

You mentioned in here about your health insurance, that they had recommended the admission into the Horsham clinic. In other words, that was your--

MS. BEDNARSH: No. The--

ASSEMBLYMAN FELICE: How did you get involved?

MS. BEDNARSH: Okay. What had happened was, at the time of the suicide attempt, when my son had been in therapy and when I contacted the psychiatrist and said, "What do I do?" I was overwhelmed. I literally had my hand on my child and my hand on the phone because he was trying to jump again. The psychiatrist said you can call the police, and I said, "But he's so scared now, the sight of a policeman will just-- He's not trying to hurt anybody but himself." If you can understand from this child's point of view. He said, "The only other option we can do is to admit him into a community hospital, and I will tell you the outcome will be terrible. There are people that are not staffed to handle this." I said, "So where do I go now?" He said, "The only place that has an excellent

children's facility is out of this state, in Pennsylvania." The one that he had recommended was Horsham.

And as a matter of fact, when I called them on the phone, their compassion at the time was phenomenal. They didn't know who I was. They kept talking to me, which is the way I think we need to be treated. At the time my son was screaming and yelling. They said, "Put the phone down. Hold him. Get somebody to help you. Come back. We'll be waiting." They helped talk me through it.

But what you begin to find as a parent, and I consider myself reasonably intelligent, you don't know where to begin. There's no one person you can call who will tell you where to go. Everybody has a different opinion, and oftentimes they then tell you the resources aren't there.

ASSEMBLYMAN FELICE: Well, probably, as my colleagues ih the Legislature would tell you, a good percentage of our contact with our constituents in our districts -- which average over 200,000 -- are for people trying to get help to get into a nursing home, or a crisis situation with young people who have problems trying to find the right facilities. I think what people don't realize is the time that legislators spend at night and during the day -- in the middle of the night -- because we recognize -- especially all the people on this particular Committee -- because this is one of the major problems facing our families, not only in New Jersey but throughout the United States. We know that there's a lack of proper facilities, but we like to hope to believe that at least the ones that we have are acting properly and giving the proper care.

Unfortunately, as I say, I can't speak for the whole State, but I know in certain areas there is some care that is loving, compassionate, and certainly qualified. I don't know the exact area where you're in, as far as trying to figure out why Pennsylvania, because of your locale geographically or your doctor or something--

MS. BEDNARSH: Because the doctor said, in terms of my son's needs, it was the only inpatient facility that he would recommend.

ASSEMBLYMAN FELICE: Okay.

ASSEMBLYMAN COLBURN: I was going to say, you struck a pretty resonant note with a lot of us, and many of us who are familiar with these problems. I think it's really hard when you're getting started on this. You don't know where to go to get the appropriate response at the right time. It's really, you know, almost impossible.

MS. BEDNARSH: And often you're in such a crisis yourself--

ASSEMBLYMAN COLBURN: Sure.

MS. BEDNARSH: --that you need somebody to hold your hand to get you through it.

ASSEMBLYMAN COLBURN: I know in our family we found there were programs but they weren't available to us, and they weren't available when they were needed. And you know, the whole thing is really at times a mess. So we set up these structures of care, but they don't always function appropriately for each person. So, I'm pretty sensitive to that, and I thank you for what you had to say.

MS. BEDNARSH: Thank you.

ASSEMBLYMAN FELICE: Just one quick thing, Dr. Colburn. A few years ago this Committee did a task force hearing on nursing homes because of tremendous demand on the larger population. And after those task force hearings at nursing homes throughout the State, through legislation, we now have a booklet which is a consumer guide to selecting a nursing home. It's a difficult thing. Maybe there should be more facilities available, that you can have a choice in the location and a select group of numbers, if unfortunately it does happen that you need that type of emergency facility. That's something we'll certainly consider.

MS. BEDNARSH: Thank you for your time.

ASSEMBLYMAN FELICE: Right.

ASSEMBLYMAN COLBURN: Thanks a lot. Regina Palo, Concerned Families for Improved Mental Health Services? Good afternoon.

R E G I N A P A L O: As a parent we could identify -- good afternoon -- we could identify with Mrs. Bednarsh's problem because we all suffer that pain, and we all have our own horror story.

My name is Regina Palo, and I am President of Concerned Families for Improved Mental Health Services in Essex County, representing over 200 families of the mentally ill.

I bring your attention to the deplorable conditions which exist at our Essex County Hospital Center. Over the past five years maintenance and services have been allowed to deteriorate to the degree that the lack of safety and sanitary conditions and effective rehabilitative services are unsatisfactory and dangerous to the welfare of the patients.

A political game exists between Essex County and the State. On one hand the State mandates that the county hospital provides adequate services to meet accreditation standards, while on the other hand a county is hard-pressed financially to meet these requirements, and a county executive is reluctant to assume responsibility for its seriously ill residents.

We parents, siblings, and spouses of those who suffer, along with the hospital staff of that seriously deteriorating facility, are caught in the center of a political battle between the county and the State as to who should bear the responsibility of the hospital maintenance. The county, who says it cannot afford to do it, and is not required to provide safe, clean, humane, and rehabilitative services and refuge for the mentally ill, refuses to accept its responsibility. They admit, and I quote a Human Services Department spokesperson from an article in The Star-Ledger on March 18, 1988, that

closure of the hospital would, "throw the whole mental health system out of whack." With the State threatening to phase-down the population of the State hospitals, and its insensitivity to a county in financial difficulties, we ask, who will respond to this problem that won't disappear? How will the State absorb county patients if the hospital closes?

Not only do we ask the State to provide assistance the county needs to remedy the deplorable conditions at the hospital, but we urge the State to consider the rehabilitation of the structurally sound but abandoned buildings on the grounds for the continued purpose for which they were constructed, to serve the mentally ill. We envision supervised residential facilities and halfway homes with the hospital as its hub for those clients unable to survive on their own.

We parents are frightened about a government that turns its back on its most fragile of its citizens. We parents are concerned that no one will speak for our loved ones when we are gone. We parents demand that a State which boasts the second highest per capita income in the nation, provide decent, humane service for the small percentage of the chronically and acutely mentally ill.

I thank the Committee for allowing me to speak for the families in Essex County. And, Assemblyman Frelinghuysen, our group supported your bill, and we hope that you lend your support to our cause too. Thank you very much.

ASSEMBLYMAN COLBURN: Thank you.

MS. PALO: Do you have any questions?

ASSEMBLYMAN COLBURN: Rod, any questions?

ASSEMBLYMAN FRELINGHUYSEN: Well I think the Department can speak to their ongoing negotiations with Essex County. Personally, I think that counties should be in the mental health business, and Essex of course they've had a history as direct providers. Given the nature of the needs of many of our urban cities, I should hope that if the State of

New Jersey, that lives outside our urban centers, is willing to go the long haul to assist our cities, that they would also assist as well to make sure that the Essex County system is maintained. I think it would be a worthwhile tradeoff to keep that hospital open, but obviously only open if its conditions could be improved dramatically.

MS. PALO: Last summer during the height of the heat wave, I visited my son, who, after four days wasn't able to take a shower because the nurse had to determine whether to use the sheets for the bed or the sheets as towels for them to take showers. We had to bring toilet paper from his home and soap from his home because there wasn't any being supplied in the hospitals.

ASSEMBLYMAN COLBURN: Amazing.

MS. PALO: This is the condition of the hospital.

ASSEMBLYMAN COLBURN: I am a graduate of Montclair High School, I might tell you. Down in our county in Burlington we did construct a small mental health hospital, at my insistence really, and I do think the counties have a great responsibility towards these institutions. Most of the counties don't have one run by the county, as you know. I'm not opposed to the State helping out, especially when things get so desperate, but I really am concerned that this has happened in a county government. I don't know anything about what's happened up there over the years, but gee wiz, there was a county institution, and I would judge that they haven't done enough themselves. That's a really pretty deplorable business. I didn't even realize that they weren't having regular supplies, for heaven's sake. That's incredible.

MS. PALO: My son first entered the hospital-- Five years ago was his first internment at the hospital. It was traumatic for me because he had come--

ASSEMBLYMAN COLBURN: Yeah, I guess so.

MS. PALO: He had been five times at Carrier Clinic, the best treatment. I was very impressed with the way they handled the hospital at that time. There were services there. There were all kinds of social workers helping. And each time he left the hospital he left in a better condition. I'm sorry to say that it's not that way now.

ASSEMBLYMAN COLBURN: That's unbelievable. I'm glad that you brought that to our attention. Thanks a lot.

MS. PALO: Thank you very much.

ASSEMBLYMAN FELICE: Counties do have a tremendous responsibility to share, not only in the recreation facilities and roads, but one of the most important -- as Dr. Colburn and Assemblyman Frelinghuysen stated -- the county hospitals, for those areas that are fortunate enough to have it. Although the demands and the expenses are there, but between the county health care-- You as local taxpayers, your money goes also to the county, and anywhere from 15% to 20%. So they have a need to cover all facilities of care for the residents, and that to me is one of the most important.

ASSEMBLYMAN COLBURN: Thanks a lot. Gail Levinson, Director of Public Policy and Legislation for the Mental Health Association in New Jersey?

G A I L L E V I N S O N: Mr. Chairman and members of the Assembly Health and Human Resources Committee, I promise not to speak for more than six minutes.

ASSEMBLYMAN COLBURN: Well listen, I appreciate that. Everyone has done very well.

MS. LEVINSON: My name is Gail Levinson, and as you indicated, I'm Director of Public Policy and Legislation for the Mental Health Association in New Jersey. The Mental Health Association is a statewide nonprofit, consumer oriented citizens group, concerned with the needs of mentally ill children and adults, and the prevention of mental illness. There are chapters and offices in 14 counties in New Jersey,

and we have hundreds of citizen volunteers. The primary goal of the Association is to ensure that every person with a serious mental handicap received prompt and adequate treatment in the least restrictive setting, closest to home, and without discrimination.

I am here today to discuss our concerns and recommendations regarding the State mental health system, and to particularly support Assemblyman Frelinghuysen's bill A-2728. I would first like to highlight some important statistics: One in every four families is affected by mental illness, a fact the Mental Health Association believes makes it everybody's business. No segment of our society is immune. Approximately 200,000 people in New Jersey use the public mental health system, either for institutional care or community mental health treatment. Close to 100,000 of these individuals are seriously mentally ill children and adults, who are unable to function independently without professional support and guidance.

We currently have several hundred people living at State psychiatric hospitals who are no longer in need of hospital treatment, but cannot be discharged because there is simply no place to send them. I would like to share with you the experience and background of one such person whose situation is representative really of thousands of persons with chronic mental illness in our system, individuals whose lives would be significantly improved if they had had access to more appropriate care and treatment.

I want to speak about a young man, John, 25 years old, a college graduate with a bachelor's degree in political science. During college he began experiencing symptoms of mental illness and was subsequently diagnosed as having schizophrenia. His problems are further complicated by excessive use and abuse of alcohol and drugs, something a good portion of the young adult population suffers from. He has

been a patient of a State institution for one year. At the time of his hospitalization he was working, and was managing to support, with the assistance of his parents, a one bedroom apartment.

Over two months ago the hospital treatment team determined that John was ready for discharge and able to return to the community. However, due to severe shortages in supervised residential programs as well as the lack of affordable low cost housing, he has been waiting for over two months to be placed in a residential facility at a cost to the State and county that is excessive and unnecessary, and obviously at a cost to his mental health, which cannot be measured in dollars. Furthermore, the type of specialized substance abuse program that he requires does not exist in his county, and when he is able to return to his county he will not be able to receive that treatment. He is eager to work and to return to work. He would particularly like employment in the computer field. However, vocational rehabilitation in this area is not available to him either. His parents are concerned but discouraged. They have little access to and are desperately in need of professional guidance and support, and as a result, find it difficult to deal with their son's multifaceted problems. As was echoed earlier, we really need to help the parents.

The mental health system, interestingly, has programs to satisfy all of his needs as well as his parents', programs which can rehabilitate an individual such as John to a level where he would be able to return to work, live independently, and coexist with his family. Unfortunately, these programs do not exist in adequate numbers throughout New Jersey. The Association believes very simply that increased funding is necessary to both stabilize and expand these critically needed services.

I just want to mention a bit about the screening law. As you all know, it's law that was designed to help people like John, through the development of community based crisis intervention services and mobile units. Such services screen clients with mental illness, and divert them from long-term State psychiatric hospitals into shorter-term local units. For persons experiencing crisis but not in need of hospitalization, these programs will additionally provide referral and linkage to community based programs such as partial care, housing, case management, and outpatient programs.

Unfortunately this law has not been adequately funded in budget year 1989, as was also mentioned earlier by one of the family members. Only $1.8 million was allocated in the proposed budget to complete the development of screening centers in geographical areas throughout New Jersey. And this coming November is the date in which the implementation must take effect. A minimum of $5 million is needed to properly begin implementation of the law, and that's at the low end. Much more funding is required even beyond this to reinforce existing programs and create additional services, in order that staff from these screening centers can appropriately refer clients for needed care.

While I have described adults in New Jersey, I would also like to emphasize the children and adolescents with mental illness have even fewer resources than the adult population. The State has just begun attempting to deal with the tragic overuse of institutional care, of the problems of children being sent out-of-state for residential treatment due to the inadequate resources here, of the thousands of children not even yet identified as needing mental health services.

The plan currently in existence has been aimed at resolving the crisis that exists at the most seriously disturbed end of the diagnostic spectrum. Its focus is to develop beds, both hospital and residential and to regionalize

treatment, but we must move beyond this point. It is essential to recognize the need for an ongoing comprehensive planning, which, as in the adult system, leads to long-term changes encompassing all levels of difficulty experienced by children and youth.

There must be a full range of services to address children's physical, social, and educational needs. The $4 million allocated in Assemblyman Frelinghuysen's bill attempts to do this, and focuses on a county or community level for increases in outpatient services, partial care services, case management, and family support. Again, the monetary need projected was $8 million, and we are hopeful that half of it can be restored.

And finally, the Department of Human Services had requested an increase of $33 million over and above the Division of Mental Health and Hospitals' continuing budget for next fiscal year. Such an increase was required in order to expand essential components of the mental health delivery system and prevent ongoing crises. Unfortunately, only $2.3 million in new initiative money was proposed. Assemblyman Frelinghuysen's bill seeks to put $15.6 million, or half of the Department's request, into the community side of the mental health system. The bill will significantly improve conditions for children and adults, and will provide for critically needed expansion in the central and southern New Jersey regions which have not had that opportunity. However, this legislation represents only a portion of what is ultimately needed to create a quality system. It is therefore of vital importance that the entire $15.6 million be released from Committee today as an important first step in the process of strengthening the Community Mental Health System.

And finally, the Mental Health Association in New Jersey very seriously applauds Assemblyman Frelinghuysen for sponsoring this bill, and the 50 members of the Assembly who have co-sponsored the bill.

We appreciate the opportunity you have given to join with other mental health advocates and concerned citizens to voice our concerns about the mental health system and our hopes for its future. I thank you.

ASSEMBLYMAN COLBURN: Thanks a lot. Mr. Frelinghuysen?

ASSEMBLYMAN FELICE: Do we have extra copies of your written testimony?

MS. LEVINSON: I have, yeah.

ASSEMBLYMAN COLBURN: Do you have -- okay. Any questions? Rodney?

ASSEMBLYMAN FRELINGHUYSEN: I should also say, Gail, that Dr. Colburn, Assemblyman Felice, Assemblyman Deverin, and Assemblyman Otlowski, were only too pleased to join as co-sponsors. It's every bit as much of their bill as it is mine. And at this time I certainly would like to acknowledge the work of the Mental Health Association in New Jersey, and those who in this room and outside it make up what is called the Mental Health Coalition, not only for being here supporting that bill, but obviously supporting measures not only in the Division of Mental Health and Hospitals, but references made of vocational rehabilitation money. And I presume that that source is primarily within the Department of Labor, but I may be wrong.

Sitting on the Appropriations Committee -- I'll share with both Dr. Colburn and Assemblyman Felice -- that at Montclair State we had our public hearing up there, and we had a large contingent of parents, families, advocates, who pressed -- and quite successfully I may add -- the Appropriations Committee to add supplemental dollars to vocational rehab in the Department of Labor budget. Hopefully these things will get together, including the salary upgrade -- which I think the Appropriations Committee will be amenable towards for mental health workers, which will be addressed in the Appropriations resolution process.

But I want to thank you and others for getting organized. This is a bipartisan/nonpartisan effort, which we hope to carry through this part of the Legislature, and into the Senate as well. Thank you, Mr. Chairman, for letting me talk.

ASSEMBLYMAN COLBURN: Thank you. Thanks a lot. Dr. Rabin, Arnold Rabin, representing the Mental Health Association of Essex County as Executive Director.

D R. A R N O L D R A B I N: Members of the Committee, my name is Arnold Rabin. I am Executive Director of the Mental Health Association of Essex County. I bring the perspective of a citizen advocacy organization which has also provided direct services for seriously disturbed children, adults and families of the mentally ill.

We applaud this effort today to better understand the nature of the problems and hopefully to find better solutions for the State's troubled mental health system. Without such an effort, one can too easily fail to see the meaning of the front page problems of homelessness, and troubles with our State and county psychiatric hospitals. Then we have those less visible, but no less painful problems of mentally ill people who are insufficiently disturbed to qualify for commitment, but are too disturbed to function adequately in society.

This large group lives at home with families which need to cope, day in and day out with the patient's unpredictability, sleeplessness, withdrawal, and reluctance to take a bath or medicine. At the same time, they must deal with their own guilt, fright, anger and helplessness. The system considers this situation a success, that we have avoided hospitalization, but not considering the incredible cost at which this occurs.

For those who have no families able to take them in, we rely upon the boarding home system. With some exceptions, it is ill-prepared to understand and deal with the mentally ill

and does not provide the structure and supervision which fearful, isolated people require. And yet, we in New Jersey, are like the man who asked how the food was at a wedding, replied that the food was terrible and even worse, there wasn't enough of it. (laughter) So it is with boarding homes; they have serious shortcomings, and yet we can't get enough of them.

There is a terrible lack of properly supervised housing which results in people unnecessarily remaining in hospitals. It leaves them in family homes where they exact enormous emotional costs and it leaves them in inadequate boarding homes where their lives are barren.

This is not to say that currently there are not significant bright spots. Our own agency's Prospect House program, with State and private aid, conducts a program of social rehabilitation targeting the boarding homes residents as well as those who live with families or on their own. We have employment programs which in the past two years have placed 140 former patients in competitive employment, and it provides supportive follow-up counseling. In addition, we have transitional employment programs through which in the past two years we have served 112 people. We have a program of socialization for geriatric former patients. From the changes in their appearance and behavior it is clear that these elderly people are benefiting from being engaged in life, rather than sitting alone and staring blankly at the blaring TV, which is too often characteristic of life in the boarding home. With a one-year United Way grant, we have recently begun a program within some East Orange boarding homes to engage additional people who are otherwise uninvolved with meaningful activities or relationships.

For families of the mentally ill, again with help from the Division of Mental Health and private sources, we conduct a program of individual and group counseling, education, and support, called the Family Resource Center. We work closely

with concerned families, of whom Mrs. Palo -- who you just heard from -- is the President. Since its inception three-and-a-half years ago, the Family Resource Center has served about 450 families, seeing them in our offices and in their homes. It is unique in the State, if not in the country. We're very proud of this service, and we think the Division of Mental Health is, as well, and properly so.

I've suggested that there are big problems, and I've referred to constructive, operative responses. Well, what's the beef?

The programs I have described -- and with sufficient time I could give numerous additional examples -- from our community are struggling mightily to make ends meet financially. In the instance of supervised housing programs, they are barely scratching the surface of an enormous problem. Community Mental Health Programs are personal, human services, and yet, staff turnover, recruitment, and retention is an enormous problem. Costly newspaper ads produce few applicants, and then the fact that we are able to offer only peanuts for difficult, demanding work, turns them away. This problem is compounded by an ever-increasing paperwork burden on professional staffs which detracts from the gratification which these people need. Nonetheless, the community mental health medical system faces the prospect next year of a State aid increase of 3.5% over this year's grant; in the face of rising health and liability insurance, social security, postage and other operating costs, on top of the inadequate salaries which, as I have said, are not enough to attract or hold personnel as it is.

This is a dollar issue, and we face a worse crisis in the streets and homes of our community if the State does not address it squarely. Assemblyman Frelinghuysen's supplementary appropriation proposal of $15.6 million is an important step in this direction.

I must deal with two other important issues. The first -- which you have heard reference to from Mrs. Palo -- is the impending crisis of the Essex County Hospital Center if it were to close. Two weeks ago a Federal team from the Health Care Finance Agency visited and found very serious deficiencies, raising doubts as to continued Medicaid and Medicare funding. In August, the Joint Commission on Accreditation is expected. While we have pressed the county on what we believe it needs to do, we must appreciate the very serious funding problems of the counties, which thankfully have been recognized by the SLERP Commission. The counties urgently need help. In the instance of Essex -- and my information is that it applies to the other four counties that operate psychiatric hospitals -- it is very serious, and I implore this Committee to appreciate how the county's crisis is the State's crisis.

I refer to the fact that Essex County Hospital Center now has 617 patients. Plug that in to Mr. Kaufman's reference earlier to the problem with 35 patients from Hudson. In 1987, with great efforts to restrict admissions, there were 678 patients admitted. Were the Essex County facility to close -- by direct decision or as a result of the loss of Medicaid and Medicare funding -- that volume of need just cannot be absorbed by the State hospital system. With this interdependency therefore, it behooves the State to help work out a solution.

Senator Codey has introduced an interim remedy -- S-1981 -- that provides $5 million of additional aid to the counties operating psychiatric hospitals. We hope this will quickly be passed, but it is a one-time transfusion. The SLERP report recommends a long-term approach of State funding to other "State" services performed by counties. Whether the SLERP recommendations are completely enacted into law or not, it is well to recognize the State's particular need to preserve county psychiatric hospital services in order to preserve the

integrity of the State's own hospital system. State legislative and gubernatorial action to address this very serious need is urgent, since continued Federal funding of the Essex County Hospital Center is under active threat, and unless a solution is quickly devised, we will face chaos in the county and the State psychiatric hospital system.

Finally, but certainly not the least of our concerns, are children's services. A plan has been promulgated -- which you heard about earlier -- which envisions the reduction of State operated inpatient services for children from 140 to 40 beds, based upon the development of alternative services in the community. Among professions working with children now there is great concern as to whether the children who are now being served in our State hospitals and who are waiting for admission, who are actively suicidal, needing close medication supervision, and who can be very destructive, can be accommodated in the community settings that are being envisioned. Furthermore, the proposed Fiscal Year '89 budget for children's services does not provide even for the development of these alternatives. It is important to address the festering programmatic and financial questions about this plan, especially before proceeding with reducing or dismantling major pieces of the current service system.

This is not a pretty picture, but I regret to say it is the reality facing patients, their families, and concerned professionals and interested citizens. It seems intolerable for a State which is experiencing unprecedented prosperity to allow the situations I have described to continue. Will we ignore the suffering of patients and families, and allow the frail mental health system, with its demoralized participants to stagger under the load and to continue to flee without replacement? Or will we provide the resources to retain and attract more of the good people with whom we have been blessed so we can build upon the creative work of which I have given a few examples today?

The means to meet this challenge is the province of the Legislature and the Governor. We need you to hear this and to respond positively.

I thank you for this opportunity to be heard.

ASSEMBLYMAN COLBURN: Thank you very much. Rod?

ASSEMBLYMAN FRELINGHUYSEN: Excellent.

ASSEMBLYMAN COLBURN: Nick?

ASSEMBLYMAN FELICE: Real professional.

ASSEMBLYMAN COLBURN: Thank you very much. We appreciate that. Let's see. Mr. Edward O'Connor, New Jersey Association of Mental Health Agencies? Hi.

E D W A R D P. O ' C O N N O R: Thank you, Mr. Chairman. I'll try to express my appreciation for the opportunity to be able to speak to you by my brevity.

ASSEMBLYMAN COLBURN: Thanks. (laughter) Anything more you ever want to send us, just send us.

MR. O'CONNOR: In fact, I'll even go one further and tell you that number 26 on the docket, John Monahan, will not be here today. He is out of-- So that gives you something else to--

ASSEMBLYMAN FELICE: So your presentation will take care of two then. Correct?

MR. O'CONNOR: With me is Bill Starrett, who is the Executive Director of the New Jersey Association of Mental Health Agencies.

My name is Edward O'Connor, and I'm the Executive Director of Bayonne Community Mental Health Center in Hudson County. I am speaking to you today as the Chairman of the Legislative Action Committee of the New Jersey Association of Mental Health Agencies. Our Association is made up of over 80 agencies from every corner of the State. These centers provide for more than 85% of the community mental health services mandated by the Legislature, and administered by the Department of Human Services, Division of Mental Health and Hospitals.

The people that we serve have a condition called mental illness. Many of them are the same people who filled our State hospitals up to a few years ago when community based care became attractive both as a more humane and effective treatment modality, as well as a more cost-effective alternative to long-term institutional care.

The problems of converting a hospital centered system to a community centered one were and are many. The promise of Federal bounty proved elusive, and a great superstructure of community services was built on an inadequate fiscal foundation. It is shocking to reflect on the fact that this great State of New Jersey, which ranks second in the nation in per capita income, ranks 35th among the 50 states in community mental health funding.

This basic flaw in the infrastructure of the program became clear to our Association a few years ago when we experienced staff turnover rates that were so high that services to clients were severely compromised. Salary levels were 30% to 40% below those of State employees with comparable positions and training. In the past two years, the Legislature has attempted to remedy this situation with special allocations for salary upgrades. These efforts have been effective in averting a complete collapse of the system. In the past two years, some 40% of sampled agencies have shown limited improvement in measures of turnover, staff vacancies, and retention of valued employees.

We are coming to you again to request a special allocation for salaries, and our need remains desperate. The solution for the future lies not in special allocations to keep the structure from crumbling, or the balloon from breaking -- to use the Director's analogy -- but a commitment to shore up the foundation and to provide adequate ongoing funding to support this system which is so vital to the most vulnerable citizens of our State, those with mental illness. The

Administration has recognized the connection between adequate teachers' salaries and excellence in education. Services to those with mental illness requires nothing less.

The Division of Mental Health and Hospitals has notified agency directors to expect a 3.5% increase in State allocation for Fiscal Year 1989. Since agency budgets are built not only on this income but on Medicaid, Medicare, block grant, and other sources which do not increase at all, the overall increase in agency budgets will be between one and three percent.

With the need to keep salaries competitive and the exploding cost of liability insurance, health insurance, and other costs of delivering services, we constantly find ourselves in the position of taking one step forward and two steps back.

What is required is a new sense of commitment on the part of the Legislature and the Administration to the concept of quality community care for the mentally ill. We seek to come before you not with hat in hand as mendicants but as partners in a noble effort that is demanded of us both by all that is holy and decent.

Our Association has joined in a coalition of associations representing consumers, families, volunteers, and other professionals, in supporting efforts in both chambers of the Legislature to correct the inadequacies of the Governor's proposed budget. We salute Assemblyman Frelinghuysen and the many co-sponsors of A-2728. Others will speak, and have spoken most eloquently, of the unmet needs of the mental health system. We recognize those needs as well and support the expansion of services. For us though, the less glamorous task of ensuring the basic viability of the community programs remains our primary focus. Thank you.

ASSEMBLYMAN COLBURN: Thank you. Rodney?

ASSEMBLYMAN FRELINGHUYSEN: Can I ask a few questions, Mr. Chairman?

ASSEMBLYMAN COLBURN: Sure.

ASSEMBLYMAN FRELINGHUYSEN: I resisted asking representatives of the Department of Human Services these questions, because I figured I might get a-- I wasn't sure what sort of answer I'd get. I'm not sure what sort of answer I'll get from you, but--

You mentioned in your second paragraph here, "The problems of converting a hospital centered system to a community centered one were, and are, many." Periodically and from time to time I get exasperated enough to posit this myself. It's been said that because we have historically been a hospital centered system, that it might be worthwhile taking a look a closing down one of our four major psychiatric institutions. Now, I would assume that around the table as an Association over the years that question has been considered. Would you care to share with me whether that has been discussed, whether in fact any people have seen that as having perhaps a direct correlation to better, and perhaps better financed, community services? Obviously the Department has another plan in mind which they briefly discussed, but I'd be interested, I know that my colleagues I think would be interested in hearing-- It's a question that surfaces periodically, and I can't help but ask two of the major players what they think about it.

W I L L I A M K. S T A R R E T T: Mr. O'Connor has asked me to respond. I'm Executive Director of NJAMHAS, our nickname.

We've talked about the future of mental health in New Jersey in lots of forums. We have 82 agencies that make up the Association. We're in every county.

Frankly, our community mental health system is still a patchwork quilt. We have across the fabric of this quilt established certain basic services. We're trying to improve acute care specifically now, along with shoring up what's existed for some 25 years in lots of places. Frankly, the

patches represented by Morris, Burlington, and Bergen County are some of our better patches right now I would add. And I think your particular interest is to help those particular areas develop a quite satisfactory community mental health system. Some of the other areas are lacking in resources and in certain connections with other systematic parts of community mental health, that lead to breakdowns and loss of care for cases such as you've heard today.

We've had a mixed view on the future of the institutional side of the equation in New Jersey. Up to now there has very clearly been a bias towards institutional supports. They have a life of their own in many ways. They become a very large civil service system, as you know. In New Jersey we have a problem with the contract system being at some disadvantage to the civil service system when it comes to incremental changes in funding over time. And some of the oversight moves you've made in the last couple of years have begun to redress those difficulties.

I would say that the original funding from the Federal quarters has never really continued at a level of growth sufficient to keep the infrastructure of the community system substantially solvent enough that we could jump off a new expansion as funds became available. So in New Jersey we have a problem. We have some areas of the State that must utilize services of the State institutions.

Therefore, for some time in the future we are suggesting that some hospital institutional setting and facilities have got to be available for a residual population of probably in excess of 1000 people, whose illnesses are going to last well into the later stages of their lives. An awful lot of the folks we treat have illnesses that last for decades. And good care, applied sequentially, and changing as it needs changes, is important over time. That's the kind of long-term care that we see as really necessary. Transitional schemes don't work for this particular part of the population.

The other half of the population that we treat has circumstantial changes that lead to their problems, and a lot of these can be ameliorated in a lot less time then, say, decades. But a very large percentage of our system, some 40 plus percent at this point, really represent seriously ill folks who are going to need some sort of care for a continuing time. So we see that the institutional services will have to be maintained and improved, if not made smaller at the same time, for the indefinite future.

Could we close down a couple of these institutions? I think we've talked about this, and we believe that is possible. However, we would highly recommend a 24-month overlap, a check and balance kind of system. If you're going to close down 100 beds in a period of 12 months, let's make sure whatever is necessary on the community side to take care of those 300 or 400 people who would use those 100 beds in a year, say, will have some alternative. Some overlap in service is necessary. So that means new expansion in services don't immediately mean a reduction in cost for the institutional side. It means that you're going to have to carry some of that expense for, say, 24 months, and then turn it off on the institutional side and move it to the community. That's a tough thing to do. We haven't figured out a lot of techniques that would make that work. We've suggested that to the Division. This overlap principle is probably necessary in order to make sure that when we get out of one boat we get into the other one cleanly.

So, I think I presented roughly our mixed view. I've looked at the Italian system. In the early 1960s they closed down their hospitals completely. Now, their political circumstances were different, and it fit their culture to make that kind of radical change. We can't do that here. Massachusetts has made a very strong effort in closing out and phasing down its institutions. It probably would be a good

model, and represents something we should look at it. Now, other areas that are fully dependent on their institutional system, or the State itself operates the community mental health system, are probably not good models for us to look at. We like the marriage of contract service provision with civil provision of services.

I hope that answers your question to some degree.

ASSEMBLYMAN FELICE: Mr. Chairman, if I may? From what I understand, you're saying that at least 40% of certain patients will have continuing care, will need institutionalized care, which I understand. We heard here today where a great percentage of those that are transitional are ready to go out into community care, but there's no facilities. If that could be expedited, then possibly you would have more room for those that would need long-term care. At the same time, if you were going to close a facility, you have those facilities emptying of the transitional patients. So, part of the problem is knowing that you are going to need continuing care for a certain percentage of the patients, but the other people that are ready to go out on transitional care there's just no community based facilities available. So that's the two centers that you look before you can possibly even close any institutions.

MR. STARRETT: I think you're very correct. If somehow we can marry our continuing support needs, and have them incrementally change in a responsible way over a series of years, while expanding the system appropriately to that basic structure underneath, we'll have really done something. That would be worth accomplishing, rather than favoring one versus the other. What we end up doing is arguing amongst ourselves, which is a bad thing to do. And this year we're more successful in forming this coalition than we have in the past. We have to some continuation support while expanding. That's principal to our needs.

ASSEMBLYMAN FELICE: That is why some of the European systems that you mentioned-- They have a tremendous amount of community care programs, where they deinstitutionalize. And the few that they had-- They had certain centers that were for the long-term care. That's why that was successful, that you were talking about.

MR. STARRETT: They also have some social insurance systems that are different from the American way of doing things, that underwrote some of their radical change. We don't have those here, so we can't make those kinds of fast paced moves. I wouldn't recommend that.

ASSEMBLYMAN COLBURN: Thank you. Rod?

ASSEMBLYMAN FRELINGHUYSEN: I think it's fair to say, Mr. Chairman, that often this question is raised. I think there's a lot of fear and trepidation about raising it, because those who have family members or loved ones in the hospital setting obviously would be extremely worried if the State were to do something precipitous. I'm certainly not suggesting by raising the question that I personally have any immediate plans to suggest it, but obviously there are people in the system -- the political system and outside the system -- who question whether in fact that would be a desirable thing. I think all of us know that we're going to need a hospital system of some sort into the next century, and perhaps forever. I certainly have no desire to antagonize, or for that matter, worry anybody here relative to anything happening on an immediate basis.

MR. O'CONNOR: I think that there's something reassuring to the family of a mentally ill person just about the structure of the State hospitals; the fact that it's bricks and mortar, it's there, and it's run by the State, and there's a commitment to its being there. I think that there's less conviction that the community system is as stable, and is therefore going to be as able to provide for the ongoing needs. Every parent of a mentally ill person, as of a mentally

retarded person, worries about the day when they won't be here to care for their family member.

I think that part of the need is to really demonstrate a commitment to community based services. This is the direction that we're going in. We're not about to close the institutions down, but we have to bring a sense of stability to community programs that will give people the reassurance that they're going to be there, that a residence established in a community is here to stay, and that the program and the commitment to that is here to stay.

ASSEMBLYMAN FRELINGHUYSEN: Thank you.

ASSEMBLYMAN COLBURN: Thank you.

MR. O'CONNOR: Thank you.

ASSEMBLYMAN COLBURN: Thank you, both. Thomas O'Neil, representing the New Jersey Psychological Association.

T H O M A S V. O ' N E I L: Good afternoon.

ASSEMBLYMAN COLBURN: Good afternoon. Are we ready? (affirmative response) We are ready.

MR. O'NEIL: Thank you, Dr. Colburn, members of the Committee. My name is Tom O'Neil. I'm with the Marcus Group. We represent the New Jersey Psychological Association.

I would like to preface my remarks by conveying to you that the Association met last evening, and in that meeting and discussion endorsed Assemblyman Frelinghuysen's legislative initiative. Though my written and prepared statement does not reflect that, I wanted to convey that to you now.

I'd like to talk about some other legislatively related problems. First, from the perspective of the patients seen by psychologists, psychiatrists, and other providers: Often such consumers of mental health services are accorded second-class status in the obtaining of insurance coverage. To remedy this inequity, Assemblywoman Ogden, together with a member of your Committee, Assemblyman George Otlowski, have introduced a package of bills which provide a minimal level of

mental health coverage. This equitable insurance package, sponsored in the Senate by Senator Codey -- the Chairman of your corresponding committee in that house -- passed in the Senate last year.

The Ogden/Otlowski bill addresses the systematic discrimination and stigmatization of mental health services in New Jersey. Often such coverage cannot be obtained or, when it is offered, there are lower benefit levels, higher co-payments, and restrictive caps are imposed.

Mental illness, left untreated, often evolves into more costly physical illness. Shall we treat alcoholism now or wait until cirrhosis of the liver develops? It is like the Midas Muffler commercial, "You can pay me now or you can pay me later."

We at the New Jersey Psychological Association strongly endorse the Ogden/Otlowski equitable coverage package. We hope that this Committee can send a strong signal to the Assembly Insurance Committee, where those bills have been assigned, to move forward on them.

Often we see problems in our society such as alcoholism, drug abuse, and compulsive gambling, identified as they fall into the headlines and they receive a tremendous amount of attention. Each time there is a tendency to create a new class of providers specific to that particular problem. It is imperative that consumers be assured that providers have the breadth and depth of clinical experience necessary to deal with the full range of issues invariably involved in the lives of people who abuse substances, compulsively gamble, or whatever. Often those are just symptoms of other, more deep-rooted problems.

Some mental health problems, as we know, become so severe that hospitalization is required. In order to preserve continuity of treatment, we believe that the treating therapist should be accorded hospital privileges. This varies

tremendously from hospital to hospital. In some cases they are routinely granted. In other cases hospitals may restrict a therapist and prevent them from seeing a patient, except during visiting hours. We would urge the Committee to consider legislation to allow unrestricted hospital privileges.

I want to bring to your attention one other dilemma often faced by providers of mental health services. This is the situation where you see a patient and in the course of that therapeutic relationship the patient conveys a threat -- a threat of violence against another individual. The therapist then is trapped. On the one hand they have a New Jersey law and an ethical obligation to preserve the confidentiality of that communication. On the other hand they may feel an ethical obligation also to potentially warn the victim, and as a matter of case law in some jurisdictions therapists have been held libel for failure to warn.

In an attempt to remedy that dilemma, Senator Van Wagner together with Assemblyman Kern, have introduced what is referred to as "Duty to Warn" legislation. We hope the Legislature will act on it this year. It spells out in clear terms the obligation to warn, when and how that warning should be conveyed.

I'd like to thank you for the opportunity to present these views to the Committee. I will gladly answer any questions you might have. We intend to supply some additional information on each of these issues in the future. Thank you.

ASSEMBLYMAN COLBURN: Thank you. Rodney?

ASSEMBLYMAN FRELINGHUYSEN: My tongue in cheek-- The psychiatrists and the psychologists are working together to support the Ogden/Otlowski package of bills? Is that--

MR. O'NEIL: That's true. That's true, and occasionally we do. There has been certainly a history of some rivalry. We are working together on that. I must tell you that I've been in Trenton in one capacity or another since

1973. I worked in the Governor's office back in those early days of Brendan Byrne's first term. And there was terrible rivalry between psychologists and psychiatrists at that time having to do with civil commitment legislation. Fifteen years later that seemed to finally work itself out in a productive way. We do much better when we can work together, and when we can reach common ground. You're absolutely right.

ASSEMBLYMAN FELICE: All professionals in all countries. (laughter) Thank you.

ASSEMBLYMAN COLBURN: Anybody have-- No, no more questions. I wanted to ask you, which committee does this "Duty to Warn--" It must be in another committee besides ours.

MR. O'NEIL: Yes, it is. It's not before your Committee.

ASSEMBLYMAN COLBURN: Okay.

MR. O'NEIL: It was assigned to the Judiciary Committee.

ASSEMBLYMAN COLBURN: Yeah, I figured it was a legal thing.

MR. O'NEIL: Yes.

ASSEMBLYMAN COLBURN: Okay. Thanks a lot.

MR. O'NEIL: Thank you.

ASSEMBLYMAN COLBURN: I'd just like to recognize the presence of Assemblyman LoBiondo, who is a co-sponsor of Rodney Frelinghuysen's bill, and you're going to stick around until we vote on that. We'll probably take it a little earlier than we had expected.

I'm going to call Mia Andersen from the PTA, Chairman of Legislative Activities. I think we might have seen you before on some other things.

M I A A N D E R S E N: Thank you, Chairman Colburn. I'm grateful for the opportunity to present testimony here today, and that you would allow me to testify out of order is very kind. My name is Mia Andersen. I'm Chairman of Legislative

Activities for New Jersey PTA, and I'm proud to be here today to represent New Jersey's largest and oldest child advocacy organization, with a current membership of 224,000 members.

We are enormously concerned about the crisis in the provision of mental health programs and services for children and their families in this State. Our society has changed dramatically over the past 30 years, and as a result we must recognize that the structure that is in place now, and what we have done historically, is perhaps inappropriate to meet the needs of a system based on 30 years ago.

Thirty years ago you had a traditional family model of a working father, a mother who stayed home full-time, with a number of children. Only six percent of today's families fit that model. As a result, we have an increase in mental health problems that affect children and families.

Today suicide is the second leading cause of death in our children. Nationally, 5 million will attempt suicide, and 5000 will succeed. That's annually. That's higher than the annual casualty rate for Vietnam.

Today, March 24, 1988, forty teen-age girls will give birth to their third child. Urban dropout rates are more than 50% in some urban areas, and this correlates with an 80% of the prisoners in jail who are dropouts. Three hundred thousand to three hundred fifty thousand New Jersey children use drugs and alcohol. Sixty two thousand New Jersey children use marijuana daily. What we're doing is not working.

Behaviors that result from mental illness and emotional dysfunction contribute to the social problems that plague our society. Consequently, families in trouble and the need for out-of-home placement of children, is higher today than at any other time in our history. What I am suggesting is that the mental health problems that affect children and families today, and the overview of those, and the responsibility for addressing those is not limited to Mental Health and Hospitals.

DYFS, in order to meet its mandate -- that is, the protection of children with the ultimate goal of preserving the family unit -- must include providing mental health services for the children in trouble and the families in trouble. Unfortunately, there is insufficient funding to provide these services. I think there is also confusion about who should bear the cost of these services. Mental Health and Hospitals believes that if the child is a DYFS candidate, then the services that are provided to that child or that family must be borne by DYFS. And DYFS believes, and I think rightly so, that if we have a troubled family and some of those problems need to be supported with therapy and counseling, that DYFS must have either additional appropriations or get the kind of support from another division within the same Department. It is essential therefore, that the Legislature, Department of Human Services, and also the Departments of Corrections and Community Affairs, work together to set policy and develop the climate necessary for the development of a broad continuum of community based care, which we do not have now.

You know, there are two scenarios with regard to troubled children. First, children who come from troubled families, and second, children who are mentally ill and whose illness is the root cause of family dysfunction.

In the first scenario, children who come from troubled homes reflect the sick environment from which they are pulled. They have got to have the kind of counseling that they need. If out-of-home placement is required, most of them will go into foster care, but we do not probably fund or support the foster care system. And as a result, there are not enough foster families, and they're inadequately trained. We have to recognize that children coming into foster care today are not Heidis. They are kids with severe and serious problems. We either have to professionalize our foster care system, and/or -- and I would say "and" -- develop a rate structure that is

appropriate to attracting and retaining sufficient foster care families to handle these kinds of out-of-home placements.

I know that my time is short, and I will try to just hit the highlights of what I had to say.

Now, with regard to the second scenario that falls within DYFS, and that is the family that has a severely emotionally ill child. The strain that this places on the family is enormous. Often it stretches parents beyond their capacity to deal. Unfortunately, there are very few community based services for such families, and less for young children. What happens all too frequently is that we have families who collapse as a result of the lack of support. Now, when those families collapse, and that mentally ill child no longer has a family base, that kid has to be placed. If he's not severely disturbed enough, he is not a candidate for residential placement. Even if he was a candidate for residential placement, there is so little for young children that there wouldn't be any place to place him anyway. So we put that now severely and mentally ill child into a foster home, or, if we're really lucky, into a group residence. But we don't have a lot of group residences. We don't have enough. Recognizing again that if we're dealing with family breakup, then that is viewed as a DYFS program, not a Mental Health and Hospitals program. What I'm suggesting is that we need better coordination between the two, and certainly more support fiscally.

You know, when we fail to provide needed mental health services, what happens to troubled children is that they often grow into severely emotionally disturbed adolescents. The Department of Education and the Department of Human Services must work together to develop procedures for identifying children at risk, and to develop intervention strategies and procedures to help these children. And most important, there must be community based services to which to refer these children.

The emotionally disturbed adjudicated delinquent is a serious problem which has, unfortunately, not gotten the kind of attention or coordination of services that's necessary. We have a basic conflict in philosophy between the Department of Corrections and the Department of Human Services. Corrections feels that any child with emotional problems does not belong -- you know, really severe emotional dysfunction -- does not belong in its system. Unfortunately, Human Services thinks and believes that any child who has committed a crime does not belong in its system. So what do you do with the violent acting out adjudicated delinquent kid? You're in terrible trouble.

There are several answers I think to this dilemma. First, there must be significant resources dedicated to prevention. If we keep de-emphasizing prevention because our treatment facilities and continuum of care is such a mess, and there isn't enough of it, what we're going to do unfortunately is not reduce the incidence of the kind of preventable emotional disturbances, and I think we need to do that. I would urge you to stress that.

Second, there must be developed a continuum of care that these children and families can access. And recognizing the access issue as an important one, you know, if these children are born into families -- children who are emotionally ill or families who are experiencing dysfunction -- if they're lucky enough to be white, Anglo-Saxon, middle or upper class, then they might be able to access the services that are available. But if they are poor and minority, their access is almost nonexistent. That's something that I hope you address.

The third answer is to provide appropriate funds so that both departments can deal with the seriously mentally ill adjudicated delinquent population. Currently a judge has two options when a juvenile is an adjudicated delinquent.

A judge can sentence that juvenile to Jamesburg. Unfortunately, Jamesburg is full. So what happens to that kid? That kid gets put in county detention, locked detention. Unfortunately those counties that have locked detention are generally full. So then they are bounced down to county shelters. Those shelters were not designed for locked detention populations. They were designed for other populations, populations that often should go into foster care, or who often have an inappropriate foster care placement. What I am suggesting to you is that what's happening here is that it's backing up the system, because we don't have the slots that we need.

The second thing that the judge can do is require that there be placement by the DYFS into an appropriate residential facility. They will give DYFS 30 days to do that. Unfortunately it takes 90 to 120 days to assess the kid and find a placement, because part of DYFS' mandate, and what the judge wants from DYFS, is for DYFS to make sure that the kid is appropriately placed. Well when you get a kid cold into the system, the only way you can determine what is appropriate placement is by doing a child study evaluation, by doing a medical evaluation, and by doing a psychological evaluation. You can't do that in 30 days. If any of you know anything about how child study teams work, you'll know that if it takes 120 days, that's good.

What all this means is that the system is backed up. There is not coordination from the relevant departments and divisions within the Department of Human Services, and that it is essential that all the relevant segments get together and cooperate.

Now, quickly about the proposed regional plan--

ASSEMBLYMAN COLBURN: I'm just going to ask you to stop right there. I read what you have said here, and we're going to have to turn that over to the rest of them. Rodney, anybody have questions? (no response) Thanks a lot.

MS. ANDERSEN: Thank you.

ASSEMBLYMAN COLBURN: I'm sorry to cut you short but--

MS. ANDERSEN: That's all right. I tried to speak with the speed of light, but I couldn't.

ASSEMBLYMAN COLBURN: We got the majority of what you were familiar with. Thank you.

MS. ANDERSEN: Thank you.

ASSEMBLYMAN COLBURN: Let's see. Samuel Fierra, are you still with us? (affirmative response) You are. Mr. Fierra?

S A M U E L F I E R R A: Thank you. My name is Samuel Fierra. I am Vice President of the New Jersey Association of Health Care Facilities. The Association represents more than 200 nursing homes and licensed residential health care facilities across the State.

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

Approximately 10,5000 New Jersey residents live in RHCFs. More than 6000 of these residents are considered disabled and are likely to be suffering from mental illness. An increasing number of these residents are under the age of 35, and cannot always be relied upon to take their prescribed medication to control major psychiatric symptoms, such as hallucinations.

With these types of people in residence, an RHCF operator must employ competent mental health attendants on an around the clock basis. This costs money. The RHCFs in New Jersey are facing a crisis which, at best, will result in lower levels of care and, at worst, will lead to increasing homelessness.

About one year ago, a series of Star-Ledger articles examined conditions in residential health care facilities and boarding homes. At subsequent hearings, one singular, critical

step was strongly urged by all respondents; an updating of the Supplemental Security Income reimbursement rate in New Jersey.

As a result of this issue, our Association commissioned a study of cost and SSI reimbursement in New Jersey's RHCFs. The study performed by Urban Health Institute of Roseland, was completed in November, 1987, a mere four months ago.

The study reveals New Jersey's serious underfunding of SSI for more than 6000 frail, disabled, and mentally ill living in residential health care facilities. This population's future access to adequate shelter, food and care is threatened by a decreasing number of beds available to them, according to the study.

The study also reveals that:

- More than 60% of the 10.5-- RHCF residents are SSI recipients who must live on $16.33 a day. Of that, $14.37 is paid to the RHCF. In contrast, dog kennel care and board can cost up to $12 a day in New Jersey.

- While the Federal government's SSI monthly share has increased from $157 to $340 since 1976 -- a 116% rise -- the State's SSI share has increased only 13% in the last 11 years, $132 to $150.

- Twenty-three other states reimburse at higher rates than New Jersey.

The study shows the cost of shelter, food, and care for a resident in a residential health care facility in New Jersey to be $21.05 per day. With the recent cost of living increase in the Federal portion of SSI, an operator of a facility today receives $14.76 per resident. We urge the Legislature and the Governor to increase the State portion of the SSI reimbursement. With an appropriate increase, the RHCFs will be in a better position to deliver the quality residential care we all seek.

Our Association applauds the efforts of this Committee, both collectively and individually, and we stand ready to assist you in any way we can. Thank you.

ASSEMBLYMAN COLBURN: Thank you. Any questions? (no response) No? Thanks very much.

MR. FIERRA: You're welcome.

ASSEMBLYMAN COLBURN: Robert Cohen, Director of Social Work, Bayshore Community Hospital, Holmdel, New Jersey? Are you still here? (no response) I guess not. Angela Randazzo for Mr. Casey, Mental Health Subcommittee on Children's Services Planning. Good afternoon.

A N G E L A P. R A N D A Z Z O: Good afternoon. My name is Angela Randazzo. I am here representing Mr. Thomas Casey, the Chairperson of the Mental Health Subcommittee of the Governor's Committee on Children's Services Planning.

The Governor's Committee on Children's Services Planning was established by Governor Thomas Kean to improve the planning and coordination of services for New Jersey's children, youth, and families.

Following a comprehensive review of the children's services system, the Committee's findings were detailed in New Jersey's "Action Plan for Children." The Committee's activities now focus primarily on the implementation of the Action Plan's recommendations.

In 1986, the Governor's Committee on Children's Services Planning formed the Mental Health Forum. The Forum, a broadly representative group of professionals and private citizens -- over 60 individuals -- were charged to examine the current system of delivering mental health services to emotionally disturbed children and their families. On the basis of this examination, the Forum made recommendations to address the problems of this system.

One of the general recommendations spoke to the establishment of a comprehensive, locally based continuum of services for these youths and families. The most effective service delivery for emotionally disturbed youths is a community based system that provides for their basic needs.

Out of this context, we are pleased with the focus of the proposed legislation directed at the expansion of community mental health services for children. We support the proposed effort to develop children's community services in the areas of residential care, partial care, and outpatient services.

I'd like to read the four general recommendations that were made very briefly, from this mental health forum. The general recommendations:

1) The Forum recommends a system wide planning process for this continuum of services, including a six-month statewide study of current services.

2) The Forum recommends the establishment of a comprehensive, locally based, continuum of services for these youths and families.

3) The Forum recommends the extension of case management services to include all children and families in the system. And,

4) The Forum recommends that the Governor's Committee on Children's Services Planning explore the establishment of an Executive level youth services department. A critical short-term measure is the establishment of a joint agency management team to coordinate the services of youth.

We commend you for your efforts and commitments toward the implementation of this new law, and we thank you for the opportunity to present our concerns.

ASSEMBLYMAN COLBURN: Thank you. Mr. Felice? (negative response) Anything, Mr. LoBiondo? (negative response) Okay. Thanks a lot.

MS. RANDAZZO: Thank you.

ASSEMBLYMAN COLBURN: Rick Lamb is still here. Mr. Lamb is Administrative Director for Youth Services, UMDNJ Community Mental Health Center, Piscataway.

R I C K L A M B: Thank you, Mr. Chairman. Now I don't have to at least repeat the name again.

ASSEMBLYMAN COLBURN: I was saving time on the recorder over there.

MR. LAMB: I am Rick Lamb from the above organization. I've been warned that when you're seventeenth on the list you better say something dramatic to catch people's attention.

ASSEMBLYMAN COLBURN: He's right.

MR. LAMB: I'm not going to quite follow that advice. As the representative of the State's largest and I think most comprehensive system of mental health services, I could tell you about a whole range of special problems we're dealing with: everything from child abuse, to AIDS, to Alzheimer's disease, to seriously emotionally disturbed children. The list goes on and on. But rather than emphasize those specific services for specific populations, even though these issues are more, kind of, headline grabbers, I want to talk about an issue that's more basic although not very exciting. And that is the status of the mental health infrastructure within this State.

By infrastructure I mean the network of resources, services, agreements, and structures, that provide the underpinning and support for specific mental health initiatives. They're like the bridges that you drive over every day, and you never notice until they collapse. I'm sorry to report that in the view of the mental health professionals at UMDNJ the bridges are on the verge of collapse, and the result will be that many of the programs that we have such high hopes for, and we put so much work into, are not going to work and are going to collapse.

In the time I have let me give you just three brief examples:

One addresses probably one of the least dramatic areas of service of all, specifically, outpatient counseling and treatment. This service is increasingly not available to people of moderate income. This service is often the glue and the lynch pin of other services. Without it, it's often very difficult to deliver other services. Very often, outpatient services are the only services people ever need. And yet, these least restrictive, least intrusive of services, are also becoming the least available. Many mental health centers have cut back or totally eliminated such services because of the funding restraints.

Let me give you a concrete example of what the implications of this are. We all are very much committed to keeping children out of institutions, out of hospitals. We at UMDNJ are responsible for doing that in a six county area. Yet, when we screen and do crisis intervention for children, we then turn and keep them out of the hospital, we then turn and find there is no place to refer them or the family.

A second example: I don't have to tell this group how hard it was to finally achieve a screening bill. Yet because of the deficiencies in infrastructure, you might have to do it all over again in three, four, five years. Think of the cost of trying to provide professional services on a 24-hour basis and you will understand the fear and trepidation that screening agencies approach providing these services. Assemblyman Frelinghuysen's bill, and with the support of the rest of you, will help with the start-up. But we believe that the long-term demand for these services is going to be much greater than has been anticipated. There's a well-established pattern in mental health that whenever you provide new services, the demands go way up.

My third example, and that's the one closest to me, children's services: You've heard about, you know about, the current plan for the seriously emotionally disturbed children.

And phase one of that is already under way. It involves providing more short-term psychiatric facilities. It involves providing alternatives to State hospitalization. Those of us who have been working with that plan and cooperating, have had a lot of reservations. The numbers haven't quite seemed to add up. But nonetheless we've tried to give it, I think, a good faith attempt. And we at UMDNJ at Piscataway are very much involved in that. But we were constantly being reassured, "Don't worry. This is only phase one." The other services, the infrastructure services, the things that you need to keep kids out of hospitals, the things that you need to keep kids from graduating to being seriously emotionally disturbed, they were going to come along in phase two. Then suddenly phase two disappeared.

Again, through the efforts of this Committee and the members, part of those funds perhaps will come back on-line again. Although again we hear that there is no guarantee that Assemblyman Frelinghuysen's bill will ultimately be signed. I must warn you, as someone directly involved in providing acute emergency services, the five counties, that unless additional services and community based services come on-line very quickly, even phase one is going to collapse even before it finishes.

One final comment. The first step in creating an infrastructure, in fact part of the infrastructure, is planning. We are long overdue for a comprehensive mental health plan in this State. Thank you.

ASSEMBLYMAN COLBURN: Thanks a lot. Rod?

ASSEMBLYMAN FRELINGHUYSEN: I think you did a pretty good job of not-- He sort of contradicted himself in the sense that you actually made some, I think, very controversial and well-spoken comments, despite the fact that you picked what you thought might not be too earthshaking. In fact, your latter comments relative to children's services I think will be particularly noted by the Committee.

Several people have called on the telephone to say, "When you helped put this bill together, why wasn't there a greater portion of attention given to children's services?" I was somewhat guided by the Department, I have to admit, in terms of their ability, as I saw it, to produce. And secondly, I was somewhat guided by my involvement with some of those who make up the mental health coalition. But I think you are forewarning us. And if there is an attractiveness about the whole package that I think should be one of the forces that drives it to the Governor's desk and ultimately to have him sign it, is the children's element; even though it may be diminutive in comparison to the screening portion and the adult portion. I think that in fact may be the central reason that it gets signed. But, hopefully that doesn't fall into the category of wishful thinking. We're going to work on it. Thank you.

MR. LAMB: Thank you.

ASSEMBLYMAN FELICE: You did wait yourself, being the eighteenth speaker. The important thing I think is the children's program. Unfortunately the only time there's movement sometimes is when there's some very bad publicity of some devastating cases involving children who have emotional problems and are put into certain facilities. I think those problems should not begin to happen if they're addressed with long-range planning, and that the facilities are at a stage where they can be addressed with the proper personnel, and the monies, and the training are there for those people. I thank you for your comments.

MR. LAMB: If I could just comment on that. The worst possible time to plan is in the middle of the crisis. And that's partly why we have the plan that we have now. It was out of a crisis.

ASSEMBLYMAN FELICE: Crisis planning is not the best in the world.

ASSEMBLYMAN COLBURN: Thank you. Mr. LoBiondo? (negative response) Thanks a lot.

MR. LAMB: Thank you.

ASSEMBLYMAN COLBURN: Let's see, Cynthia Newman, Union County Child Protection Council?

C Y N T H I A N E W M A N: First I'd like to thank you for letting so many children's providers speak today.

The Union County Child Protection Council is a county children's service providers' organization that has been working since 1974 to provide a voice for children. I am also including in my testimony a letter from Dr. Nancy Durant, a respected colleague, and practicing child psychiatrist in Union and Middlesex Counties for the past 25 years.

The Union County Child Protection Council supports Assemblyman Frelinghuysen's budget resolution. We are committed to seeing that intensive services to seriously emotionally disturbed children/youth be provided in their homes and local communities. Funding is needed to develop, support, and enhance the continuum of care so that children will be able to remain within their families.

However, it should be noted that the pattern of over-utilization of inpatient and residential beds will continue unless other services that are at least as effective, less restrictive, more family centered, and less costly, are developed.

I'd just like to call your attention to the green thing that I had handed in.

The Council would further like to inform you of their ongoing and serious concerns regarding the Department of Human Services plan for SED children and youth, which was initially released in February of 1987. There's been some discussion about what that plan calls for.

You will note that I have printed the report on green paper, and that is because I think the color green represents three things:

1) Hope that you may review the materials presented today, and more closely examine children's mental health services as they currently exist.

2) Green also represents renewal, that with your support, community agencies can renew their commitments to children and not be afraid to say what they know. I also hope that with your support we can renew our faith in the system, and who it is we're supposed to be helping. The Union County Child Protection Council requests that you support and call for the convening of a committee to review the SED plan before any further implementation.

3) And of course green represents money, the monies that will be needed if we are to close Trenton Psychiatric Hospital, reduce the beds at Arthur Brisbane, and truly develop a continuum of care in the community for our children.

On page 11 there is a humorous, but I think appropriate illustration of what I think will happen to children's and youth services if the SED plan is implemented without any review and adequate funding. Perhaps I take my job as a social worker too seriously. However, I have spent the last 10 years tinkering with other people's lives. I feel I owe it to the children of families I work with to share with you my very deep concerns about this plan.

In supporting Assemblyman Frelinghuysen's budget resolution, it should be clear that these monies will shore up the SED plan. Requesting monies to supplement the SED plan, while not truly developing a continuum of care in the community, is like building an addition on a house with no foundation.

Given the limited services outlined in the plan, many youngsters will be under served and the reality is that some of our neediest will not be served at all.

Unfortunately, deinstitutionalized adult psychiatric patients may choose to sit idle in boarding homes. Unstable emotionally disturbed children will not fade into the woodwork. They will be extremely difficult for the parents to cope with, they will be impossible for the school systems to handle, and they will put a severe strain on limited community mental health services, and they will act out and harm themselves and others.

It can be stated, without appropriate community services, our SED teen-agers will end up in the juvenile justice system which is happening now. It can also be stated that our children, ages 10 and younger, will be referred for lengthy residential placements, and that is also happening now as there has been an intensive push to get the youngsters out of Arthur Brisbane.

It must also be emphasized that a 28-day stay at a local CCIS inpatient unit may be sufficient for a youngster from a well-functioning intact family. However, for a youngster without a family, or from a seriously dysfunctional family, a 28-day stay is inadequate.

The combination of a brief stay on a CCIS unit, and inadequate community aftercare service, contribute to referrals to State hospitals and residential placements. Due to the poor quality of the original plan, additional monies will be needed to develop community alternatives, as what is currently outlined in the plan is inadequate and shortsighted. The same concerns have been echoed by numerous experts around the country who have critiqued the plan. The Union County Child Protection Council urges you to ask the Department of Human Services for these critical evaluations for your review.

In closing TPH and focusing on children and the youth in the community, we must consider the very real question of what will happen to those children? If they need continued intensive services -- and they will -- who will finally provide these services?

Some of my colleagues wanted the Union County Child Protection Council to just support the budget resolution and say no more; a kind of take the money and run attitude. However, we feel you need to know that it will cost more, much more than the initial budget allocation, if we are to appropriately service these children. I thought it would make more sense to tell you now, so that if the SED plan is implemented and we come back asking for more money, you won't be angry but expecting us. (laughter)

I'm not entirely sure that you understand who I'm talking about. When I'm talking about seriously emotionally disturbed youngsters I'm not talking about kids that may be a little unhappy or depressed because mom didn't give them the car on Saturday night. I'm talking about eight-year-olds who try to hang themselves in the basement, eleven-year-olds who set a ladder by the railroad tracks and attempt to jump off as the train passes by. I'm also talking about teen-agers who hear voices telling them to kill their families, and who sit and cut their wrists and methodically watch the blood run out, or go to the bathroom and swallow everything in the medicine cabinet.

These are New Jersey's children who need help, and if we don't help them they will harm themselves or others, or grow up to be our next generation of mentally ill adults. Many of these children can be helped, and it is our obligation to do just that.

In conclusion, the Union County Child Protection Council is urging you to convene a statewide committee to reevaluate the plan. The committee should be composed of community agencies that provide direct services, and parents who were eliminated from the initial statewide organization. We also request that you consider halting any further implementation until all evaluations from all the experts can be reviewed, and that you might then ask the Department of

Human Services, in cooperation with this committee, to write a new plan based on fact, not fantasy.

As responsible adults committed to our State's children and youth, we must ensure that youngsters remain in the community, and are not simply dealt a new version of abandonment. The Union County Child Protection Council is in hopes that in the rush to close Trenton Psychiatric Hospital, we in the community will not be forced to provide second-rate services to our State's children and youth, or even worse, have nothing at all to offer them. Thank you.

ASSEMBLYMAN COLBURN: Well done. Rodney?

ASSEMBLYMAN FRELINGHUYSEN: Yes, Mr. Chairman, I'd just like to-- There's a distinction between what-- There is a bill, which we will be voting on prior to the end of this meeting, and there is something called a budget resolution, which the Appropriations Committee may or may not hear, which may in fact be for the same amount as the bill. I'm not sure that you are aware that there actually is a distinction. In other words, the Appropriations Committee often will consider a variety of resolutions which really add up to a supplemental to the overall budget that the Governor proposes.

MS. NEWMAN: It would still have to be a tremendous amount of money--

ASSEMBLYMAN FRELINGHUYSEN: Yeah, I realize that.

MS. NEWMAN: --to provide the kind and the quality of services. I mean we--

ASSEMBLYMAN FRELINGHUYSEN: Just for the record I want you to know that there's actually a bill, and in all probability there will be a resolution. As with the previous speaker, the children's plan-- I was somewhat disturbed when I heard the Assistant Commissioner talk about it, as did others, that there was a reduction in population in Brisbane. Is that right?

MS. NEWMAN: Well because they're discharging them quicker, and some children that need to go there aren't admitted. I mean, we're having kids in there and back to the county and then within days back again, and much more serious shape then when-- It's like if you say to somebody, "Well you've graduated from college, but as it is you need six more credits and you've got to go back." I mean, these kids come back, and because we don't have the services, the things that they do the next time are even more horrendous then what they did the first. It's just not the kind of services that I think New Jersey could be proud of.

ASSEMBLYMAN FRELINGHUYSEN: You're talking about obviously -- and you listed a very comprehensive group of services-- At one time Brisbane had children as young as five.

MS. NEWMAN: Right.

ASSEMBLYMAN FRELINGHUYSEN: Some of us caused a stir a few years ago relative to at least making Brisbane available to adolescents, and doing a good job for them; but the burden was put on the Department at that time -- which in fact may have provoked partially the movement into more planning -- to put a burden the Department to do a better job in terms of finding an appropriate placement for the younger children. And quite honestly that's where I've heard -- if there is criticism out there in the mental health community -- that the Department hasn't worked actively enough in that area. Not to say that adolescents don't deserve appropriate placement as well, but certainly younger children deserve our prompt attention.

MS. NEWMAN: Before all of this took place, I felt in terms of the youngsters coming back to Union County, that they did an excellent job. Our youngsters came back. They were healthy. They got back in school. They were back involved in their community.

And in defense of Trenton -- and I'm not a person that thinks institutional care is the answer for everybody, but there are some youngsters and some families that have such problems that the children really can't be handled in the community, at least in their current state of health or ill health. And I think one of the problems with Trenton is that they were dealing with the most disturbed youngsters, with the least effective families, with the most long-term problems, and they never really had the resources to do the kind of job that they needed to do. Even given the problems that they had, they did some excellent jobs with Union County kids. I mean, we had kids that at the end of the CCIS stay were really not in good shape, and you go down on a monthly basis and work with them at Trenton and you'd be surprised at how much improvement they made.

So I don't think they necessarily deserve such a bad reputation. I know there have been problems there, but I think some of it was inherent in the system that was designed from the beginning.

ASSEMBLYMAN FRELINGHUYSEN: Okay. Thank you.

ASSEMBLYMAN COLBURN: Thank you. I was just going to say one thing to you before you leave.

MS. NEWMAN: Yes.

ASSEMBLYMAN COLBURN: You refer to the hot potato case, which I thought was pretty good.

MS. NEWMAN: You liked that?

ASSEMBLYMAN COLBURN: Well over the years I've noticed the window dressing services that we have, where we say we have a service, and it's supposed to be there, and it really isn't there. I noticed that. So, that's my contribution.

MS. NEWMAN: Okay.

ASSEMBLYMAN COLBURN: Mr. LoBiondo, did you want to ask anything? (negative response) Thanks a lot.

Grace McGrath? I think I probably should have brought you two up together. You're both from Union County. Chairperson, Children's Mental Health Services Committee of Union County.

G R A C E M c G R A T H: Before I start I'd like to say I concur with what was stated by Cynthia Newman, by Dr. Rabin, and by Rick Lamb, about the children's plan.

The Union County Children's Committee has been in existence for many years, and was instrumental in developing the case management model that presently exists in Union County, and was the model that the Division of Mental Health and Hospitals has incorporated into their planning for future case management services.

I will limit my comments to the reaction to the official written material on this children's plan, since we have learned during the past year that verbal statements and rumors have clouded many issues.

The recommendations of the Children's Committee are that Governor Kean and Commissioner Altman be advised that Union County finds the New Jersey Plan for Mentally Ill Children, and the process for implementation, unacceptable. There are specific recommendations, which I won't go into but they are in your report. Our other recommendations, as I said, if Trenton Psychiatric Hospital must be closed down, I've enclosed.

I want to give you some back history on that. That's what I have dealt with in this report.

Our committee became involved with this plan about a year ago, when one of our members brought it to a meeting we discussed it as a concept paper. It seemed obvious at that time that professional mental health planning had not been involved in its development. Also, we found out that no input had been obtained from mental health associations, mental health administrators, local provider agencies, case management

services, county governments, and the boards of education. Even the hospitals and the residences involved in the plan were not asked for information about their populations and the services needed to maintain or to help them if inpatient care was terminated. It took several months to track down a person who was knowledgeable about the plan.

Although the plan was issued as a mental health plan, it seemed also obvious that the Division of Mental Health and Hospitals is and was being pushed to put this plan into place quickly, despite their own concerns about it and the outrage expressed by the mental health community. At that time we were reassured by the Division of Mental Health and Hospitals -- this was a year ago -- that this plan developed by the Department of Human Services was only a shell, and that each region would be able to individualize its services. We were also reassured that Trenton Psychiatric Hospital will not be closed down until alternative services were in place. However, when questioned about the plan's budget, the responses were rather vague. This type of interchange has been typical of the entire process during the past year.

I have enclosed a letter sent to the Division of Mental Health and Hospitals by Union County on 8/13/87, stating that the concerns of Union County about the process in which the plan was being implemented, and the issues which we had identified as problematic. We have never received a response to that letter.

An example of an issue was obvious at a meeting when a question was asked, "What happens when the 40 beds for adolescents are filled and another child needs hospitalization?" The answer was, "That is not in the plan. The local community will have to become involved."

During the past year there have been several regional meetings regarding the plan to supposedly develop it. But complicated material was handed out at this meetings that were

very large -- too large for discussion -- and with not enough time allocated to discuss anything. A problematic example is, a rough draft was handed out at the end of one meeting developing the responsibilities of the lead regional coordinating group. The following month our committee brought back its concerns about this concept, only to be told that the draft had been discussed at the last meeting, and the final report had been sent. I have enclosed that memo from this date. Our concerns about this were put in writing, but no response has been received.

I have enclosed the Division's interoffice communication which developed this lead regional coordinating group concept. We have questioned this concept from the beginning because of its obvious conflict of interest. We asked the question, how can one agency do all of the following: provide CCIS crisis intervention, screening, provide inpatient services, outreach services, coordinate and plan regional services, collect data and assure quality service -- in effect monitor itself -- identify regional needs, communicate with county coordinating bodies, and plan training and conferences?

To finalize my report, the committee supports Senator (sic) Frelinghuysen's bill which would restore about half of the dollars which were recommended by the Division to develop the resources needed if Trenton Psychiatric Hospital is closed. This only highlights our concern that the plan needs to be developed carefully and slowly, with facts about the population needing service, and with knowledge of existing resources and with input on the local level.

The Governor was pleased to announce in his State of the State Address that children under the age of 10 will no longer be institutionalized. What he left out was, what will happen to them? I don't think he, if he is around next year, or you when you are around, will be pleased with the stories you will hear if this plan is pushed into place. It shall be a disgrace.

Thank you for this opportunity to speak. Do you have any questions?

ASSEMBLYMAN COLBURN: Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: I would like to say that if in fact you write a letter to somebody down in Trenton, unless you know that person pretty well, it doesn't do any harm to write directly to the Commissioner then send a carbon copy to the legislators who represent you directly. Then more likely than not, you will get a response back. (laughter)

MS. McGRATH: We'll do that. We'll do that immediately.

ASSEMBLYMAN FRELINGHUYSEN: The problem is -- and I don't think the word goes out, and it's not only true in this Department -- but sometimes the people that you write to have a lot of coals on the fire and it's difficult for them logistically to respond perhaps other than orally, and to put together something in the way of a written response is too much of a task for them. Obviously it's inexcusable for people not to answer their letters, but I'd suggest as a proper step it would be better to write, if it's in fact let's say a caucus of mental health advocates or a group of people -- official or unofficial -- that you write directly to the Commissioner and do as I suggest. Thank you.

ASSEMBLYMAN COLBURN: Mr. Felice?

ASSEMBLYMAN FELICE: Let me reply to that also. I find that when I have mail that is different reports or opinions or intentions, that sometimes rather than trying to go through a whole report -- and it's something that we're working on -- sometimes by adding a day or night phone number-- I try to catch up and save a lot of paperwork, trying to write out letters for my agents to type the next day and so forth, when I'll put a note on it and I'll find that I can pick up the phone and maybe get my message across -- how I feel, what I feel the Department should be doing -- by a five or ten minute

phone call, rather than trying to answer 50 or 60 pieces of mail a day sometimes. I think that's helpful. I think that personal contact doesn't hurt either.

MS. McGRATH: I must say that the letter from the Department of Human Services in Union County was to Dan Bachalis, and was in response to their request for information regarding what we saw as issues. We had expected either a meeting or a response in writing, and nothing occurred. Most people from the State, I think, provided information about their concerns about this plan, and there was no feedback. There was no interchange. That was our complaint.

ASSEMBLYMAN COLBURN: Thank you.

MS. McGRATH: You're welcome.

ASSEMBLYMAN COLBURN: I think I better say now -- and I don't know if these people are still here -- but we had three people who asked after the list was made of people to testify who wanted to testify. It appears to me we have about ten more people before the hour of 4:30. I don't see how we can-- That's not including the three. So, I apologize that we're not going be able to hear Mr. Adams, Mr. Coleman, or Mr. Vincent, if they're still here. If you have something to give us, again we're going to go over all this. We also have Mr. Frelinghuysen's bill to vote on.

Julie Turner? There you are. Did I receive a letter from you?

J U L I E T U R N E R: Yes.

ASSEMBLYMAN COLBURN: Which I thought was your testimony.

MS. TURNER: No.

ASSEMBLYMAN COLBURN: It was not?

MS. TURNER: It was not. I thought I would pull together something a little more current.

ASSEMBLYMAN COLBURN: Okay.

MS. TURNER: I'm Julie Turner, Executive Director of the New Jersey Association of Children's Residential Facilities. I also serve on the State Task Force that is supposed to be advising on the Children's Mental Health Plan.

ASSEMBLYMAN COLBURN: Supposed to be, you say?

MS. TURNER: Yes, sir.

ASSEMBLYMAN COLBURN: Advisedly you said that?

MS. TURNER: Yes, sir. I will summarize instead of reading, because I think you can read as well I can read it.

ASSEMBLYMAN COLBURN: Yeah.

MS. TURNER: Our facilities are both the group homes and private residential treatment centers in the State. We serve a high proportion of emotionally disturbed children. Many of the kids who are in the facilities right now have come out of Trenton or Arthur Brisbane. Somerset Hills -- which I'm happy to say Mrs. Bednarsh was happy with -- is one of our facilities.

I'd like to talk about several issues:

One, the lack of any kind of needs assessment or documentation on which the plan was based. That was an issue that every critic brought up over a year ago. That is still true. There is no information on the kids, their needs. Bob Nicholas was talking about apparently how well the plan was working. I have, and the State Task Force has, no information on any kind of follow-up on those kids; where they are. Are they in placement? Are they home? Are they getting the services they need? Anecdotal reports indicate a lot of serious problems, but I don't have the facts, I don't know what's happening, and I don't know if anyone knows what's happening.

It seems to me -- and I would think it would be true from a legislator's standpoint -- that any plan needs to be based on some kind of facts, some kind of needs assessment. You've been asked to put a lot of money in. I think you want

to know is it going to do the kind of job you want it to? Is it going to where there are most the needs?

Union County brought up very clearly the question of the process of developing the plan. I would make it very clear that Union County is not unique. That has been a concern from all over the State, both from the regional committees and from the statewide committee. It was a plan that was presented with basically no community involvement, again, no research involved. It is sort of going on its merry way in spite of the major concerns that have been voiced by not only mental health providers and child advocates. It's a little bit wrong.

Third, in terms of residential services, I am going to quote one thing. In the original plan it noted that many children were in State hospitals: "Due to the absence of appropriate beds in the DYFS residential system. It is imperative that DYFS proceed with planning for the expansion of resources for these children." It's worth saying that the plan was really not worked out with DYFS before it was presented. Over a year later there has been no expansion of residential services in the State. Far more difficult kids are being referred. We are dealing with an issue where we have 500 kids placed out-of-state. We have 600 kids waiting for placement. The plan calls for, says it is contingent upon DYFS expanding residential services, and there's nothing in their plan that relates to it. Nothing.

I'm going to add-- I think, or I hope, you gentlemen remember my testifying not too long ago about salaries for child care workers in residential facilities. I will not repeat it. I will point out that at this point our child care salaries are $3500 below those of the mental health workers. They have talked about their needs in terms of turnover and retention. As you might guess, ours are even more serious. And I support their salary issue. If they are successful -- and I hope they are -- in getting the salaries that they want

and need, we will be $6000 below. I would add to that that some of the facilities are going to be forced to close; those that you and we need for the kids.

I think several people talked about the kinds of problems, what I call the "systems issues," the kids who belong to you. And that's envisual. Notice that it blocks off the one in the middle. We have in the past, and we are in the process of expanding a development of four separate overlapping residential systems: the Department of Corrections, DDD, DYFS, and Mental Health and Hospitals. The problem is, kids don't have labels on them that say, "I am purely a DDD kid," or "a DYFS kid." And those that don't fit -- and those are often the most seriously disturbed kids and the kids with the biggest problems -- don't get the services.

I think all of you were very moved in hearing Mrs. Bednarsh. A few months ago, because of an article in The Record, a parent said she wanted to start a support group. And the reporter called and asked could the Association's phone number be used as sort of a contact number? I said, "Sure." For three days, starting at nine o'clock Sunday morning and going up until 11 or 12 -- actually, I put on the answering machine at 11 -- the phone did not stop. For the next two or three weeks it was maybe 10 or 12 calls a day. I was hearing stories from parents like her over and over. You would have been deluged. I was.

The needs are out there. They are not being met. And the plan does not make sense. We need your help in this. The advocates have said to the Department, they have said to the Divisions, "Where are the facts? We know there are problems."

I've put down some specific recommendations. One of them-- You are in position of requesting information and facts through the Commissioner, whether it is DMHH or DYFS that provides the facts, I don't care, but I think you and we need them.

I've listed some issues that I think should be addressed in a comprehensive plan, but I think you as a Legislature need to have a three- to five-year plan so you can make decisions about where you want to invest the money, where the taxpayers' money should be going, and whether it makes sense to you.

Clearly, additional funds are needed. I think you need to be thinking about that.

And the last thing I would say is that the children's mental health plan, children's mental health is only one piece of a broader issue involving children's services.

And I thank you very much for having the hearing. I think it's very valuable. I'm here if you have any questions.

ASSEMBLYMAN COLBURN: Thank you. Anybody?

ASSEMBLYMAN FELICE: I thank you for the job you're doing in my district.

ASSEMBLYMAN COLBURN: I think I had better adjourn the public hearing just for a few minutes while we hear Senator -- Senator, gosh I promoted you again -- Frelinghuysen's bill.

(RECESS)

AFTER RECESS:

ASSEMBLYMAN COLBURN: Sue Dondiego -- if you're still surviving this -- Legislative Chairman, New Jersey Foster Parents Association. Good afternoon, almost good night.

S U E D O N D I E G O: Do you know that I'm the first of the next four speakers, and I understand-- (inaudible)

ASSEMBLYMAN COLBURN: Okay. I'm glad that you-- Let's see. Where are they? Cecilia Zalkind?

MS. DONDIEGO: Yes, she's here.

ASSEMBLYMAN COLBURN: Okay, and Jeff Fleischer?

MS. DONDIEGO: And Marshall Bord.

ASSEMBLYMAN COLBURN: Marshall Bord, okay.

MS. DONDIEGO: Is that okay?

ASSEMBLYMAN COLBURN: Yeah, sure. Do you want to have them all come up at the same time? (affirmative response from audience) I thought we'd let you all speak simultaneously. (laughter) Now you've all got a place to sit. Okay. Let's come back to order.

MS. DONDIEGO: Would you like me to start?

ASSEMBLYMAN COLBURN: Yes please. Thank you.

MS. DONDIEGO: I'm Sue Dondiego. I'm a foster parent, and I am Legislative Chairman for the New Jersey Foster Parents Association. And, especially with this busy schedule, I wanted to thank you for the opportunity to address this Committee on the subject of aging-out.

Aging-out, to foster parents, means watching the adolescents and teens in our care leave our homes, and the DYFS system, at the age of 18, with no place to go and no services or programs in place to help them make the transition from foster care to useful members of our communities.

Because of the lack of support services to both foster children and foster parents, many adolescents and teens end up being warehoused in foster care until they reach 18 years of age, when they become someone else's problem.

This is not to say there are not some teen success stories in foster care, but when successes occur it is because individual foster parents are aggressive enough to seek out and demand the services they and their foster children need, and are willing and able to assume the financial obligations for many of these services. Some foster children remain in their foster homes after reaching 18 years of age, but this arrangement leaves the foster parents assuming all financial responsibility for food, clothing, medical expenses and other basic essentials.

Under these conditions, recruiting, and retaining foster homes for adolescents and teens is virtually impossible because we are expected to do the impossible.

DYFS has done a much better job of keep families together by providing services to youths and their families in their homes. Many of the young people coming into foster care are those who in addition to having normal adolescent problems, have a history of poor school attendance, abuse of drugs and alcohol, and in general have no living skills. The problem goes beyond funding.

While DYFS should be responsible for providing training, adequate reimbursement rates, and other supports to foster parents, providing a comprehensive program for adolescents and teens in foster care will take the cooperation and coordination of many systems.

Education, mental health services, and job training are a few of the components essential in any program if foster parents are to help the young people in their care achieve independence. Yet adolescents and teens in foster care continue to be DYFS' problem, and many services are provided through the aggressive advocacy of individual foster parents and DYFS workers.

Our youngsters should not age-out. They should age-in to an appropriate program which will enable them to become self-sufficient, rather than ending up on the streets and/or remaining dependent on other State systems for the rest of their lives.

While our concern is primarily for those in our care, the aging-out problem crosses all department and division lines. Programs have specific qualifications and age limits, and when these no longer apply, people of all ages fall through the cracks. Trying to pick up the pieces at a later date is far more difficult and far more costly.

We urge this Committee to take a broad look at what is commonly called aging-out, in order to meet the immediate needs of those already in State systems, and ensure a continuity of care for the future.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: No, thank you.

ASSEMBLYMAN COLBURN: Anybody? (no response) Thanks a lot. Cecilia, we had you down next. Would you like to go?

C E C I L I A Z A L K I N D: Sure. That's fine. I submitted copies of our written testimony. I'm Cecilia Zalkind from the Association for Children of New Jersey.

And one of the issues that we wanted to address with you this afternoon was the issue of aging-out, but we had some other concerns about the delivery of mental health services that I want to just briefly mention. The advantage of following so many wonderful child advocates is to say that I agree with everything everyone has said ahead of me, and just have a couple of points that we're very concerned about from our perspective.

We do not offer direct services, but we are a child advocacy organization. We do monitor policy and programs on the State level, and we have gotten a number of calls over the last 18 months from parents who are very concerned about the mental health system in this State. So we are doing some case advocacy that gives us a different perspective on issues and problems.

The three areas that we're very concerned about, you heard a bit about already. One is the need for a comprehensive coordinated service delivery system; second in the issue of aging-out, which the four of us are talking about in some aspect with you; and the third issue, which I'll address at the end, is an issue of permanency services for children who are in placement already.

Let me begin very briefly with the comprehensive service delivery system. The testimony you've heard from people this afternoon -- both in the adult and children areas -- stress what has been called a need for a continuum of services. From the problems of children and families that you've heard, these are not children who are served in any one particular program. They are children who may need treatment in the community, children who may need some intermediate care, children who may need restrictive settings. There are needs on all levels, and we are very enthusiastic about supporting your bill, and pleased to see it come out of this Committee, because that's a start to providing some funding for community based services, which we feel are very important.

Our second concern is that not only is this continuum necessary, but that it's a continuum that exists in more than just the mental health system. From our perspective of looking at children and adolescents -- troubled youth who need some type of treatment -- we see some remarkable similarities among the different State systems. The children you've heard about today are very similar to the children in the Corrections system, the children in the Division of Youth and Family Services, services in the residential system, children in DDD, as well as children in Mental Health and Hospitals. What's different is that their problems are manifested in different ways. Or, as Julie pointed out, they are kids that don't fit into any one system, but are made to fit into whatever system that exists to give them treatment. We have some very serious concerns about that, and feel that some coordination is necessary because these children do not fit into any one specific place.

And when we look at the systems who are involved in providing care to these kids, what we see is a system that doesn't talk to each other except to say that they don't want to service a particular type of child. A child who the

Division of Mental Health and Hospitals, for example, might not be willing to service -- might be a kids who goes over to Corrections or over to DYFS. There seems to be some competition among these systems for who they are not going to take care of. And in our mind the only system that has the right not to say no, that has to accept these kids, is the Department of Corrections. And what happens is the children wind up in Jamesburg incarcerated for what may be mental health problems, and we're very concerned about that.

This competition also is a tremendous barrier to effective program development. I think the issue about a needs assessment for these children is very appropriate. These kids in each of these systems have very similar needs. It's very expensive to treat them individually in each of these individual systems. Some coordination might be highly cost-effective in terms of finances, but also cost-effective in terms of what services are provided to these children.

We also have a concern about competition among adults in children's services. Several of these systems -- Corrections, and Mental Health and Hospitals -- are systems that serve both the child and adult population. And too often in the past the children's services have suffered because of that. They cannot compete with the need for adult services.

We feel that the time has come to really look at this coordination piece much more closely. Other associations have recommended the need for some cabinet level department or position to coordinate services. We would support that. That, however, will take a long time to ever be achieved in our State, and we feel that some leadership is needed to ensure that some questions are asked about who are these kids and where are they being served? That leadership can come from you as our legislative representatives.

I think we've become very cautious in terms of implementation because of other programs such as the Medically Needy Program and the REACH program; which sounded terrific on paper, which sounded terrific in the development, but not so terrific in the implementation. We are concerned about that.

I just wanted to say a brief word about the Department of Education. In looking at all of these systems, we have a concern that the Department of Education is not looking to treat children who are not academically oriented. If you are a kid who wants to go to school and has some academic focus, you are fine with the Department. If you're a child who needs some kind of services from the Department, who is not going to be able to be contained in the school system, you are not necessarily going to receive services from the Department. We have advocated for a long time on children who need educational services who are in detention and shelter facilities. I think this issue extends to children in residential placement and in the mental health system as well. Someone must hold the Department accountable for these children who are not within the norm of the academic achievers.

In terms of the aging-out issue, I think others here will address that more fully than I. We are very concerned about children who are in placement right now and need some services to transition out of what is a very dependent environment into independence. And this can be services from the basic needs such as housing, assistance to do job search, learning how to do self care, to helping to refer children to other systems that they may need as adults to depend on for financial assistance or some type of supervision. This is an area that has not gotten much attention, that we feel is very important. And, as in the mental health delivery system, some cooperation and coordination among the various State departments is essential here too.

Lastly, the issue of permanency is one that is very dear to us. When you look at children who are in residential placement, who finally make it into that treatment system, very often the treatment becomes the goal for the child and not what happens to the child afterwards. Permanency has been a very strong philosophy of the child welfare system. It's part of the foster care system. What's going to happen to this child? Foster care, for example, is not an unending placement for a child. We feel that that should go into the mental health system as well. Treatment should not be the only goal for the child, but some services to help that child reunite with his family, adjust back to his community, are also very necessary. Thank you.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: If I can, Mr. Chairman-- Cecilia, would you be so kind as to-- I know you were reading from notes there, but I know that you have the ability to prepare something. I would be interested -- not to take away from obviously the focus of the four of you, which is on the aging-out population -- if you could prepare something for me that I could use relative to Commissioner Cooperman's testimony before the Appropriations Committee. I'd like to be able to work on that.

MS. ZALKIND: I would be delighted. I think that's an issue we have been very concerned about. We started looking at this issue in terms of children in detention, because the Department -- our history of this is about eight years old -- the Department has a very small budget for children in detention. And these kids somehow are exempt from the State's thorough and efficient education law.

ASSEMBLYMAN FRELINGHUYSEN: And they shouldn't be.

MS. ZALKIND: And they shouldn't be. I'd be delighted to do that.

ASSEMBLYMAN FRELINGHUYSEN: Thank you.

MS. ZALKIND: It's touched upon briefly in our testimony, but we can follow up on it.

ASSEMBLYMAN FRELINGHUYSEN: Good. Well, thank you very much.

MS. ZALKIND: Thank you.

ASSEMBLYMAN FRELINGHUYSEN: I should also say, Mr. Chairman -- I know you want to move on-- One of the things that we hear today is the whole coordination issue. And I must say, all it does is aggravate me to hear that one division within one part of the same department appears not to be able to communicate with the other. It's not only Human Services. There are other departments that appear to be just as guilty. Thank you.

ASSEMBLYMAN COLBURN: Mr. Felice?

ASSEMBLYMAN FELICE: Thank you. I also think he has a valid point. I think we realize more than anyone else the departments have an internal competition sometime for achieving what we all would like to do, and that's help our people in the State of New Jersey, especially our children. That's a valid request, for Assemblyman Frelinghuysen to have those facilities when he works there with the Department.

MS. ZALKIND: I think that this Committee is always very impressive, because you have both a Committee and an individual commitment to children. I think it's very good to testify before you because you take the comments that come out in other ways. Good questions around legislation, and we appreciate that.

ASSEMBLYMAN FELICE: Well, one thing that we all have to consider, you know, one out of every five families have internally in their families either physical or emotional problems that we all, if we are fortunate right now not to have to address, then in our lifetime we might. We could all be on the other side of the microphone very easily.

ASSEMBLYMAN COLBURN: Mr. Fleischer?

J E F F R E Y F L E I S C H E R: Yes. Thank you. It's hard to follow Ms. Zalkind and Ms. Dondiego.

ASSEMBLYMAN COLBURN: True.

MR. FLEISCHER: I'll try to echo their thoughts and throw in a couple of curves perhaps.

I am the Director of the New Jersey Advocate Program which provides services to high risk youth and their families throughout ten counties in New Jersey. I am also a member of the Essex County Human Services Advisory Council, and a member of the Board of Directors of Independence Inc., which provides services to again our kids.

I believe the problem of children aging-out of the system is a result of the way in which we provide services to children in general. A large bulk of our resources, well over $100 million, is used to isolate children from community and family, while our neighborhood services are scarce and inadequate. As a result we have many children, 16, 17, and 18 years old, who are isolated, confused, unprepared, and are headed for the adult correctional system.

I would like to begin my testimony by describing some real faces and situations that may help to illustrate what is happening to a large number of children in our State. I will use initials for their names.

J was involved with the juvenile justice system at age 14. Classified as emotionally disturbed, he was truant from school, living in a small apartment with his single mom who was being abused by a boyfriend. At age 16, J's mom was hit by a car and killed. Then J moved in to live with his grandmother, illegally in her senior citizen apartment. He was forced out of school for his acting out behavior and was put on probation for drug possession. He then participated on and off in another school for two years. At age 18 he was forced to leave his grandmother's apartment, began to live on the street, was shot and wounded while walking at night, and today he is

homeless, unemployed, and about to be violated by his probation officer and placed in the county jail.

L was 14, homeless and begging in the hallways of a housing project. A crisis workers found him and got him to a shelter. From there he went from institution to institution, from foster home to shelter, and at age 18 found himself on the street, off the DYFS roles, alienated from his family, lacking life skills, motivation, and hope.

M was taken from her drug abusing mother at age 14 and put into foster care. She began running back to her mom and was placed in a shelter. She assaulted a staff member, went to a detention center, and to a State psychiatric facility, and finally to an out-of-state residential facility until she was 18. During this time no State agency worked with the mother, as if there was no treatment for drug abuse, as if no bond between parent and child ever existed. It is a State policy that once a child is removed from the home, the caseworker is no longer required to work with the parents. M returned to the community, 18 years old, confused, hurt, angry, and unprepared to live life on her own.

R, who is 18 years old, has spent his last two years in a temporary shelter designed for 30-day stays. He was placed in an independent program, acted-out, and was discharged. He was then rejected from other programs based on his problem with the one program. Shelter staff where he is staying now, however, view R as a cooperative, workable youngster. But no one is working with his mom who lives in various places nearby the shelter.

A spent two years in a residential facility, aged-out of that program at 16, and was subsequently rejected by every other facility, who cited his sexually acting-out behavior and low I.Q. He was placed in the detention center awaiting trial on a burglary charge, where he was given the wrong medication when his medication ran out. In the meantime, no worker has

visited his family in the past year. The State, which is focusing on placing A in an institution, has failed to do so, and has failed to develop an appropriate community plan. What treatment will A receive to prepare him for his 18th birthday?

K is now living is a detention center, simply because no one else will provide shelter for this borderline developmentally disabled young man, who was once involved with a sexual offense. He is 18 years old and no State or county agency has yet found a program that will serve him in an appropriate setting.

B is now 10 years old, and has been institutionalized at a State psychiatric facility for two years, even though her grandmother wants her back home and she wants to go home. No one has been working towards family reunfication. B will someday be 18 and age-out of a system that has actually increased the severity of her crisis by isolating her from her family and by not providing the family support when it was needed.

All of these faces that I have described happen to be poor, black, or Hispanic. Many of the youth from the poorest neighborhoods age-out into our correctional facilities. Almost all of the youth in these facilities are from a few urban areas, and approximately 80% are black or Hispanic. Seventy seven percent of New Jersey's adult inmate population are black or Hispanic. Most of our juvenile detention centers in our urban counties are filled at 150% to 200% capacity -- which is illegal according to our juvenile code -- with most of the youngsters being 16, 17, or 18 years old. Despite this crisis, the Youth Service Commission legislation, which would provide support to this population, has been delayed for probably over two years. Instead of these kids continuing in independent living programs, group homes, peer support groups, day treatment programs, partial or short-term hospitalization, work programs, many of these youth are aging-out of the juvenile justice system and into the adult correctional system.

How could this situation exist in 1988? One important reason is that our system does not value family and community when it comes to implementing policy. We have a State bias towards institutionalization. We spend millions of dollars on institutions when the real need is to develop communities of care to strengthen families and neighborhoods.

The cost of institutionalizing youngsters can be $40,000 per year, per kid. If we can envision for a moment using that dollar amount and spend it in the community on effective support systems for the entire family, we could keep the family together, develop services for aging-out youth, and still have dollars left over for or two other needy families,

Professor John McKnight of Northwestern University writes that, "Institutions exist at the expense of communities." Today DYFS spends over $66 million per year on institutionalizing youth. We must change our focus from isolating youngsters to a statewide effort at strengthening families and revitalizing neighborhoods.

We will continue to have youth who are not prepared for adulthood, who cannot read or write, cannot locate safe affordable housing, or obtain meaningful employment, or get access to needed mental health or support systems. We will continue to find the poor and minority youth are disproportionately represented in both juvenile and adult facilities. We will continue to expand our welfare programs and find more and more homeless families, pregnant teens, and increased drug abuse. To break this cycle, we must launch a prolonged coordinated effort to develop a continuum of care which is family focused and community based.

ASSEMBLYMAN COLBURN: Thank you.

MR. FLEISCHER: I would just like to point out too that the Canadian Mental Health Association has developed a really neat plan for mental health services. It may be used as a model for future times. Also, the Governor's Committee

report -- which was alluded to by Ms. Turner -- is an excellent document, which has not been published yet. It's been delayed in publishing for about a year and a half.

ASSEMBLYMAN COLBURN: Is the Canadian report available?

MR. FLEISCHER: Yes it is. I can send you a copy, Assemblyman.

ASSEMBLYMAN COLBURN: I'd appreciate your doing that. Thank you. Mr. Bord?

M A R S H A L L B O R D: I'd like to thank you, Doctor, the members of your Committee, and particularly your staff, for carving out this segment on aging-out within the context of the hearings on mental health problems.

Some of the problems of aging-out are very much related to the mental health issues that have been raised here, and people like Julie Turner and Mia Andersen have touched on them.

It's so hard becoming independent at 18 if you're normal, if you're healthy, if your family is intact, if you have all the good things and the nice things that probably most of us in this room share.

For somebody who has been in and out of home care -- which translates into foster care, group homes, or residential treatment centers, and teaching families, and shelters, and detentions -- and if you've been in three, four, five, eight, ten, twelve, fifteen of these different placements since you are five or six years old, when you turn 18 it's even harder to function as a self-possessed, independent, competent human being. The odds are enormous. That any of these kids who get their cases closed at 18 make it at all, is a wonder.

Approximately 10% seem to need little or no service when they hit their 18th birthday. For the other 90% -- and right now there are 7000 youngsters, active open cases under DYFS supervision who are age 16 and over, for these 7000 a significant number -- 50%, 75%, 90% -- are going to be able to

profit by some kind of assistance, some kind of services, when they hit age 18. For most of those youngsters, when they hit their 18th birthday or earlier, DYFS will close their cases. They will not be picked up by the adult system. They will not be picked up by the Division of Developmental Disabilities in the main, who have very very specific entrance criteria. As of today it's still, "You'd better have an I.Q. of 69 or less or we won't even look at your case." They will not be picked up by the Division of Mental Health and Hospitals, who tell me again and again and again, that unless this youngster is at risk of going into Marlboro or coming out of Marlboro, they can't handle it at this point in time.

Last night I put under my pillow -- at least figuratively -- a package of case studies. I'm not going to read them to you. I'm not going to even bother to reiterate them. There have been enough compelling stories given to you. They are youngsters in the program that I work with called the Transitional Opportunity Program, which is one of the few programs that does serve youngsters past the age of 18 -- under contract with DYFS, 17 to 21.

Back in 1985, I thought I had it licked. DYFS signed the contract, and I very casually went around to the then three directors of, DMR -- it was at that point in time -- DYFS, and Mental Health and Hospitals -- who at that point also happened to be a Deputy Commissioner -- and they all put their names on one piece of paper, which in itself I thought was probably nothing short of miraculous. I still have that piece of paper. They said that for those youngsters who come into this Transitional Opportunity Program and approach the age of 21, who are still in need of help, what were the other of the adult agencies -- meaning DMR/DDD or DMHH -- who would assume responsibility for continuity of service. It hasn't happened.

I keep sending, as this agreement calls for, packages of referral material on one youngster or another. All three Divisions -- DYFS, DDD, DMHH -- agree that this youngster at 18 or 19 or 20 or 21 needs help. And from DDD I get, "Well, we'll put him on the registry, and when we come up with our new evaluation criteria we'll reexamine that candidate then." Now these new criteria I hear are about to go into effect on April 1. Having seen the draft of these eligibility criteria, I would not be terribly sanguine about the prospects of most of these DYFS youngsters -- more than four or five or six percent maybe -- being picked up by DDD as being developmentally disabled.

Literally, I could produce the letters for you if you wish. I'm not getting any more letters from Mental Health and Hospitals because the last letter I got from them said, "Don't bother making any more referrals. We don't want to hear about it." It was signed by an officer in the Division of Mental Health and Hospitals. If you detect a note of anger in my voice, it's very real. Prior to this letter saying, "Don't bother to send us any more," I can literally show you packages where DDD says, "Give them to Mental Health." Mental Health says, "Looks like they're perceptually impaired, give them to DDD." And DYFS is saying, "Hey look, they're past 21. We've got to close the case. We are not legally mandated or funded to go beyond the age of 21."

A kid I've grown close to, I see them everyday, I have pizza with them on Friday night, whatever-- These are not statistics. These are viable, vital human beings, that we are in the process of tossing down the drain. They fall into the cracks. They disappear. And as my colleagues and others have said, they reappear. They reappear in prison. They reappear in our mental health hospitals for long-term care. They reappear on the police blotter, either as suicide victims or as perpetrators of a range of significant crimes. They show up

among the homeless. I've talked with the people who are running the Elizabeth Homeless Coalition, and casually asked them, "Hey, do you know how many of these--" Half the people who are homeless are kids. A significant portion of their parents were under DYFS or the Children's Bureau, as the case may be -- the Bureau of Children's Services, going back a few years. They appear. They cost us again.

And if we could provide some transitional services for them, at the very minimum -- as Cecilia has suggested -- housing, a decent place to live at age 18; the skills to get a job, because it's impossible to survive -- I don't care what your mental health may be, or your developmental disability may be -- if you don't have a job, if you don't have an income, you can't survive; and how to take care of yourself, how to travel, how to get to work, how to keep your apartment clean, how to relate to other human beings, about your sexuality -- because a number of these young women, at 17, 18, 19, are on the welfare rolls with one, two, three, four, five or more kids by the time they're into their early 20s. We pay for it. I think we would be happier, better off, more effective, if we paid some of this money up-front to develop new programs, additional programs, across the State, to deal with the problems of these kids.

I think no case should be closed until several things have been determined:

1) Does this youngster need help?

2) Does this youngster want to accept help? If the youngster doesn't want to accept help, at age 18 they're adults. They can leave. They can walk. You can't force them unless them you have them committed, declared mentally incompetent, or unless there is a court order involving some kind of adjudication.

For the rest of them, we should have, what are their needs, what are their problems regardless-- Forget the labels. What do they need? Do they need a place to live?

Let's help them get a place to live. Do they need job skill training? Do they need mental health counseling? Do they need long-term mental health care? Do they need to learn how to read? God knows how many kids I have encountered in the last few years who have graduated from high school, either mainstream or special ed, who are functionally illiterate or who are actually illiterate. They cannot read and write. I handed two of them a menu at Pizza Hut a week ago Friday, saying, "Hey, pick out whatever you want." It suddenly occurred to me as they sat there staring back at me, that they couldn't read the menu. So I said, "Try a number six. It's great," to get them off the hook. That hurts.

I beseech you to look at this problem. Today we're not going to answer it. Tomorrow we're not going to answer it. But if we don't begin to address this problem significantly -- not only a little program here and a little program there -- if we don't address this problem in a meaningful, systematic, comprehensive way, we will all be paying for it. These kids go back to every community in the State, and they raise hell in every community in the State.

For a kid who has been in residential care for 15 years, we have spent hundreds of thousands of dollars to take care of that kid. And at 18 we're saying, "Forget the investment, you're on your own Charlie. Go swim." Well, nine times out of ten, in some way or another, Charlie ain't going to swim. He's going to sink. And we're going to end up paying the cost for Charlie sinking.

I would like to add one more small piece about the availability of information. In 1986, the AMH signed a contract. Part of its contract with the Division of Youth and Family Services was to do an in-depth study of youngsters in the DYFS system, age 16 and over. That study was completed in July of 1987. As soon as the Division of Developmental Disabilities and the Division of Mental Health and Hospitals

heard that DYFS was funding a study through the private sector, they immediately contracted for their own study, so that three studies now exist, one in the hands of the Division of Developmental Disabilities, one in the possession of the Mental Health and Hospitals, the other, the pride -- I hope -- of the Division of Youth and Family Services. The one done for DDD has been made public. The one done for Mental Health and Hospitals, I don't know what the status of that report is. The one done for DYFS has not been released by the Department of Human Services. If it had been, copies would be sitting in front of you at this moment.

On that somewhat discordant note, let me end my, hopefully testimony, probably tirade.

ASSEMBLYMAN COLBURN: Thanks very much. Rod?

ASSEMBLYMAN FRELINGHUYSEN: I've heard Mr. Bord on a number of occasions, and I'm glad he's still at it. I'm not sure I would have the willingness to persevere, and I do appreciate it. If through the Chair, Mr. Chairman, we could ask staff to request from the appropriate divisions whether in fact those reports exist, and whether we could get a copy of them?

MR. BORD: They exist.

ASSEMBLYMAN FRELINGHUYSEN: Maybe that would be a good faith gesture on our part, that we'll shake a few people up to see if we could obtain them. I must say that it is incredible-- Well, the Department you didn't mention was the Department of Labor. Are you leaving them unscathed in this process?

MR. BORD: No, no.

ASSEMBLYMAN FRELINGHUYSEN: I suspect not.

MR. BORD: I have several soft spots on my head for banging it into DVR, both locally and at the State level.

ASSEMBLYMAN FRELINGHUYSEN: I hadn't heard them raised except by myself in earlier testimony.

MR. BORD: Then let me throw it into the pot for you, because they belong in the pot, along with the Department of Health, the Department of Corrections, the Department of Education, as has been said again and again. At this point I'm willing to settle for some cooperation within the Department of Human Services first. Let's get that inter-nation warfare ended, and then go on into departmental cooperation. I mean, if I were a representative of the Department of Human Services -- which is not a very likely occurance-- (laughter) I worked there once a few years ago, on a Federal-- (inaudible) -- I might add. If I were a spokesman for the Department of Human Services, and I was going to speak to Dr. Cooperman, or whomever in the other departments, and say, "Let's cooperate," I would be very leery or wary of the response being, "Get your own ship in order first, then maybe we'll cooperate." You can't even get your own three service Divisions, who provide direct care, to talk civilly to one another, much less cooperate. The energy level is, in part, spurred on by that kind of fragmentation. Thank you,

ASSEMBLYMAN COLBURN: Thanks a lot. Pat Devaney? Are you still here by chance? (affirmative response) Cape May, that's a long one. Are you planning to spend the evening in Trenton?

ASSEMBLYMAN FRELINGHUYSEN: Well, if you stay much longer Chairman Colburn will take you to dinner. (laughter)

ASSEMBLYMAN COLBURN: I've got to drive down to Virginia tonight. And you haven't helped a bit. (laughter)

ASSEMBLYMAN FRELINGHUYSEN: Now, you've been very good up to this point.

ASSEMBLYMAN COLBURN: I feel better now. I just said something.

Cape May County Department of Human Services Director.

P A T R I C I A A. D E V A N E Y: Is this working? (referring to microphone)

ASSEMBLYMAN COLBURN: That's just for recording. It's not amplifying.

MS. DEVANEY: Oh, all right. Good afternoon. My name is Pat Devaney, and I am the Director of Human Services in Cape May County. I will say I appreciate the opportunity to come to you and give you a local perspective in terms of planning that we see in our county.

I was rather relieved to see that I wasn't going to follow John Monahan because generally it's been our experience that when a county like Cape May follows a Newark or a Mercer County or a Camden, that our numbers look so insignificant that people really don't take them so seriously. What I'd like to really say though is that they are real, and they're very basic.

I think if you look at the mental health system as that patchwork quilt that was defined earlier, you would see that the southern part of the State is pretty threadbare when it comes to actual resources and what you can do in terms of minimal systems to deal with some of the problems that have been identified today.

What I'd like to do, because it is late, and because I think I have the longest drive out of everyone here home -- I'm not going to Virginia though, so you have a longer drive than I -- is really to skip to a couple of points that are in the testimony.

The one thing I would like to call your attention to is the screening legislation section. And really on page two you can see that we're facing the implementation of this mandate with six missing items: local inpatient, holding beds, outreach, supervised crisis, after hours psychiatric coverage, and clinical case management. In essence is a mandate that is almost impossible for us to even think about meeting without significant resources.

In addition to that, the summer population -- which obviously impacts our county quite a bit -- is also something that has to be looked at in terms of resources directed. I would probably say that the estimation of $210,000 in operations is probably one of the best deals the Division will be offered in terms of implementing this bill.

For residential services, again, I'd like to call your attention to the fact that we have a very basic bare bones system, one group home and three supervised apartments. We did do a survey with most of our chronics. We have 122 really hard-core chronics that we think will never work again and collect SSI. And 70 of those, or 58%, live with their families. This is reflective of a lot of what was said earlier in terms of the family plight. These people are 60 years old, and they cannot really take care of their child any more. It's my feeling that they have really done their responsibility as much as they can do by just even having a home for the mentally ill relative to return to. We as a system really need to look at those people and respond to them.

Our MICA population -- which is pleasant for me that I can say MICA and not necessarily have to describe it because everyone here seems acquainted with that word and what it means -- is high in our county. We have an addiction rate, generally, on alcohol and drugs, and it's spilling over into the mental health chemical abuser. We do find that, again, they live with their families, almost half of them. And when the family situation disintegrates, they end up in the homeless shelters or in jail. So we would like to do something about them. Unfortunately, they are so service resistant that case managers seem to be the reality for them, instead of a supervised residence with a strong substance abuse and employment component.

The other part that I'd really like to make a case for again is families. We have a family support group that is struggling, and those people really respond so well to psychoeducation. It also seems to me that there has to be some kind of initiative where every county is assured of having some kind of family support structure within it. The family group that Cape May County has also did strongly identify the need for drop-in centers and case management, the same as the Burlington County person identified.

For children's services, probably if I can say that our adult system is overextended and at capacity, I can see our children's system is nonexistent pretty much at this point. We really have no distinct children's service, not even a partial care program, at this moment. We are targeted in the new plan -- the $8 million plan -- to have one. The way we, optimistically perhaps, try to look at the children's plan is that it can only be considered a first step, and what it does do is build somewhat of an additional capacity regionally to deal with acute care. But what it doesn't do at all is deal with post discharge needs and reunification of the families.

What I tried to do is call DYFS and DMHH and try to get a better feeling of what was going on in the region. And you can see on page four, basically, items two and three -- which I really won't read, you can read yourself -- indicate the prevalence of what seems to be a need and the system's capacity to respond, which is drastically insufficient if you know anything about kids' services.

Locally we see the same. In FY '86 we admitted 30 kids to TRIS, which is RCCIS. We were the second highest county in the region, and that's from a relatively small county in comparison to Burlington's population and Cumberland's population. Camden was ahead of us. Many times we found this year kids couldn't get into TRIS and were stabilized in the shelter, and if it wasn't for the intense cooperative efforts

of Mental Health Services in essence sending over somebody to be on staff at the shelter almost overnight, we don't know what would have happened to those children because there was no placement for them.

We definitely do see a need for psychiatric services, and I think that was mentioned before. Cape May County is a psychiatric manpower shortage area. At this particular moment I think there are two places on the east coast -- us and North Carolina -- that still have that designation. So obviously we are in need of additional manpower, not even necessarily if we had the money could we purchase it. We need to attract psychiatrists to our county.

ASSEMBLYMAN COLBURN: Do you send acute care patients to Ancora then? Is that where they go?

MS. DEVANEY: Well, believe it or not -- and I think this is a real statement to what our county system does-- We have an emergency services system that sees about 500 people per year, and has the lowest number of admissions to Ancora. We admit about 60. And that's basically without very much -- an informal system that in my opinion, probably because it's rural, makes agencies respond to each other because they're the only game in town. And there's a lot more compassion for the client than I can see in other urban areas when I talk to my counterparts.

But we do need services. We need services to build on to make a base in order to keep that thing going. What I've listed there was a couple of recommendations that came out of my planning sessions for kids' services.

The one thing I would also like to mention is Cumberland and Cape May were targeted for the Family Preservation Program, which was known earlier as Home Builders. It's an intensive in-home, eight week, therapeutic, I guess, hands-on training with the family member and the youth. The purpose of it is to prevent placement. In our

county it's prevented 17 out of 22 placements, and it's been very successful. Even a three month follow-up has indicated that it has maintained that family from disintegration into placement. It would be my recommendation that that service be looked at to do reunification services, and be available to help train families to help adapt to their child when they come home from a residential placement or psychiatric hospitalization. I don't know if I can say that all of the families, at least in my county, are as wonderful as the woman who talked about her 10-year-old committing suicide, in terms of support. I think we have a lot of dysfunctional families that would really need assistance in trying to make an environment where a kid could survive again.

So, that's pretty much my statement. I don't know if anybody has any questions?

ASSEMBLYMAN COLBURN: Thank you. Rod?

ASSEMBLYMAN FRELINGHUYSEN: I just have one question, Mr. Chairman. On page one you gave an extent of need section, where you cite a document from the Division which gives some statistics. In addition you made some reference to some statistics -- number two and number three on the last page. You've been able to obtain those statistics from the Division. Reference was made earlier to this whole ongoing question of a needs assessment. You would agree though, very much so-- In other words, some people appear to have statistics. And I'm not quite sure. Could you sort of--

MS. DEVANEY: I think the problem is in definition.

ASSEMBLYMAN FRELINGHUYSEN: Definition?

MS. DEVANEY: What is an SMI? What is a seriously mentally ill kid and what is a residential placement, and are we talking the same population? I think that's seemingly where it breaks down between DYFS and Mental Health. I also do think that the southern region in terms of children's services is uniquely blessed because about ten years ago someone had the

wonderful idea of having our CCIS non hospital based. So the DRG pressure to discharge within 28 days is not on that service. It's directly paid for by the Division to the tune of about a million dollars a year. But what it does do is allow the child to get the appropriate placement and not look for the next place to send the child because in essence it's running out of money. That is probably a very costly alternative, but one that has worked really well in our region.

ASSEMBLYMAN FRELINGHUYSEN: But school-age children -- and maybe you can answer this, maybe there are others, there may be others, I put the question out just to have it on the record -- school-age children though, as they enter the school system, assuming that they are able physically and mentally to do it, certainly fall into at present the categories that are established by the Department of Education, even though there is thought of maybe having three instead of twelve. Isn't that correct? I assume that those statistics must be available.

MS. DEVANEY: I know that they are in my county. But again, I really honestly have to say one of the advantages of a county like mine is that people talk and people live next door to each other. It really works to be able to get the figures that you need to plan a system. Statewide, when I hear the massive systems issues that are expressed here, it makes me happy I have two hours to drive and a nice beach to return to at times.

ASSEMBLYMAN FRELINGHUYSEN: Yes. All right. Thank you.

ASSEMBLYMAN COLBURN: Thanks a lot.

MS. DEVANEY: Thank you.

ASSEMBLYMAN COLBURN: Pat DePalma of the Communication Workers of America, Local 1040, AFL-CIO?

P A S Q U A L E D e P A L M A: I guess we could say good evening now, instead of good afternoon.

ASSEMBLYMAN COLBURN: Almost. Almost.

MR. DePALMA: I heard the three gentlemen, when we first opened, from the Department of Human Services paint a rosy picture about which way the Department was going. As a staff representative of the Communication Workers of America Local 1040, I represent primary and higher level supervisors, clerical, and professional employees -- including doctors and nurses within the institutions. I, myself have worked 30 years in one of those institutions. I believe that has enabled me to become quite familiar with mental health.

It kind of saddens us all that the conditions at our public psychiatric facilities today are a tragedy. Ironically, Human Services has evolved into an inhumane machine which has trapped clients and mental health care employees into its grip.

This situation has not always prevailed. In years past, we had a more effective system of mental health. The roots of our current situation may be traced to the implementation of a social model, versus the older and more effective medical model. The administration of clinical services were in the hands of physicians who had direct contact with the clients.

The concept of deinstitutionalization brought about disastrous effects. The physicians in charge of our institutions realized that discharge into the community for the majority of patients was extremely ill-advised. Unfortunately, the physicians were forced to leave the system and administrators were brought in who were willing to accommodate for the system's approach. The administration of the social model lacked clinical expertise, and did not heed the insights of their predecessors. Numerous clients were discharged and let out on the streets to fend for themselves, despite their active disabilities.

Meanwhile, New Jersey spiraled into the trend we witness today, the spirit of social approach. It is very much alive with respect to not permitting mental health professionals to do their job.

Administrators are more concerned with passing inspections of regulatory agencies. Therefore, approximately three months before an audit team's arrival, our institutions are in a frenzy to uphold an image that quality care is being provided. Large expenditures of funds are allocated for overtime in order to compensate for a desperate lack of direct service personnel. These overtime expenditures, in combination of high salaries paid to the overabundance of middle managers, bleed the facilities' budgets. Staff from other institutions, who are not familiar with the patients, are also brought in to portray a facade of proper staffing levels.

Employees are given contradictory messages. They are expected to write reports and complete paperwork to meet regulations, yet later they are reprimanded for sitting in their offices and not interacting with clients. This is, by far, not the only example of impropriety. State workers are required to work under extremely poor and punitive conditions. When inspectors are anticipated to arrive at a facility, approved vacations are canceled. Disciplinary actions at some facilities run rampant in order to shift the responsibility of blame to the worker. Employees are suspended and wait months for a hearing. When employees file grievances, management identifies them as troublemakers and unwilling to do their job. The Department of Personnel has developed a performance assessment and review system to monitor and improve job performance for State employees, yet high ranking officials of our hospitals and the departments are precluded from scrutiny. Inept administrators are not disciplined for their inefficiency or incompetency. Instead, they are transferred back to the Department and retain exorbitant salaries.

We do not witness shortages of staff and meager salaries within the central office of the Department of Human Services in Trenton. Yet, institutional employees have to work in unsafe, overcrowded, and in dehumanizing environments.

Professional staff are coerced to comply with unclear policies, designed by management dictators to promote a "cover yourself" mentality. An example of this lack of direction is evident via the hands-off policy. Workers are instructed in the use of restraint and physical intervention techniques, yet, legally mental health personnel are not permitted to apply these methods. Therefore, they are placed in a "Catch-22" situation. If two clients are involved in a physical altercation, staff is in jeopardy of discipline if they intervene. If they adhere to the hands-off policy, they are chided for not intervening. Indemnification against legal suits or malpractice insurance is not afforded to professionals. Thus, further fostering a fearful, paranoid atmosphere which contributes to a posture of inaction.

We need State hospitals to serve our citizens with quality treatment and care. Community placement is not a panacea. If community placement is to be successful, the prerequisite is a good foundation to build upon within our institutions. How is a client to react when warehoused with up to 60 other peers, then discharged into the community where they are expected to adjust with no preparation? Proper transition measures are not instituted and a dire need for structure is answered with more chaos. Staff positions in the budget are constantly juggled throughout the State. This must stop.

Structure and continuity of care need to be guaranteed at the top levels of government. The care of our disabled and needy should be taken out of the political arena, which is subject to frequent administration changes.

CWA has attempted to offer its aid in beginning to resolve these grave problems. However, our pleas have fallen on deaf ears. The Department of Human Services is a self-contained system that has not been held accountable, and allowed to run amuck. The recent hearings at our psychiatric

hospitals were held by the very same leadership who maintain the status quo. Thank you.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Mr. DePalma, where did you work?

MR. DePALMA: I worked for 30 years at Ancora, sir.

ASSEMBLYMAN FRELINGHUYSEN: I was a little bit confused by your statement on page three and I quote, it's the first real paragraph, "If two patients are involved in a physical altercation, staff is in jeopardy of discipline if they intervene."

MR. DePALMA: Yes.

ASSEMBLYMAN FRELINGHUYSEN: "If they adhere to the hands-off policy, they are chided for not intervening." What does that mean?

MR. DePALMA: Okay. For instance, if two clients are in an altercation, and I intervene, and one of them should come up with a bruise or should happen to bump into a wall and get hurt or something, there are many many cases that I have seen that they are charged with abuse of clients. Simply because there is a mark on the client, an incident report must be made, and somebody pays the penalty for it. So the HSDs and the HSA and the nursing department, at Ancora and other institutions that I have been to, are very reluctant when it comes to interfering with client activities such as that.

ASSEMBLYMAN FRELINGHUYSEN: So you're basically saying that as a result of this--

MR. DePALMA: You're damned if you do and damned if you don't.

ASSEMBLYMAN FRELINGHUYSEN: Well, what I'm asking is that in most cases the staff doesn't intervene? Is that what happens?

MR. DePALMA: No. I'm not saying that at all. I think in most cases the staff does intervene, but there's

always the thought in their mind, "Am I going to be charged if this--" For instance, if it happens to be two young ladies, and I intervene and should happen to throw my arms around one and my hands get in the wrong place, and I am charged with -- you know. It's a very precarious situation, and does happen.

ASSEMBLYMAN FRELINGHUYSEN: Okay. Thank you.

ASSEMBLYMAN COLBURN: When did you leave Ancora?

MR. DePALMA: I left Ancora the 15th of January of this year.

ASSEMBLYMAN COLBURN: Of this year?

MR. DePALMA: Yes.

ASSEMBLYMAN COLBURN: I'll be darned. I was their first dermatologist in 1956 or '57, when they opened just about.

MR. DePALMA: I went in September of '55, sir.

ASSEMBLYMAN COLBURN: How about that. Well, we have something in common. Okay.

ASSEMBLYMAN FRELINGHUYSEN: Youth shall be served,

ASSEMBLYMAN COLBURN: That's us.

MR. DePALMA: That's when Dr. Brunt was the Medical Director, right?

ASSEMBLYMAN COLBURN: Yeah, sure. Harry Brunt.

MR. DePALMA: Thank you, gentlemen.

ASSEMBLYMAN COLBURN: Thank you. Richard Bundy? (no response) Is Richard Bundy perhaps no longer here? (no response) Mr. Kalaman, Mr. Vincent, or Mr. Adams, have they survived? (no response) Does anybody else want to say anything? (no response) And now we have free time.

I declare the public hearing ended. Thank you.

(HEARING CONCLUDED)