
Public Hearing

before

TASK FORCE FOR THE REVIEW OF THE TREATMENT OF THE CRIMINALLY INSANE

LOCATION: Morris County Administration
and Records Building
Morristown, New Jersey

DATE: May 13, 1997
3:30 p.m.

MEMBERS OF COMMITTEE PRESENT:

Senator Robert J. Martin, Chairman
Assemblyman Anthony R. Bucco
Ralph R. Rotando
Daniel P. Greenfield
Lily DeYoung
Carolyn Beauchamp
William H. Thomas

ALSO PRESENT:

Alan G. Kaufman
(representing William Waldman)

Richard S. Cohen
(representing Deborah T. Poritz)



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Senator Robert J. Martin
submitted by
Debra L. Wentz, Ph.D.
Executive Director
New Jersey Association
of Mental Health Agencies, Inc.

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lmb: 1-88

ROBERT J. MARTIN (Chairman): We're killing a little time only to make sure that all of our members get here, but let me make a couple preliminary remarks.

This is a Task Force which was organized at the request of Governor Whitman, and we were charged with looking after the issue of security for those patients at psychiatric hospitals in New Jersey. The official title of the Task Force has a more sort of, I think, a general name, the Task Force on the dealing with the treatment of the psychiatric insane at the psychiatric hospitals. Our origin really springs from the fact that there was a Senate task force last year that did a lot of work coming from some of the problems that were here at Greystone Hospital, which is only, I'd say, three miles as a crow flies from Morristown, right? Is that about right, three or four? I jog in this area, and I'm pretty good at distance-- Maybe it's three and a half, but it's not much more than here from downtown Morristown.

We had had hearings all last year-- Introduced a series of nine pieces of legislation. One of the cornerstones of that legislation dealt with the security issues at Greystone. It wasn't just at Greystone, but it was based upon some of the problems that had come up with Greystone. We had been concerned about the number of incidents in which employees had attacked patients, patients had attacked patients, patients had escaped and threatened the community-- Were a series of issues that were threatening to both other patients, employees, and the neighboring communities.

Since I live in Morris Plains, which is in part of the grounds of Greystone is on, I was just drawn into this the last 25 years just by sort of osmosis. But it is more than that. This particular Task Force grew out of one

of the pieces of legislation that I alluded to earlier. After studying the issues involving Greystone -- we were, I say we, the Senate Task Force, last year had issued a series of recommendations. Among the recommendations was one particular piece of legislation that dealt with security. That piece said that there should be, in some cases, separation, separation of those patients who we could determine from their past history were dangerous. That they should be separated from the other patients out of Greystone, out of Marlboro, out of Ancora, out of Trenton Psychiatric Hospital, and any facility of the State of New Jersey. From that, we were moving legislation.

Now, of our total package, we've had several bills passed by the Governor. This particular piece we were asked to not to go fast-forward with until there was a secondary look at. That secondary look involved primarily issues involving legal issues and questions of public policy about whether separation was really in the best interests of the patients, as well as the community, and whether under U.S. Federal constitutional guidelines and even the State, with its prior history as far as legal issues, whether we should do this. We were always advised that there was a standard that said that we should look at what's in the best interest of the patient, and we should have the least-restricted environment. These are standards which get into very fine point law as to whether it's Federal, whether it's State constitutional issues. But, generally, I think most of our Task Force agrees with that. We don't want to see persons subjected to some kind of confinement which is greater than what it should be. On the other hand, we have to counterbalance that with the issues of protection of the community.

The Governor asked for a Task Force. She asked me to serve on the Task Force. I didn't ask to be Chair, but she asked me to be the Chair. So I am serving in that capacity. We had an organizational meeting in February. Since then, we've had a meeting in March, which was held at Forensic Hospital in Trenton, and in April where we held a meeting at Ancora, which is further south than many of us ever knew was there. It's a long ways down. I guess it's in Camden County. I thought I had crossed into Georgia, but it's different in its whole confines. It was very different at least for many of us in the way that they had developed their kinds of-- The way their population was treated. We will have a third meeting scheduled at Greystone in a couple of weeks, but we wanted to have a public hearing.

I commend Assemblyman Anthony Bucco who said we should have a public meeting. We should have it in the midst of our hearings so that we can take some testimony and think about any issues that may be developed as we go along. That's what this meeting was scheduled for. We had talked about having it on April 30. We delayed it a couple of weeks to try to get out notice to as many groups as possible to come forward and testify.

The issues that we are dealing with in this meeting are essentially the security issues. I've got to stress there are other issues. Since yesterday and even last week, there are other issues that are important to me and important to many others that may or may not be dealt with today; although, I would ask, since we do have a panel of persons who are familiar with almost all the issues at Greystone and the other psychiatric hospitals, to comment on those issues.

There are two principle ones, and I think they are fairly obvious, but I'll just say them. Yesterday there were reports -- well, it was in today's paper, but it was issued yesterday officially -- from Greystone the fact that they had not received accreditation. They had received preliminary nonaccreditation from the accrediting agency, which is not a Federal accrediting agency, but in which they are empowered to review the psychiatric hospitals and, upon their review, the ability of Greystone to receive Federal monies is virtually depended upon.

Greystone gets approximately \$40 million of their \$50 million funding from the Federal government, and if they did not receive accreditation, there could be a serious problem with this Hospital and sort of, I would think, an overview of what might have to happen with the hospitals generally in the State. That is of primary concern to, I think, everybody who is on this Task Force, and we can talk about it, as well as perhaps many other people in the room.

The other issue -- I asked Senator Codey to come, and I think he will -- is a bill that he and I had sponsored which is not directly related to this, but it is associated, and that deals with the problem of patients and their treatment regarding AIDS and hepatitis at hospitals. We had, in our Senate Task Force, submitted a bill that said that all patients who were incoming at Greystone and all the other psychiatric hospitals would have to receive a test for AIDS and hepatitis B and C. We felt very strongly that this was something that was important for other patients and employees to provide them with protections at psychiatric hospitals.

We had testimony, and I know there is a woman in this room, a doctor, who gave testimony who said that in the psychiatric hospitals there is, as much as we want to avoid it, there is patient contact, sexual contact. There's also situations where there's violence and where there's blood spilled between patients. And given that, we think it's important as a lifesaving measure that those persons should be protected.

I was extremely disappointed that the Governor vetoed this bill. She said in her veto message, which was issued last Friday, that she felt that it wasn't-- I don't want to read words, I'll just tell you what I think she said. It wasn't as serious as we had thought because most patients aren't serving that long in these psychiatric hospitals, and they should be allowed to provide their own consent. I disagree. I know there are others who disagree with me on this Task Force -- and this is part of a public debate -- and my feeling is, if even most patients only are at psychiatric hospitals from 30 to 90 days, that doesn't solve the problem. In fact, if they are only there but-- They could become victims themselves and then subsequent carriers to others outside the community, to them, and to others.

I just think that this type of environment is one where we need a heightened protection for those who are patients and those who are employees. I'm not convinced that employees should use universal precautions. I think it's human nature that people act more carefully when they know what exactly the life-threatening circumstances are. I think these are truly life-threatening circumstances.

The other issue that gets involved in this is whether there's a question of informed consent. The Governor would prefer that there should

be informed consent. You should ask the patient or should ask their family members before they should be admitted whether they want to submit to AIDS and hepatitis testing.

My view is that if somebody who is being subjected to being confined to Greystone or other psychiatric hospitals is not in a position to be able to make an informed decision. I mean that's the very reason they're being committed.

Those are two huge issues that have just come out this week. Just to repeat, we have the question of accreditation and we have the question of AIDS -- the veto of the AIDS and hepatitis testing. I think they sort of flow into what this Task Force is doing, although, not directly to the extent to which some of these questions, however, give comfort. As far as whether a facility like Greystone, a facility without walls, without fences, continues to exist in a manner it does is to me, I think, something that we should talk about and possibly consider recommendations.

Going into this, I was predisposed to feel that Greystone did not provide enough security for dangerous patients. There's a lot of different dangerous patients. What we've learned through some of our previous hearings is that not everybody who's-- The two types that we had looked upon as being considered dangerous are those persons who are considered not able to even go through a criminal process, because they're considered not able to be able to go through a criminal proceeding. The other ones are those who would otherwise be convicted, but they have a defense of not guilty by reason of insanity. So we either have those who cannot be given a trial because it's

judged preliminarily that they are not competent to stand trial or that those who do stand trial but raise a defense of not guilty by reason of insanity.

There are others, of course, who are dangerous. Some of those may not be considered dangerous by other peoples' standards. There's been some data which has been handed to this Task Force, and I know the Task Force members, we've talked about this rather significantly, data that may suggest that some of these patients -- the ones who can't stand or who are not permitted or don't have to stand trial or determined not guilty by reason of insanity -- are actually some of the brighter people and actually make model patients. At least, that is what some data has suggested. That needs to be sort of ferreted out as we go forward.

The point is that some of the data the hospitals have suggested that some of the more dangerous people are not necessarily typecast, if you will, by those two categories, but rather just based upon an individual assessment of their categories. The other thing, and I'll close because I've overspoken already, is I was astonished about the differences at Ancora as opposed to Greystone from what my previous experiences have been and my investigations and review of Greystone and Ancora just about looking at the facilities.

For those who are interested in this topic or issue, I can't stress-- I think you have to see the different facilities. But one of the things I was struck by at Ancora is that, I think, there was a higher standard of maintenance and sort of quality. I don't mean to begrudge Greystone, which is going through enough, but the more important issue was the question of security. It was clearly a heightened measure of security by those who were designated

in those two categories which I just have indicated. They are confined to a particular area. And though they may be given privileges which are the same supposedly as Greystone, nevertheless, they are continued to be confined to a security facility which is much different than Greystone. When you have to go through two sally ports, when you have to go through security yourself as an Assemblyman or a Senator or others and also look at the kinds of protections given, it's a slightly different feeling about the comfort level which has been raised at that facility.

I think that sort of, not in a nutshell but in a long-winded statement, gives you some update about where we are. This is the public portion. We wanted to invite, at least, the public to participate in our discussions. Before we do that, I would ask, since I hogged the floor here, Task Force members, if there is anyone who would like to speak at least at this time before we take the public.

Tony.

ASSEMBLYMAN BUCCO: No, Senator. I think you've said it all as far as I'm concerned, and I have to agree with you, the difference between Greystone and Ancora. I think we were all-- Our eyes were opened as to what can be done, and I think that's what we're here for, to listen to the people now and see what else can be accomplished with these hearings.

SENATOR MARTIN: We have our Division Chair--

MR. KAUFMAN: Oh, I agree, I'd like to hear the public testimony.

SENATOR MARTIN: Lily.

MS. DeYOUNG: Absolutely.

SENATOR MARTIN: Councilman Rotando.

MR. ROTANDO: I agree with your statement very much. I have not seen Greystone, but I will very shortly.

SENATOR MARTIN: We plan to have our last meeting in Morris County at Greystone, so we cover the three major institutions. We have not had an official tour of Greystone. I have many times. Going back 15 years ago, as a councilman in Morris Plains, I know Greystone. The Task Force will get a chance to look at Greystone, and I'm sure it will be in the best condition that I've ever seen it, but nevertheless, we still want to compare and contrast as we go along.

That being said, we are going to start the public testimony. So let us begin-- Mayor Letts, we'll get to you second. There was a time constraint on the prosecutor, John Dangler. So I would allow him to speak, and then we'll get to the Mayor of Parsippany, where Greystone is located.

I also want to say that the Attorney General's Office cannot be here. There's an emergency meeting. I'm also told that the *Abbott v. Burke* decision will be out tomorrow. So I think that's what's going on over there.

JOHN B. DANGLER, ESQ.: Good afternoon. For the record, John Dangler, Morris County Prosecutor. I'm joined with the testimony this afternoon by my Assistant Prosecutor, Thomas Kritchley. Tom currently serves on the Security Council. He's been on the Council for almost four years. Prior to that, we had other representation by detectives and other assistant prosecutors.

My comments will be brief, and basically it's more from a law enforcement perspective. We, of course, share in the concerns in the police

departments that are represented here today and any changes that would affect the security or safety of the citizens who live in the neighboring communities that surround Greystone. I think, in fact, there are almost four or five communities that technically border the properties of Greystone.

I can indicate that we've seen a great improvement over the last few years as far as the reporting of incidence to our office. For directives both from our office, as well as the Attorney General's Office, certain incidence must be reported to the prosecutor's office within a certain period of time. We have seen a noticeable increase in improvement in that area in the last couple years. Whether that has been fostered because of the inquiry that this group has made or just basically better handling of the situations, but we're on top of things a lot quicker now than perhaps in the past.

We have also seen and have enjoyed a very good relationship with the Department of Human Services Police Force. Every time when there has been an incident that they had reported to us, it was prompt, it was professional, the manner in which they secured the scene. We did have unfortunately some suicides in the recent year or two. Everything was done very professionally, and I have no negative comments whatsoever about the police force up here. Everybody does their job. We have recently-- Of course, every time there is an incident, per the directive, I believe, from the Governor, the Governor's Office has been notified which is slightly different than it was in the past, but we've enjoyed a good relationship in that regard.

I'll ask Tom Kritchley to make a few comments based on his experience on the Security Council and some of the things that he would like to add.

THOMAS KRITCHLEY, ESQ.: My experience-- I guess my appointment to that Council came about because I actually have had occasion to litigate a lot of insanity defenses in the context of various serious crimes. When it became time for somebody from our office to be sent to the Security Council, they selected me because they said, "You know about the Krol issues at least on the court side." And I have to say that it's certainly a different--

SENATOR MARTIN: Tom--

MR. KRITCHLEY: Yes, sir.

SENATOR MARTIN: --just by clarification, we've all learned about Krol. Krol is a named defendant, I think, in a case, and Krol generally means that somebody who is not guilty by reason of insanity. It's a type of case which is of great concern to this Task Force because those are persons which we have sort of inherently deemed to be very dangerous. It also, in some cases, will mean those who are not able to stand trial because they're deemed to be not capable. And there may be even others. But generally it means not guilty by reason of insanity, which is also referred to as NGRI in its technical fashion, known in New Jersey as Krol.

MR. KRITCHLEY: Right. We run into both in our courtrooms here in the county -- both persons who are deemed by the courts to be not competent to stand trial or, after litigation, after a jury verdict, or a court decision, not guilty by reason of insanity. I can tell you that a lot of the folks that have gone-- A lot of the defendants who have gone that route over the years have been people charged with very serious crimes. That's when a defense attorney will go that path. They're not going to claim insanity in a

case where the stakes are low in terms of the incarceration. It's going to be in the serious rape or murder case. So, obviously, it's always a serious issue.

Our experience with Greystone has been that by and large the specific Krol detainees have been held reasonably secure, but there are constant concerns obviously on the part of the community and law enforcement that persons who have committed an act -- and I can think of one double murder that I know many members of this Task Force are familiar with -- although they have been found not guilty, that does not mean that they're not dangerous. So the prosecutor's office obviously has a high concern with that.

I would have to say that, in general terms, over the years Greystone has done a generally competent job and there has been some improvement. But it's a constant tension between the rights of the patient -- because that's what they become, patients, when they're Krol patients -- and the security of the community. That's just an overview over 15 years. I would say that the institution has done better recently, and there's obviously room for improvement.

If anybody has any questions about specific cases or specific experiences we've had, I'd be glad to answer them. But that's my impressions, and I'd be happy to answer any questions about any specific matters.

MS. BEAUCHAMP: When you say that there is room for improvement, can you describe a little bit of what you mean?

MR. KRITCHLEY: Well, there are always situations where persons will elope or escape and it's--

SENATOR MARTIN: Elope means to be off the premises without permission.

MR. KRITCHLEY: Right.

SENATOR MARTIN: Escape is--

MR. KRITCHLEY: Escape is a little bit higher level of breach of security. And whenever that happens, there is a potential danger to the community even in someone who is not a Krol patient, if they are just committed involuntarily on other grounds.

I'm not really an expert in the internal workings of Greystone. We deal with it more from a law enforcement perspective. The thing I'll comment on is I think it helps and I'm very happy that we've had a chance to be on the Security Council because ultimately the issues have to be resolved sort of jointly between the legal jurisdiction and the clinical jurisdiction. I try, when I know something about an individual, to communicate it to the appropriate persons, and I know that Greystone has tried to communicate to us. In fact, one specific thing that has been done, when there is an elopement or an escape, there's a little bit quicker notification to the surrounding communities than there has been in the past.

I don't think that the task will ever be done, because Greystone or any similar hospital is always going to have a very difficult task obviously of dealing with these folks. But I just don't want anybody in the public or anywhere else to lose heart. I think forces are being brought to bear on it. My experience as an Assistant Prosecutor is that in 1982, when I started, it was much worse than it is in 1997. Now, that doesn't mean that we can let down. I am very happy that this is taking place. But if there has been some improvement-- In the mid 1980s, when Prosecutor Trumble was in office, it was almost a standing joke in our office that periodically we were going to have

to investigate Greystone and police them from the outside in. I think with the activities of many of the people here it's changing and internally with Greystone to where they are willing to police themselves.

These are, again, comments from somebody who's been in a very particular perspective. That is a prosecutor sending people into that system. I don't have the entire perspective, but that's just my little slice of it.

MS. BEAUCHAMP: So speaking from-- If I can extrapolate from what you're saying, I'm hearing two things. One is that you're finding over the last maybe 15 years that there's more safety and security going on within the Hospital and, also, the communication between the community and the Hospital has improved to a good degree.

MR. KRITCHLEY: Right. I'll be direct on this point. When Mr. Waters, I believe it was, was in charge of Greystone, that was probably a high watermark in my experience in terms of communication--

MS. BEAUCHAMP: No pun intended?

MR. KRITCHLEY: Yes. No pun intended. That was very open I thought and much more so than it had been in earlier years. To some degree, I was sorry that he moved on to another position. But, again, that's the administration that other people are responsible for. But there has been progress made over the last decade and a half, and that's the perspective that I have.

MS. BEAUCHAMP: Thank you.

SENATOR MARTIN: Tom, when I sort of got involved in the mid-1980s and we created the Security Advisory Council, which I think has gone on and has become more sophisticated since then -- I know Ralph has

chaired -- there was no contact between Greystone police necessarily and the police forces outside of Greystone when there were elopements or escapes, however you want to define those issues. I always thought it was to some degree a self-protection mechanism--

MR. KRITCHLEY: Right.

SENATOR MARTIN: --the less the public knew the better. On the other hand, there were a couple serious incidents, going back even then, where public protection, I thought, was put at risk because the Morris Plains police -- which is where the bus station and the railroad station and where, if you came down the hill from Greystone, guys would likely to go -- or Morristown for that matter, which is even a bigger transportation hub-- But since, I think, that has been put in place, maybe you could comment on this -- and Councilman Rotando -- I think there's been, at least for all the other problems at Greystone -- there's pretty good communication. And even though there's a couple times where they haven't done what they're supposed to, and that is, give immediate notice to Morris Township, Parsippany, and Morris Plains, and maybe even Denville, and I not sure exactly the hub of that area-- Yet, it's been pretty consistent as far as giving notice to the surrounding communities.

MR. KRITCHLEY: Right. You remind me that anecdotally, a high-ranking law enforcement officer from one of the surrounding communities was telling me that when he started as a patrolman, people would just wander around the communities almost at will and without very much consciousness on the part of the local police departments, etc. It's changed in his view very much from that time. Anecdotally, nobody really kept close

statistics, but I believe that kind of testimony comes to me in my role as a prosecutor. That's one of the reasons I think it has improved in many ways in the way that you observed. We record the elopements and the escapes a lot more religiously now than they were in the past, and people may become more aware of them. But I do think the efforts to make it a secure area are yielding some results.

SENATOR MARTIN: The related issue-- And I would ask, Prosecutor Dangler, is the incidents which are internal-- There's some understanding that there's supposed to be at some level directed to the prosecutor for at least some independent review. That's one of the things that we discussed with our Task Force about having because of the sort of human nature aspect of trying to contain stuff so there's not bad publicity but rather to at least have a review by the prosecutor's office. What is your feeling about how Greystone's done--

MR. DANGLER: So far, as I said earlier, I think there's been a substantial improvement over the last couple of years. Many times there's a situation in which there is a death that may not be what it appears. It may not be a suicide. It may be something other than a suicide. As I said, most cases we're alerted as quickly as possible. We've had a couple of cases where-- I remember an individual hanged himself, and the individual was reported missing from where he was supposed to have been. We were alerted fairly quickly. Unfortunately, by the time we found the person, it was some distance, still on the grounds I believe, but some distance out in the wooded area. He had hanged himself, but I think we were notified as quickly as

possible. As Tom mentions, that was not the case going back a number of years.

So they're right on top of things. Internally, many of the incidents involving a patient committing some type of assault, if you will, against another patient -- every now and then we do run into cases with employees, but most of the time they're patient against patient -- quite frankly, usually you find both of them are really not competent, so it's very difficult to find out whether it was a consensual situation that occurred or somebody perceived something that wasn't there. So it can be very difficult. But we are alerted to any type of serious assault. If there is a little scuffle in the hallway or something like that, obviously they are not going to alert our office, but suicides, sexual assaults, things of that sort we are alerted to.

One of the concerns we have, too, is you have a procedure internally -- back on Krol patients -- where I believe from time to time they're assessed and a judge actually makes a determination as to whether what level of security that patient receives. If they've been there for a period of time and there seems to be really very little to be concerned with, as far as safety to themselves or to others, they're given a lot more freedom. Our concern would be that we really don't want to tamper too much with that. Or some of these people do get a day pass from time to time and get out of that and get into the surrounding community.

So our concern would be that we are not letting somebody out that might have a potential to cause some harm to the citizens in the area. We haven't seen that, but that would be a concern from law enforcement standpoint, that there not be any changes in that area. Sometimes when you

have an increased population, things have to be rearranged, if you will, and allow some of these people perhaps a little bit more freedom. So that would be a concern from law enforcement standpoint. But we have seen a good reporting of the incidents.

Fortunately, there are not very many of them. In fact, they seem to have actually dropped off, I would say, in the last year or so. We've seen less and less activity. I have to attribute that to all the various people that are involved making the improvements.

SENATOR MARTIN: Thank you.

MR. COHEN: May I ask a question?

SENATOR MARTIN: Yes.

MR. COHEN: Prosecutor, is there any information that you know to show whether or not Krol patients are more, less, or equally dangerous to other patients or to the public?

MR. DANGLER: I don't believe so. I don't know that we have any studies, if we were to look back over the last few years of the incidents which were reported to our office -- the nature of that patient. Whether that patient was in there as a Krol patient or simply was a patient who had some sort of mental illness, not committed a crime, and while inside committed some kind of an assault, I don't know that we have any of that information.

Tom?

MR. KRITCHLEY: My impression is, and I don't have a statistical abstract, is that it is true that a Krol patient generally would pose more of a danger to the community than a non-Krol patient. The reason I say that is, a Krol patient is someone who has committed an act -- an antisocial act,

a criminal act, and has been found not guilty by reason of insanity. It would seem to me that just that fact alone would establish that that is a more dangerous population. That doesn't mean that someone who is clinically diagnosed as being an antisocial personality but has not yet committed a crime or been caught for one isn't dangerous. But by and large, I would say, the Krol population is more dangerous.

SENATOR MARTIN: Tom, that's one of the things that was brought up to us is that there are, in that same sort of class of dangerous, persons or people, because they've frequently been in settings like Greystone, they may have committed acts which would otherwise have been criminal in nature, but they're not always prosecuted.

MR. KRITCHLEY: Sure.

SENATOR MARTIN: So that there are a number of persons who committed violent acts, but they don't reach that status of Krol patients only because they've been institutionalized--

MR. KRITCHLEY: That's--

SENATOR MARTIN: --or in some way not protected, but sort of--

MR. KRITCHLEY: Sure. If someone commits a violent act against a family member, that family member may say, "Don't prosecute them, hospitalize them." But in effect, as you point out, they have done the same act as someone else who may thereby become a Krol patient. So it's kind of a gross generalization, but to answer the question, I would say in general Krol patients would be more dangerous than your average patients.

SENATOR MARTIN: Thank you.

MR. THOMAS: May I ask one question?

SENATOR MARTIN: Yes.

MR. THOMAS: My question is with your studies and your knowledge over the years as to the operation of Greystone, and we understand now the operation is improving as far as Krol patients and other patients, and so forth, but do you feel that Krol patients and similar patients with previous violent acts should be treated and retained in an open facility such as Greystone?

MR. KRITCHLEY: If I could, I actually have a strong opinion on that. I'll say this. I would prefer myself and as an Assistant Prosecutor in this State that there not be-- Let me say this. The way we deal with insanity is not to have not guilty by reason of insanity, but guilty but insane. Now, that's not on the menu for this group or for us. So that would be my first preference.

As far as the different treatment, I think as was pointed out, there's constitutional issues at work there. When somebody is Kroled, they're not guilty. Those are limits. Now, if I had my druthers, I think my vote would be for the safety of the community as opposed to necessarily giving effect to the rights of the individual. But that's a constant tension, and we're never going to resolve that. I don't know if that's--

MR. THOMAS: Well, I don't know--

MR. KRITCHLEY: --resolves the question, but that's my perspective.

MR. THOMAS: Thank you.

MR. DANGLER: Thank you.

SENATOR MARTIN: Thank you.

We wanted to ask Mayor Mimi Letts, from the Township of Parsippany-- We should point out that Greystone is virtually, although there's little bits of property outside, but the Hospital itself is entirely within the township. When we were talking about security issues, especially going back to the 1980s, some of the more serious problems were between the Greystone police and the police of Parsippany, who were charged with protecting the whole township. And yet, this was sort of like a separate place within a place. I think there's been improvement, and I know you have Deputy Chief Dowd here today with you, but we wanted the Mayor to speak.

Thank you for coming, Mayor Letts.

MAYOR MARCEIL LETTS: Thank you, Senator.

As you said, I'm only going to speak for a moment, because Deputy Chief Dowd is here with us, and he's been a member of the Security Council for a lot longer than I've been Mayor. But I would say that one of the first things that I did do after being elected was to request a tour of Greystone, which I did take with our Chief of Police, to try to get some understanding of the security issue there. It was fairly obvious to me, although I certainly don't presume to be an expert in law enforcement or security, but it was obvious that Greystone was never designed to be a secure facility for people with dangerous criminal backgrounds. It is our contention that Greystone is a hospital and that that's what it should be kept as.

I want to say something that-- This is not a typical not-in-my-backyard discussion on my part. I've lived in Parsippany for 30 years, and I don't think that I've ever heard anyone there complain about housing the Hospital. There are many people in our community who will

volunteer to Greystone. I just saw Ruth Riker come in. She serves as a member of the Board of Trustees. And, in fact, I think that we're, in Parsippany, proud that we have Greystone there. Mental hospitals are an important part of our social fabric.

However, in the past several years, the number of escapes, the number of elopements is not in any way reduced even though there have been attempts to improve the security. The communications have improved greatly. What that does is give us the ability to notify the neighborhoods which are adjacent to the Hospital, all of which have set up neighborhood watch committees, by the way, so that when we get notification that an elopement has occurred, it could be potentially dangerous. We notify the neighborhood watch committee. They then notify all of the people in those neighborhoods to be aware of it. So that the communications are working very well. I just don't really feel that the folks who live in those neighborhoods should really have to be subject to the kind of fears that they have when these folks do elope. And the elopements, no matter what has been done in the past couple of years, continue to occur all the time, the last one when somebody pried open a window. They're able to do it fairly simply.

I'd just like all of you to take that into account, that we're not necessarily saying to get rid of the patients with criminal backgrounds, but I would like you to at least make it secure if it's the decision to leave them there.

Thank you very much.

SENATOR MARTIN: Are there questions for Mimi?

MR. ROTANDO: No. No. I don't have a question for Mimi.

Thank you, Mimi. I'm sorry.

Maybe as a point of clarification, the prosecutor, Mayor Letts, and ourselves have made reference to the Security Council. Just for the edification of the audience, the Security Council is a separate group, aside from this Task Force. The Security Council is comprised of public officials, law enforcement, and the prosecutor's office, as well as members of the Greystone staff. It's a group that holds regular meetings four times a year, two being the general sessions and two law enforcement.

Prior to 1990, there probably were meetings held at Greystone, but they were as needed, so to speak. And in the early '90s, there was a need to have regular meetings with regular groups of people so that we could discuss the security problems, and that's what the Security Council does. It still is enforced, and it still meets to this day. As a matter of fact, we had a meeting just last month. Several members-- Mayor Letts, Chief Dowd, Chief Scherzer, Ruth Riker, and myself are members of that Security Council, as well as the prosecutor's office. So I just wanted to explain what the reference was when we keep talking about Security Council. It pertains to Greystone, in this case, only.

SENATOR MARTIN: It's a good segue to introducing Deputy Chief Dennis Dowd, from Parsippany Township. Well trained, I may add.

DEPUTY CHIEF DENNIS P. DOWD: Thank you. Good afternoon, Senator, and members of the Task Force. I'd like to thank you for giving me the opportunity to be here today and be heard.

I've been a police officer in the Township of Parsippany for 25 years. I've been on the Security Council committee at Greystone, that Councilman Rotando just spoke of, since 1991. I believe I'm going to echo

some of what's already been said today, but I think some of it needs to be restated.

Conditions at Greystone on a security level have gotten better over the years. I tracked the number of elopements and escapes from the time I got on the committee, and there were improvements made. The Security Council would sit a meeting, and we would discuss possible remedies when we would review the figures on how many people have escaped or eloped. And there were recommendations made about locking, increased awareness of staff, security screens, fencing, removing certain shrubs and trees which provided cover where people didn't get brought back inside, and then they had the opportunity to remove themselves from the grounds.

Reporting has gotten much, much better. I think part of that is due, in fact, to technology. It seems to me that the fax machine was the greatest gift to all of us in law enforcement for notification of elopements and escapes at Greystone. But the community-- The police department and the community, as well as the administration of the township, still has concerns.

Our Puddingstone section of the township, as Mayor Letts has stated, we're very concerned. There had been incidents in the past that involved them. Someone escaped from Greystone, got up to Puddingstone Heights, and broke into a garage and stole a car to help them make their escape.

We're not in the situation, I don't believe, that Morris Plains is because it's a lot easier to walk downhill to get to Morris Plains than it is to walk uphill to get to Puddingstone Heights. So we can thank geography and topography for that. But it does happen, and we have community concern to

the point that I advise the people of Puddingstone Heights that we would work out a notification system for them, which is very difficult for police.

When you get into individualized notifications-- If we did that with every area of town that has an endemic problem, we would spend our whole careers on the telephone making notifications. But I felt it was that important to allow this one exception to the general rule, where we notify their contact person and in just through like a daisy chain, I guess with what you would do with school closings, this person calls this person, calls that person, and down the line. Then, we conversely notify them when that person has returned or been apprehended.

These people have always been good neighbors, as the mayor so well stated. They're not complaining about Greystone. They're complaining about these legal-status patients getting out, and that's frightening to them because they have school-aged children. They want to know when their kids are going on the bus or getting off the bus that they're safe.

Our community is also growing. When I first came on the police department, that area of town had Puddingstone, and that was about it. Now it's -- Powdermill South has grown to large proportions. We have also additional planned growth in that area, I believe it's called Glenmont Commons. So there's more people.

SENATOR MARTIN: I think so.

DEPUTY CHIEF DOWD: Whatever it will be. More people means increased probabilities and possibilities.

Another concern of the police department, as well as the community, is we had discussed back in I guess it was December of 1996, I

think it was our December 12 meeting. There was some general discussion that took place about Marlboro. With Marlboro closing, Greystone was scheduled to inherit some of their beds. By doing that, it was also scheduled to inherit some of the legal-status patients, and when I say legal status, I'm including Krols, ISTs, which have been discussed. And the percentage -- I did some rough figuring as I sat there that day listening to the staff of Greystone. You could see Greystone population going down. I think that day the population was at 574. They had said that they would be going down probably to about 450 beds with outsourcing patients who could be released from Greystone into community health care.

If they do that and if we inherited the projected number of increased in Krol, IST patients, just through my calculations that day, we could see a rise in percentages from 20 percent of the total patient population being legal status to 33 percent. I'm not sure on the numbers here. I'm not a statistician, nor am I a staff member of Greystone, but if that happens, that is going to, just by sheer nature of occurrence, increase the potential and possibility of more dangerous patients getting off the grounds.

SENATOR MARTIN: Dennis, just so you're aware, one of the things this Task Force has been told -- this is no secret -- that with treatment of the types of persons who are now committed long term to the psychiatric hospitals, be it Ancora, Marlboro, which is in transition, or Greystone, is changing. The more benign patient, if you will, is being moved out into community type of settings. So that there is sort of a tougher segment, maybe not violent, although I think that percentage has increased as well, but there's a hard core which are in need of much stronger treatment are staying in with

Marlboro closing. Greystone is getting a-- Just like Ancora in the south, Greystone is getting the same kind of population. So it's a different mix, the number of patients who are not as severe both in terms of their treatment and maybe their violent tendencies.

I mean, I'm right on that. Right, Alan? We've talked about that.

MR. KAUFMAN: Yes.

SENATOR MARTIN: Call it what you will. With drugs, those patients who are able to take drugs and function in the community are being-- That's our goal to move them out into community settings.

MR. KAUFMAN: If I can, it's a very complex kind of issue. The hospital system-- All the beds are going basically from 2300 and some down to 1730 as a result of the Marlboro closing. In effect, what that effect is, is that those people who don't require a hospital where they can be diverted from the need for inpatient services or can leave the facility are occurring. And those who are going into the hospital, a large proportion are there for shorter periods of time. But there is a larger number of people, as you have said, Senator, a larger proportion, but not in total numbers of individuals, who are some of our longer stay patients.

So individuals who have legal designations, as Mr. Dowd is indicating, would represent a higher percentage of the population across all hospitals but not that drastic an increase in the total number of such patients across the board. It's that everybody else who doesn't need to be there are moving out.

I don't know if that clarifies it or makes it more confusing.

DEPUTY CHIEF DOWD: Perhaps I was unclear. The way I had understood it, if you had 107 legal patients out of 574 population, it would give you a certain percentage. If the downsizing of beds through outsourcing occurs, the way I was led to believe, and I could have misinterpreted or could have misheard, but I thought it would be approximately out of the 450 beds, 148 of those would then become legal-status patients, which would represent not only a real-time figure, but also an increase in percentage.

Be that as it may, I think that's part of the reason we're all here today and part of the reason why the security committee at Greystone meets to see how we can improve it, how we can add to it, and continue to make the system better. That's the goal, I think, of everybody concerned.

My own personal feeling is, I think, with the most dangerous of patients, if a provision could be made or if standards could be changed or laws enacted that would enable those people to be put in a central location, I would favor that. Not to say I don't favor the clinical and aggressive clinical treatment of people with mental health problems, but I think in the needs of the community and in the public safety interest, I think, we may all be better served. I hope that can be accomplished. If it can't, then I think we all have to continue working together to make Greystone a more secure facility for those people who are classified patients.

Thank you.

SENATOR MARTIN: Chief, would you want to be advised if a Megan's law patient of the more serious type, Type 3, was being transmitted to Greystone? Right now, there's no obligation of the State to advise any of the surrounding communities about Megan's law patients, even those of the --

most of what we would consider a dangerous type. Would you want to know that?

DEPUTY CHIEF DOWD: Absolutely, Senator. I think there was a big hubbub created in just what you're speaking about on the Security Council. I think Ralph will remember where it was discussed. "Well, what do we do about Megan's law patients?" And the way the law is currently structured and the challenges and the appeals to the law as it exists-- There are many parts to the law. I don't think it's just a one-law type. It's many components to the law. That can't be done at this point. If that can be changed and if the challenges that exist to Megan's law can be overcome, I would welcome that type of notification. I know our community would.

MS. BEAUCHAMP: Could you help me sort out a couple of things?

DEPUTY CHIEF DOWD: I hope.

MS. BEAUCHAMP: At this point, my understanding is that anyone who escapes from the Hospital, you're notified about. Is that correct?

DEPUTY CHIEF DOWD: Correct.

MS. BEAUCHAMP: Whether they're innocent by reason of insanity, not guilty by reason of insanity, or simply a patient who happens to have a mental illness. I guess one of the things that puzzles me is, if I were living in the area right around Greystone and I thought there was someone who had escaped, it wouldn't matter to me whether they had committed a crime or were simply escaped and were mentally ill. If I knew if someone had escaped, I think I'd be just as worried in either instance. So I'm a little confused about why there's a distinction being made about-- We're worried

about these people who are -- may have done a crime versus someone else who may have escaped. And maybe it isn't versus, maybe that's where the confusion is.

It seems to me that in general what I hear from communities is, we don't like the idea that people whose behavior we can't predict, and you can't, may be on the loose and are not being supervised, and that makes everybody really anxious and uncomfortable. So I'm not sure why the distinction, except that we're talking about the criminal issue today. Is that where we're coming from?

DEPUTY CHIEF DOWD: The distinction with our Parsippany Police Department's notification to the Puddingstone Heights area was the sheer numbers. There were so many elopements that I just couldn't have our offices and dispatch people making that number of calls. And what it would have been like is alert them, unalert them, alert them, unalert them. So I had to bring it down to a reasonable parameter. There's a lot less escapes and elopements of Krols and ISTs than just general elopements of patients that are there for whatever it may be, whatever mental health reason that have not been deemed to be dangerous or a threat.

MS. BEAUCHAMP: So you notified just for the ones who are Krol patients?

DEPUTY CHIEF DOWD: Just for Krol or ISTs or even if a detainee patient. Now we go into another area--

MS. BEAUCHAMP: Right. Right.

DEPUTY CHIEF DOWD: --that some people may not be aware of. A detainee patient is, I understand, is someone that's come from a facility

that's a prison or a county jail and is sent to Greystone for a review. Maybe they acted out at the jail to get out of there, and they figured they'd rather be in a State hospital than be in the county jail.

MS. BEAUCHAMP: So do you have a sense of what the percentage is in terms of escapes of patients versus escapes of Krol patients?

DEPUTY CHIEF DOWD: No. But I can give you some gross figures.

MS. BEAUCHAMP: Could you guess?

DEPUTY CHIEF DOWD: For example, during 1994 there were 204 elopements. Of that 204, and I only tracked Krols back then -- I guess as time has gone on I've gotten a little more sophisticated with my tracking-- I'll bet of 204 elopements, 5 were Krol patient escapes. So the notifications significantly diminish when you eliminate that whole elopement population, and I only notify the people as to what we perceive--

MS. BEAUCHAMP: As more dangerous.

DEPUTY CHIEF DOWD: --as a danger to a community.

SENATOR MARTIN: I don't know if this helps, but having lived in Morris Plains, which is down the hill instead of up the hill, we knew people from Greystone who literally eloped a lot, who left the grounds. I'm not sure, maybe in some cases, they had permission. I don't think they did. But regardless, there were people that you came to know who were from Greystone who were benign, who were people that -- that's okay. They wanted to walk along the sidewalks. It's a nice spring day. There's not a problem.

There is a difference between that type of patient, and you know eventually they'll wander back onto the grounds or maybe they understand

what they're doing. I mean, my family, we identify people as-- We knew different ones. A Krol patient is a slightly different context or, as you say, detainees, who may be even more threatening in some cases, who are maybe persons who are smart enough, at least anecdotally, we were told who would know that their best chance of trying to avoid prison was to somehow get detained over to Greystone, have a period of psychiatric evaluation, and because they didn't have the ability to provide much or at least as good a protection, if you're going to make your escape, that was the place to do it.

MR. COHEN: Chief, did I understand you correctly that out of the 200 and some elopements, 5 were Krol patients?

DEPUTY CHIEF DOWD: As my figures indicate, yes.

MR. COHEN: Okay. I just wanted to make sure I heard--

DEPUTY CHIEF DOWD: And that was 1994.

MR. COHEN: Okay.

Of the other, roughly, 200, do you know how many of them had been judged dangerous to others, and that's why they were involuntarily committed to Greystone who had eloped also?

DEPUTY CHIEF DOWD: What they used to do and what they still do is, although the forms have changed, they would check off certain information on the fax that they would send us whether or not the person was a Krol, an IST, a detainee, or just an involuntary commitment. What the percentage would be of that number that were, I don't know. I didn't track that.

SENATOR MARTIN: Chief, they now have four levels, at least that was advised to us. Are you aware of that classification, Level 1, 2, 3, or 4?

DEPUTY CHIEF DOWD: Then there's levels of privileges you're speaking of, Senator? There's Level 1 through 4, I believe, 1 being the most highly restrictive down to Level 4 which is the most liberal with the freedoms that that patient enjoys.

SENATOR MARTIN: Are you advised of what level privileges they have?

DEPUTY CHIEF DOWD: We just brought that up at our last meeting. They redid the fax sheet that we get, F-A-X, fax sheet, and they omitted that, and I have brought that up at our last law enforcement meeting of the security committee. And I believe it was Lieutenant Brady of the Greystone police who is going to attempt to correct that so that we have that information. I considered that, at the time, important information for us to have.

SENATOR MARTIN: Well, in some ways, that's our own internal classification system of the dangerousness of the patient, because Level 4 means they have freedom to roam. Whereas, Level 1 is a highly restricted environment, regardless of our outside classification. That's our own internal classification.

MR. ROTANDO: I think again for clarification, Senator, when we discuss things at the Council meeting, we generally refer to elopements as people who have just wandered off and probably have ground privileges. There's also an elopement where a patient has been out on a pass and doesn't come back on time but may be a half hour late. There's a reporting factor there, and they become a statistic. That doesn't mean that a dangerous person has run loose. The word escape has generally been referred to the other

security type person, maybe one or two, who has forcibly gotten their way out of Greystone. So the elopement category should be brought back, and we've discussed this because whether it's right or wrong, we don't feel this is that much of a dangerous situation. Because, generally, what it is, is just a patient who has privileges has either returned late or has wandered off the grounds. It could very well be a lot of them -- be three and four levels -- which have pass privileges without escort.

SENATOR MARTIN: Are there any other questions? (no response)

Thank you.

DEPUTY CHIEF DOWD: Thank you.

SENATOR MARTIN: Next, Charles Goldstein. Thank you for coming up to this area.

After Mr. Goldstein, who is the representative for AFSCME, will be Dr. Louise Riscalla.

CHARLES GOLDSTEIN: Thank you, Senator, and we'll be brief. As our testimony and our concerns are not dissimilar to the prior investigation that was conducted a couple of months ago, AFSCME, the American Federation of State and County Municipal Employees, represents most of the frontline staffers, the HSTs, the HSAs, at Greystone and other hospitals.

We are gravely concerned with the impact that the ill-advised closing at Marlboro is going to have on the community there. We think that Marlboro needs to be either not shut down at all or it needs to be extended out in such a way so as to have the minimal impact on Greystone. We hope that that will be seriously considered. With regard to--

SENATOR MARTIN: By the way, Chuck, you can talk about Ancora as well. This--

MR. GOLDSTEIN: Yes.

SENATOR MARTIN: We tend to focus a little bit more about Greystone because of where we are, but this is statewide, and I want everyone to understand that this is a statewide Task Force issue.

MR. GOLDSTEIN: I appreciate that perspective, Senator, and that reminder. And again, the comments that I might make inadvertently about one institution, of course, would apply to all of them, too, since they are an integrated, organic system.

We feel that whatever ultimate decisions are made the most important procedure that needs to take place for the community-at-large, for those who are there because of a mental illness, and for those who are there because of a Krolnal act wherein they've been placed pursuant to that -- in all of their situations, one of AFSCME's primary concerns is the concern that should occur statewide and community-wide, and that is, the woeful inadequate training and staffing at these institutions.

With regard to some specific situations, and we'll be very brief, Anna Sutton, who is the President of the Local there, will briefly comment on some of the situations, understaffing, and some of the cottages they're building.

SENATOR MARTIN: Anna, just so we understand your position and title, you will tell us.

A N N A S U T T O N: My name is Anna Sutton. I'm President of Local 2216 at Greystone.

You were talking about the security at different systems. We have improved a whole lot. We have bells on our doors -- on our cottage doors -- that we didn't use to have before. People could walk out, but you couldn't come in, and our patients could walk out. That's not happening anymore.

We have greatly improved with the Krol building with the camera. You just can't walk in those buildings anymore. You have to be admitted into those buildings. A lot of things have improved.

SENATOR MARTIN: When you say the Krol building, are you talking about Able? (phonetic spelling)

MS. SUTTON: No, at 10 Ellis Drive.

SENATOR MARTIN: Ellis, okay.

MS. SUTTON: It's a special building, but you do need more staff in there. You need more staff in that building. That building is the least-staffed building in the Hospital, but the security measures have improved. But we still need the staff because of the patients there. I think that we were told a long time ago that you're supposed to staff according to the patients' needs and diagnosis, not to the number of patients on the ward.

So I'm saying that we need more staff in these buildings and more training for these patients.

SENATOR MARTIN: We're working on that one.

MS. SUTTON: Well, I hope to be here to see that you really carry it out because Greystone's been getting the bum rap these last few days and these last few months. We really don't deserve that, because we are very hard-working people, dedicated people, and we don't deserve what's been

going on in the newspaper and different places. And this nonaccreditation, that's terrible, too. We don't deserve that.

SENATOR MARTIN: Questions?

MS. BEAUCHAMP: I just wanted to ask one thing. You mentioned the 10 Ellis Drive. Does it house only Krol patients?

MS. SUTTON: Yes.

MS. BEAUCHAMP: And it's a locked, secured building?

MS. SUTTON: Beg your pardon?

MS. BEAUCHAMP: It's a locked building?

MS. SUTTON: Yes, it is. It's very secure, but we still need more staff inside the building on different shifts. I can't even get in there. Truthfully, I tried to get in there the other night, and there was nobody to let me in. I guess they didn't want to see me come in (laughter) because I come in with a lot of stuff. It is very secure.

MR. THOMAS: Let's keep this simple.

MS. SUTTON: Beg your pardon?

MR. COHEN: Are all the Krol patients in that one building?

MS. SUTTON: Yes, in 10 Ellis Drive.

MR. COHEN: Without respect to their behavior--

MS. SUTTON: It's the Krol building. You have three floors for the Krol patients. We have Krol patients in other places, but most of that is for that building.

MR. THOMAS: How long have you had a Krol building?

MS. SUTTON: Oh, jeez. It's been quite a while. I can't remember.

MR. KAUFMAN: About seven years.

MS. SUTTON: I'm losing track because I've been there 31.

SENATOR MARTIN: That's something that I didn't know. I didn't know that there was a building--

MR. COHEN: How does it differ from the other buildings?

MS. SUTTON: Well, it's a very, very secure building, I mean with the locks, with the cameras, and everything else. It's not a building that you just walk in and out of unless you're really staffed there at the administration.

MR. ROTANDO: Insufficient staff, there's less staff there?

MS. SUTTON: But there's less staff. We need more staffing there.

MR. ROTANDO: But you did specify that there are Krol patients in other buildings at Greystone, correct?

MS. SUTTON: That's according to what the judges order. If the judge orders that they can go to another building, then that's it.

MR. GOLDSTEIN: Obviously, if that is exclusively for Krol, there is a more serious concern that is occurring there. And while the security measures may be adequate or may be better in terms of protecting the public as they have in the past, the security of the workers there is also a legitimate concern. One of the ways to ensure the security of the workers is by having increased staffing. That security would also transfer into the other patients who are specifically in that Krol unit. As Ms. Sutton indicated, the theory is supposed to be based not just on plain numbers, but based on the severity of the situation. Considering that it's exclusively a Krol building, I think that speaks quite directly to the fact that there is a need for more staffing there

than in other buildings not left even with the increased security that exists there.

MS. BEAUCHAMP: Are the patients there-- Do they leave for their activities in other buildings, or do they stay right there in that building?

MS. SUTTON: I know that when they have to go to court, they're always escorted. We call the police, and they take them to different places. Everything is predicated upon what the judges orders for them. It's not like we have a treatment team and we decide what happens to that patient. It's what the judge orders.

MS. BEAUCHAMP: Are they ever escorted to something that is going on in a different part of the Hospital, or do they just have to stay there?

MS. SUTTON: No, they're escorted to different places. If the judge says that they can be escorted out, they're escorted.

SENATOR MARTIN: It better not be an escape.

MR. GOLDSTEIN: Sorry.

ASSEMBLYMAN BUCCO: Does that Krol building have a perimeter fence around it, security fence?

MS. SUTTON: Yes, it is fenced.

ASSEMBLYMAN BUCCO: Completely around it?

MS. SUTTON: On the sides, on the sides where the patients go out.

SENATOR MARTIN: Thank you.

MR. GOLDSTEIN: Thank you. I appreciate it, Senator.

SENATOR MARTIN: Dr. Riscalla, who will be followed by Ruth Riker and waiting patiently.

LOUISE MEAD RISCALLA, Ph.D.: For present purposes, I have been on the staff of county and State facilities for over 30 years. A large part of my work has been in the forensic area. I was on the staff of Greystone Park Psychiatric Hospital as a clinical psychologist for 13 years where my experience included the evaluation and treatment of patients with a Krol type of commitment.

SENATOR MARTIN: And you're a psychologist and you've been retired since--

DR. RISCALLA: I'm retired, but I've been retired to an active life, so to speak, because I really feel a strong sense of responsibility as a professional and a taxpayer to share with you my experiences with hopes that it may benefit all concerned.

It has already been stated what a Krol patient is, so I don't want to be redundant on that. I think the difficulties such as escape, assault, rape, larceny, and so forth, in all the psychiatric hospitals are largely due to the Krol and all other involuntary civil commitments. I have reasons to believe that these involuntary civil commitments are archaic, abusive, punitive, countertherapeutic, and extremely costly to the taxpayer. They also perpetuate pathology. For example, an individual with command hallucinations who hears voices ordering the person to kill can be released to the community, thereby placing everyone in danger of being murdered. There is practically little or no concern for staff members injured by patients on the job, and other victims and their families who can experience severe physical damage and psychic trauma for the rest of their lives.

I feel that the Krol type of involuntary civil commitment and all other civil commitments should be abolished. A person who commits a crime can be under an involuntary civil commitment and not be under a Krol commitment. The type of commitment is determined by a judge.

The Krol patient has all the rights and privileges of other patients. So a patient could have on- and off-ground privileges, overnight, weekend, or longer stays in the community, be placed on a coed unit, unlocked ward, and so forth. As a consequence, the patient has the opportunity for acting out behavior such as rape, suicide, escape, assault, infecting others with AIDS and other sexually transmitted diseases and hepatitis B, larceny, and so forth, thereby jeopardizing the safety and health of other patients, staff, and the community.

The Krol commitment also interferes with treatment. For example, in my experience, when treatment was focused on helping patients accept responsibility for their crime and to face and deal with it -- I had this in group therapy -- a number of patients told me that they didn't really have to because they weren't guilty of any crime due to their civil commitment. The patients believed that because they were found not guilty meant that they actually did not commit a crime. Consequently, it is difficult or impossible to help them realize and admit to a crime which is an important part of treatment. The Krol and other involuntary civil commitments often creates a conflict between clinical treatment issues and public policy, particularly exemplified by the current one involving *HIV* and hepatitis B patients in psychiatric hospitals. I've already made my comments in favor of that kind of testing.

SENATOR MARTIN: Thank you.

DR. RISCALLA: The Krol and civil commitments are adversarial. On one hand, you have the patient who is represented by a lawyer or a public advocate. On the other hand, you have the psychiatrist who is there representing reasons for commitment. The patient goes before a judge who decides whether the patient should be continued in hospitalization or be discharged. The patients at these hearings are exposed to discussions and arguments regarding the extent of their pathology, often and in very graphic details and gory at times, so that the judge can make a determination concerning continued hospitalization and discharge. The patient is sitting there while everything with a lot of personal material and everything about them pertaining to the case is heard in public. I don't think this is very helpful to the patient and can interfere with treatment because the patient, by appearing before the judge and in this type of setting, is then treated as a criminal.

In order to be discharged, a patient-- It has to be proven by the State, who is represented by the prosecutor and psychiatrist and other members of the treatment team can be present-- After you've proven that the patient is not a danger to self or others-- If you want to keep a person in the hospital, you have to prove that they're a danger to self and/or others; otherwise, they have to be discharged. If you can't prove dangerousness, then the patient must be released in the community.

As a consequence, an individual can actually get away with murder. Newspapers have frequently carried accounts of former mental patients who have committed murder and other crimes. It is likely that many of these crimes could have been prevented by the need to prove dangerousness

by the court as a criterion for continued hospitalization or for discharge. All patients with an involuntary commitment including Krol are under the jurisdiction of the court. Treatment decisions are actually made by a judge who may or may not agree with treatment decisions made by a psychiatrist and/or members of the treatment team. As a result, for example, this psychiatric patient is perceived as a criminal and the hospital a place where a patient serves a prison sentence with treatment as part of fulfilling this sentence. Patients have told me that they are there to do time. So it is difficult to convince patients that they are in the hospital for treatment, especially if they must appear before a judge to determine whether or not they should remain hospitalized or be discharged.

I'm going to date myself. Before the Krol type of involuntary civil commitment, an individual judged by the court as committing a crime by reason of insanity was sent to a psychiatric facility for treatment until they're considered competent to stand trial. Patients were under the jurisdiction of a psychiatrist, medical doctor, who is still legally responsible for the care of the patients. It is a doctor who made all decisions regarding admissions, treatment, and discharge, which is also done when an individual is admitted to a hospital for a physical illness. The individual was perceived as having an illness and was hospitalized for treatment until the psychiatrist, a medical doctor, discharged the patient as competent to stand trial. The patient was then placed under the jurisdiction of the court upon discharge.

Krol challenged this based on double jeopardy of having the person undergo two trials for the same offense. As a result, an individual was judged not guilty by reason of insanity and then placed under a civil commitment.

Actually, the person did not have to stand trial for their crime, because they were already judged as not guilty by reason of insanity. So a person who committed murder, they never ever had to stand trial for that murder under a Krol commitment. This double jeopardy then places the person whose offense is a symptom of mental illness in a legal contest with court jurisdiction and legal intervention. As a result, placement in a psychiatric facility is considered as imprisonment which, I think, is very archaic and outmoded.

Individuals who commit offenses such as murder, assault, rape, larceny, and so forth, are not the same as patients in the general population of a psychiatric hospital under civil commitment and are in need of specialized treatment provided in a forensic facility. People who commit crimes by reason of insanity and others who commit crimes as a manifestation of mental illness should be placed in a State forensic hospital for treatment until they are found competent to stand trial. When found competent to stand trial, the person should then be discharged and placed under the jurisdiction of the court to be tried for their crime. By so doing, everyone will be protected.

I might add that there are people who are so sick and so disturbed that they can never ever be discharged to the community. I'm talking about serial killers. I'm talking about people who are sociopathic. I'm talking about individuals who are so distraught with a combination of illness, especially patients with neurological impairments whose crimes are manifestations of the neurological impairments, I don't think these people should ever be released.

SENATOR MARTIN: Dr. Riscalla, should they be separated?

DR. RISCALLA: I'm having trouble hearing.

SENATOR MARTIN: Should they be separated if the extent to which they are kept in some facilities they have to be separated from the general population?

DR. RISCALLA: Yes. As a matter of fact, it was a desire of some of the Krol patients to want to be separated from the regular population because they said that when they were in the regular population, they were called names such as killer, murderer, and the other patients were unhappy with them there. It was very difficult to treat them under those conditions and also to treat the other patients. Finally someone went along with the patients and said, "Okay, you can have your Krol unit." But then, on the other hand, I don't think that the Hospital had enough room to accommodate all the Krol patients. So that's why, I think, that they really need specialized treatment.

The hospitals should focus and zero in on the treatment so that they can hopefully get better. I would hope for the day where intense therapy could be done with this population. I don't think it can be done if you keep these patients in a general population. I'm not talking about a punitive side, I'm very treatment oriented. I've been committed to helping patients, not hurt them. I see that in many instances the system has compelled us to hurt patients.

SENATOR MARTIN: Questions for Dr. Riscalla? (no response)

MR. THOMAS: Thank you, again, for your testimony.

DR. RISCALLA: Mr. Thomas--

SENATOR MARTIN: Are there any questions? (no response)

DR. RISCALLA: --I enjoyed working with you. We were on separate sides of the fence, but I can assure you that even though we were, and

we were in an adversarial position, we were very much concerned with the patients. So from a legalistic standpoint, I can understand the legalistic perspective.

SENATOR MARTIN: Thank you, Dr. Riscalla.

DR. RISCALLA: Right.

SENATOR MARTIN: Ruth Riker, followed by Karen Spinner, who I saw before. Ruth is Chairman of the Greystone Park Psychiatric Hospital.

R U T H C. R I K E R: Ladies and gentlemen, it's still good afternoon, barely. I thank you, Senator Martin, for giving me the opportunity to speak today. I appreciate it. As Senator Martin has said, I'm Ruth Riker. I'm Chairman of the Board of the Greystone Psychiatric Hospital. I've been a resident of Parsippany-Troy Hills for 45 years. I live within three miles of the Hospital. I've been an in-service volunteer at the Hospital for 29 years. I started when I was 20.

Greystone Park has long had a proud history serving the community and the people of this State for over 100 years. The Hospital has seen many changes in law and regulation, in treatment philosophy and treatment modalities, and in the characteristics of the patient population. Throughout all of these changes, the mission of the Hospital has always been the same: to provide state-of-the-art, quality care to the patients it serves. In recent years, the Hospital has seen the influx of patients with involvement in the criminal legal system. I believe the mixing of some of these patients with civilly committed patients dilutes the mission and purpose of the Hospital.

The crux of the problem lies in how we define “criminally insane.” By law and regulation, these patients are not alike. Greystone currently admits patients who have pending criminal charges against them. Detainer patients in jail and sent to Greystone with psychiatric problems and IST, incompetent to stand trial, patients who are sent from the courts for evaluation as to competency to stand trial -- for these individuals, the hospital is an extension of the criminal justice system. They are criminals first and patients second. The role of our staff gets corrupted from that of healers to de facto jailers. Our mission becomes diverted from providing treatment to preparing the patient to return to the criminal justice system. These shifts in staff role and function are complex and have broad philosophical and ethical implications, in addition to the practical implications which impact on the day-to-day running of the Hospital.

The confusion places an undue burden on the administration and staff who are forced to meet conflicting needs. The mixing of purpose is wrong and, with the help of this Task Force, can be corrected. Greystone should not be forced to admit patients with an active involvement with the criminal justice system. Patients who are so involved, that is, patients on detainer and IST status and from a jail setting of bars and armed guards, should be in a more secure facility. Patients with a civil status, patients judged NGRI, not guilty by reason of insanity, a Krol patient not active in criminal justice with active oversight from the Superior Court and the Hospital can and should be treated in a civil hospital such as ours.

The issue to be resolved for all patients is not only one of legal status, but of safety and security. There are patients who are better off in a

setting which does not permit them free access to the community. Some patients may become endangered if they were to go off grounds alone. They may be confused or unable to care for their medical needs. Others may present psychiatric vulnerabilities, and others may present risks to people in the community, but these patients are not defined by legal status alone.

I ask the Task Force to keep the mission of the civil State hospitals focused on treatment. We urge you to recommend that this difficult forensic population be kept in separate, secure facilities designed for this purpose. It is also necessary for the State to evaluate how to increase the capacity of its hospitals to provide security for its vulnerable patients. However, this may be outside the scope of this Task Force.

Thank you for your attention.

SENATOR MARTIN: I just want to say I think you raise an excellent point. If we understood that Greystone's mission was going to be one in which you had very dangerous people with a criminal law background, then we'd be advocating high fences and guard stations. On the other hand, I think in terms of treating the other patients, if you put that kind of surrounding on a Greystone in terms of their ability to function and possibly ultimately be released from the setting, it's going to hurt them because they're going to look at it as something like a prison compound. That's sort of what we got right now. We've got some apples and we got some oranges, and we only have one facility which is designed for the apples.

Questions for Ms. Riker?

MS. DeYOUNG: Could I ask a question? As I understand your testimony, you distinguished between IST and detainer patients on the one

hand and other civilly committed patients, like Krol's or NGRI patients, on the other hand?

MS. RIKER: Yes.

MS. DeYOUNG: Okay. You're comfortable with the Krol patients being treated in the State hospital?

MS. RIKER: Yes.

MS. DeYOUNG: What's the distinction in your mind between those two categories of patients?

MS. RIKER: Well, let me give you an example. We have a young man who has been a patient at Greystone for 29 years. I would say Dennis is about 48 now. He's there not guilty by reason of insanity. Dennis is not capable of doing a lot of things, but he is not capable of being discharged, may never be. He committed a murder when he was 18 years old. He suffers seizures. He was brought up on a farm by foster parents, who he refers to as mom and pop, who are long gone, and he is perfectly content at the Hospital. He would be more so if Greystone were as it had been some years back with the farm because he is a farm boy and enjoyed working on the farm. Now we hope to get him a Level 2 privilege so that he can go with escort to our horticultural program. Well, a patient like that couldn't possibly be put in a jail situation. So that's how I differentiate patients such as Dennis and others like him.

MR. KAUFMAN: I have a question. Hi, Ruth.

MS. RIKER: Hi.

MR. KAUFMAN: I want to make sure I don't characterize this differently. Are you suggesting in your testimony-- Let me back up. A

commonality of patients with an IST designation and those with detainers are that their legal charges have not been resolved yet in the courts?

MS. RIKER: Yes.

MR. KAUFMAN: Would it be fair to characterize your testimony that what you're saying is that when legal charges have not been resolved, the hospital is not appropriate, but if they have been resolved, as in civil committing or NGRI, that is appropriate in a hospital?

MS. RIKER: Is that a trick question?

MR. KAUFMAN: No. (laughter) I didn't mean it to be.

MS. RIKER: I guess the way I look at it has to be almost on an individual basis, but we find many of the patients-- I'm not always sure that they're mentally ill when they come directly from the jail and we have them on detainers.

MR. KAUFMAN: Thanks.

MS. BEAUCHAMP: Do you have a particular position on sexual offenders who are currently coming into our hospital system?

MS. RIKER: Myself personally?

MS. BEAUCHAMP: Yes. Do you believe-- Where would they fall within your sense of it? Would you still say it should be an individual kind of decision?

MS. RIKER: Well, I have very strong feelings on that. I'm afraid I would have to say that I don't know that I'd want to see them on the streets. Is that what you're asking me?

MS. BEAUCHAMP: No. I'm asking, do you want to see them in Greystone and other State hospitals, or do you feel that they belong someplace else?

MS. RIKER: No. I feel there should be another facility.

MS. BEAUCHAMP: That's all I wanted to know, thank you.

SENATOR MARTIN: Thank you very much for your testimony.

MS. RIKER: You're welcome.

SENATOR MARTIN: Karen Spinner is with the New Jersey Association on Correction. Is Tom Bruno here? (affirmative response) You will be next.

KAREN SPINNER: My name is Karen Spinner, and I'm the Director of Public Education and Policy for the New Jersey Association on Correction. The association is a nonprofit organization which works for the improvement of the criminal justice and correction system in New Jersey. I think there are a couple of issues before us today: Those who are incarcerated for crimes who suffer from various forms of mental illness; those whose crimes are so repugnant to the community that they are perceived as being a danger either to themselves or to others; and those who are committed to mental facilities because they have been found not guilty by reason of insanity.

I'm going to attempt to focus my remarks on the first two groups since they make up the largest number of the mentally ill among the incarcerated population. Let me say that I think the Department of Corrections is doing a lousy job in dealing with the mentally ill. It's primarily a custody-oriented organization and the level of medical and psychological services leave a lot to be desired. Many times acting out behavior that is part

of an inmate's mental health problem is perceived only as aggressive behavior. Instead of receiving treatment, the inmate is sanctioned. At the Adult Diagnostic and Treatment Center, many times an outcome of therapeutic activity, inmates display assertive behavior which is misperceived by custody staff as a threat, and they are administratively segregated for punishment, thereby denying them access to participate in therapy when the need is the greatest.

This stems from a lack of understanding and training of corrections officers about therapeutic processes. Officers need to become part of the therapeutic process if there is to be a success in dealing with psychological problems in prisons. There are also problems with inmates and staff who actively encourage acting out behavior in psychiatrically disabled prisoners.

Prisons are incredibly boring places for the most part. The behavior of the mentally ill can be perceived as a diversion. Other inmates and occasionally staff have been known to taunt the mentally ill for their own amusement. There is also a revolving cycle of the mentally ill inmate. When they are experiencing the acute episode of illness, they are moved to forensic. Once they're stabilized they are brought back to the usual prison site. There they may or may not take their medication, and the officers are not aware of what triggers them and the cycle starts all over again.

There is, however, a fair amount of research, most of it Canadian, which provides guidance in the way mental health services should be provided to offenders which will maximize its effectiveness. I think this could work both in prison settings and in the settings in the mental health facility.

SENATOR MARTIN: Is there a specific report, Karen, that you are referring to? I guess my follow up question would be: I'm not sure Canada has a kind of-- Many of our patients have strong drug histories, and I'm not saying that drugs haven't entered Toronto, but is it the same?

MS. SPINNER: No. Most of the research that's done, and it comes out of Canada because they're the ones who spend their time and money on research, not that they don't have the same problems-- I do have a copy of the report. It's a research article that was done, and I will be glad to forward that to the Task Force. But what they point out is that research on criminal and violent recidivism of mentally ill offenders indicates that the personal characteristics that predict antisocial behavior are the same as the ones that predict recidivism among criminal offenders. Okay, so that the treatment should be somewhat similar to the treatment we provide to offenders when we're dealing with the mentally ill. It's mental illness -- according to the research, other than antisocial personality disorder -- appears to be unrelated or even negatively related to recidivism among persons who have already committed a serious offense. The risk of criminal and violent recidivism among mentally ill offenders can be appraised with reasonable accuracy using an objective instrument, and that allows interventions to be targeted to those exhibiting higher risks.

So I think there is a need to look at our risk factors and use risk assessment tools with these, because they could be treated differently in mental health facilities based on their risk factors. They are not necessarily the same as a regular mental patient, but there's also a perception that if you're a violent

offender and mentally ill, you'll never be able to get out, and that is not necessarily true.

From an empirical standpoint of mentally ill offenders, there is a description of what would be an appropriate treatment for them. It includes the conservative use of psychiatric medication which has a means to maximize patient compliance. One of the biggest problems with the mentally ill offenders is that they don't want to take their medication. And when they are removed from a therapeutic environment, they don't take their medication.

We need to use behavioral and psychoeducational training and skills targeted at their criminogenic needs, and those are needs that you can change. We also need to have assertively deliberate service in proportion to the clients' actual determined risk. The other issue, of course, is having a staff that's selected, trained, and monitored so that they are actually working towards the goal, which is to put the person either back into the community or restore them to a level of treatment and functioning in the community. I think that's one of the issues that's somewhat lacking in mental health, a focus on outcomes -- concrete outcomes: Can this person live in the community, or does this person need to be psychiatrically maintained in a facility forever.

There are a lot of different organizations-- The State of Nebraska has an in-patient program for their mental health inmates. They evaluate them on 20 baseline behaviors, social interactions, the ability to maintain hygiene, treatment-related behaviors, and therapy-related behaviors. They also do ongoing groups with criminal thinking and behavior. That's really an important factor with them. They don't many times -- our regular offenders and particularly our mentally ill offenders -- don't recognize their criminal

behavior as being abnormal. I know that might be hard for some of us to recognize, but it's true, they don't. Also, they try to help the mentally ill offender understand the importance of his medication and medication awareness. So many times we're going to find that even if the person has been an offender, also having mental illness problems, they may have completed their term of incarceration, and they may still need to be committed to a psychiatric facility. But the treatment needs to be different for a mentally ill offender perhaps than just a regular mental health patient.

The other issue, I think, that I've never heard addressed is the need to prepare mentally ill offenders to return to the community. You just can't release them on parole just like everybody else, and I think that is something that somehow propels them back into crime, because they don't have the supports in the community. There are some suggestions that there should be interdisciplinary case management teams for mentally ill offenders that assign them -- assigning those people the responsibility for linking an integrated services for these offenders.

The other key factor is releasing a mentally ill offender during the daylight hours and not on weekends, so that they can be hooked up immediately with services in the community that would stop the cycle. We have mentally ill offenders recommitting. We also may have to consider developing surrogate families to help them stay in the community. So many of the mentally ill, both offenders and nonoffenders, have no one to go back to, and truthfully, our community mental health programs are not particularly effective. We move people out of institutions, but we've never funded those programs that will make the mentally ill successful in the community.

I think those are the issues that I want to share with you, because I think there's a sense that if the person is an offender, that we do need to keep them locked up forever and that the same kinds of therapy that works with a voluntarily committed person might work with an offender. I think that there are some distinct differences, and I think the research, which I will gladly share with the committee, would indicate some areas where we might be able to improve our treatment and perhaps release some people to the community.

I'd be glad to answer any questions.

MS. DeYOUNG: You said that with respect to the mentally ill offender, you didn't think that they could simply be released to the community on parole. Can you say more about that?

MS. SPINNER: I think there's a perception that-- Well, there's a couple of perceptions about parole, and frankly, parole doesn't do a great job in supervising any of its clients based on lack of resources. But the mentally ill client is different. One, you may have to monitor the medication. Okay, most parole officers are not into -- I don't want to say nursemaid, but if you have someone who needs to remain on medication, you need someone there to monitor that. You also need them to recognize when the person might be slipping away from reality or not being able to deal with what's going on, looking at, you know, if the parolee shows up for a visit and he's disheveled and his clothing is in disarray -- should clue you in that you might want to call a crisis intervention unit. You need to do more with them. They're not the average person who might make it on the street, and that's important that we do that.

MS. DeYOUNG: Would this transition be more successful if that supervision were handled by someone in the mental health system, someone in the community mental health program?

MS. SPINNER: I think it needs to be a joint type of venture. For the most part, it's been our experience that people working in social services in the mental health field-- Many of them are somewhat uncomfortable with criminal justice clients. So it would probably be most beneficial to have kind of a joint or team effort. Whether that means picking a parole officer in each district office and training him to work with the mental health practitioner, so that the two of them can work cooperatively--

MS. DeYOUNG: Thank you.

MR. THOMAS: Yes. I have a question. We've met many times before. We talked about evaluation, treatment in our prison system. We have an example of that in Avenel. Now you mentioned that we should have records. We should follow through with our prisoners upon their release. We have done none of that. We have not kept any records as to the successfulness of treatment since 1989, I'll say, in Avenel. We spend a lot of money. We've done the same in other institutions. We talk about probation. Every year probation is cut. We talk about parole. No one follows up. We release people onto the street from the prison system without any notification to anyone. It's just not right. But how we can do more, I really don't know, because we've tried a number of times. We've spent an awful lot of money, and I'm not against spending money, but I think we have to change some ways that we're doing it. We have to look for success somewhere along the line. I don't think

we should be intermixing our mentally disabled people with people that have committed violent crimes in the same facility. I just can't see that.

Thank you.

MS. SPINNER: May I just say that I would disagree that we have worked very hard at doing--

MR. THOMAS: I don't think we've worked hard. If I said that I made a mistake.

MS. SPINNER: No. I don't think we've worked very hard at all. I think we can trace the failure at Avenel to the time when they gave up their therapeutic attitude and their therapeutic modality when the Department of Corrections came in and instituted a punitive role model for that institution. But I don't want to argue that. I would say to you that I agree with you.

One of the things that the Canadians do, which is why I cite Canadian research, is that the Canadians have spent years looking at what works. They put their money into it. If it works, they research it, they publish it. If it doesn't work, they do something else. Here, we spend dollar after dollar creating programs. We don't do the research. We don't keep the data. We have done a bad job, quite frankly, in Corrections and other systems as well.

MR. THOMAS: Right

MS. SPINNER: So we have thrown good money after bad. I would never disagree with you on that point. I don't have a whole lot of good to say about Corrections, and I'll probably will stop right there since I'm leaving that field.

SENATOR MARTIN: Thank you.

MR. THOMAS: Thank you.

MR. KAUFMAN: Just one question, Senator.

Karen, you've been talking obviously about services for Corrections inmates in prisons. Do you have available any estimates as to the percentage or number of inmates that might be in the correctional system who you would think to have serious mental illness?

MS. SPINNER: The national data suggests somewhere between 10 percent to 25 percent of all inmates have mental health problems. Some are more serious than others. The Federal system does have a model that they use where they have the most difficult cases in closed environments, and then they have those who are less dangerous or less psychiatrically disabled in a more open environment. But it's a prison setting, and it's a closed environment. They do have gradations how they deal with the inmates.

MR. KAUFMAN: I'm familiar with the Federal issue, but you don't have anything available in New Jersey?

MS. SPINNER: No.

MR. KAUFMAN: Okay.

SENATOR MARTIN: Thank you.

MS. SPINNER: Thank you.

SENATOR MARTIN: Mr. Bruno, who is the CWA Local 40, speaking on behalf of Carolyn Wade. It's my understanding that Captain Loughman, from the Morris Township Police Department, had to leave. I know the Chief of Morris Plains is here. I will say that Liz Bitterman will be the person to follow Mr. Bruno, who is the liaison with a community

organization closest to Parsippany, the Puddingstone group. First, we want to hear from Mr. Bruno.

Thank you.

T O M B R U N O: Thank you.

Senator Martin and distinguished committee members, I first want to apologize for the copy of the testimony before you. I noticed a typo that you've all been promoted to the Senate, congratulations, but I do understand that it's the Governor's Task Force, and somehow a Senate Task Force got in there.

In any case, my name is Tom Bruno, and I'm here on behalf of President Carolyn Wade and the nearly 10,000 members of the Communication Workers of America, Local 1040. I'm going to summarize, frankly, because you've obviously heard what I was going to say already. Frankly, Local 1040 is quite concerned obviously. This is a multifaceted problem. It's multidepartmental. But there's a common denominator, and that's the budget.

We've heard the discussion about ADTC in Avenel there. One of the big problems that we see, for example, when CMS took over, the Correction Medical Services, a private health care services organization in the prisons, right now we have five prisons that have no psychologists. None. That was a stipulation on the contract with CMS. You wanted information, Division Director Kaufman wanted information on the number of or the percentage, it's 20 percent. That's the Department of Corrections' own data. Twenty percent of the inmate population is in the inner-psychiatric care. That's dangerous. That's a dangerous thing, to have no psychologist in the

State prison and then release these individuals into an unsuspecting community.

The closure of Marlboro Psychiatric is particularly alarming because it forces a reallocation and a deinstitutionalization of these criminally insane patients into what's scarcely available out there, and it's beds. It's scarcely available. You can't find a bed out there. So there's this big shuffle to move patients who quite frankly may be doing well right now, but they're doing well because they're in a therapeutic environment receiving medication. There's trained staff there, familiar staff. They're able to detect idiosyncratic behaviors, little behavioral changes, or whatever. They know when they're palming their medication or putting it under their tongue. They're there to observe that.

A recent study that I just received on my desk just before I got here was that they've looked at this one year after release of some of these patients. Fifty percent of them stopped taking their medication. Fifty percent. The behavior is fine as long as they're on the medication, but you can't control that once you release them. That's the danger in the institutionalization.

SENATOR MARTIN: That information-- Can you just tell us a little more where it came from?

MR. BRUNO: I'll be more than happy to fax that to you. It just came to me. I just glanced at it. I read the summaries.

SENATOR MARTIN: Is that a New Jersey statistic, or are you not sure?

MR. BRUNO: Excuse me?

SENATOR MARTIN: Was that a New Jersey statistic?

MR. BRUNO: No, I believe it came out of California. I believe it was a California study. I'll be happy to fax that. I'm going to write that down. It's a very interesting study. I glanced at the summary of it, and the summary was very interesting. I'll get the fax number from you later.

In any case, I mentioned this is multidepartmental. I say that because, first of all, with the closure of Marlboro, you're deinstitutionalizing these patients, and that deinstitutionalization is based solely, and predicated solely, on the fact that they continue to take their medication.

A lot of these patients that were released from the 450 Marlboro Plan went into Corrections-- They wound up in Corrections because Marlboro had a 0 percent return on them. They weren't allowed to come back to Marlboro if they were released under the 450 Plan. So--

SENATOR MARTIN: I don't know what that means.

MR. BRUNO: That was the last attempt at the institutionalization at Marlboro.

SENATOR MARTIN: Four hundred fifty, is that a number of patients?

MR. BRUNO: The 450 Plan-- Probably the Division Director could probably come up with a better-- It was 450 beds, I believe, is where the number came from; although, I don't believe 450 actually left.

MR. KAUFMAN: We're a little bit off the security issue, but in 1990 there was a three-year plan called the 450 Plan, which was based on an assessment of patients in the Hospital at that time. Community resources of about \$15 million worth were used to establish a series of group homes, supervised apartments, and other settings. It cost the system-- Actually it

ended up to be about 539 patients were able to be moved successfully to the community, but the original estimate was 450.

SENATOR MARTIN: When they all went down to Ocean Grove and Asbury Park?

MR. BRUNO: Yes.

MR. KAUFMAN: Not hardly. No, actually they all went to additional group homes built specifically in the community across all 21 counties for specifically that purpose.

MR. BRUNO: In any case, they do make up the landscape. Some of them do make up the current landscape in the once-thriving shore communities. They are there urinating and defecating on the community properties. That's where some of them wound up. The luckier ones wound up in prison. They got the three square meals and a roof over their head. That's where a lot of them went now.

The problem of course to the Local 1040 is that we're looking at a reduction in the Department of Human Services police force. So right now you have here at Greystone-- They're sharing the Department of Human Services police with Hunterdon Developmental Center in Clinton and with Hagadorn, which is another DMH facility in Glen Gardner, which is near Clinton, 45 minutes to an hour away from here. So there's a sharing of police officers. That's a security problem in and of itself for both the patients, as well as the staff that are here. Additionally, the Human Resources Development Institute, HRDI, under the Department of Personnel, which was charged with the responsibility of training staff, has been all but decimated. I think they're

down about 20 people now. It might be less than that. I know they are gearing up for another layoff.

The whole training of the staff is nonexistent, literally nonexistent. There are people out there working that aren't even certified in CPR anymore, and that's a requirement. Because it's so seriously deficient in terms of the available manpower to do the training, it's not happening, let alone the type of psychological training that you'd want to do in a mental health facility that deals with violent behaviors and what have you.

We have nationally recognized studies. I'd be more than happy to give you copies of those as well, because we've been doing an awful lot of research on this at Local 1040, gearing up for privatization efforts frankly. Many of the them, nationally recognized studies, published in a variety of psychological journals, have shown where mentally ill patients have died as a result of being moved from their familiar surroundings. Federal government review of psychiatric hospitals showed 64 percent of the patients were improperly treated or hospitalized, and many of the programs provided poor or dangerously deficient care.

In the five years after Governor Weld closed mental health hospitals in the State of Massachusetts, patient deaths increased 79 percent. Suicides rose 58 percent. The total savings on that plan was \$15 million. After Michigan closed its mental health hospitals, hundreds of mentally ill patients were forced into community placements. The state required that social workers visit those mentally ill patients that were forced into the community just as their own department of human services is currently doing now with the so-called PACT teams. During one of those required visits in

Michigan, the social worker was killed by the person she was to check on because he wasn't taking his medication frankly.

Now, currently, we have in the New Jersey Department of Human Services we have a group called Towers Perrin. It's a management consultant group that the Department of Human Services has hired. It's a multimillion dollar contract, and one of its goals is to determine among other things the cost of noncompliance with regulations. We have internal documents from Towers Perrin that state that they're going to meet with the Department and the State's Attorney General's Office to determine whether the Division of Mental Health's regulations have the effect of law or are merely advisory and what the potential cost would be in terms of money, possible jail time for noncompliance, etc. This is the same company incidentally that's currently being sued for over \$110 million in Canada and in the U.S. for false representations.

SENATOR MARTIN: I'm sorry. Are you summarizing--

MR. BRUNO: I'm summarizing right now.

Quite frankly, the Department of Human Services has an abysmal record at best of dealing with this population. Local 1040 is very much concerned as I said before. We think it's time to stop the politics on this matter. What we're seeing is a-- We seem to be going over a Niagara of political rhetoric in a barrel full of holes.

SENATOR MARTIN: Can I use that line some time?

MR. BRUNO: Certainly.

SENATOR MARTIN: In a different context.

MR. BRUNO: No problem. Go right ahead. I probably borrowed it from somebody myself.

Quite honestly, too many people, too many leaders out there see State workers and labor organizations and special interests groups as a bulletproof excuse that they can pick up and use like a club to ward off any personal responsibility for their own actions. Quite frankly, these ill-conceived budget cuts have really devastated this State in all the departments.

Local 1040 remains adamant in our belief that Marlboro Psychiatric Hospital is not only a viable component in the treatment strategies of the criminally insane, it's a necessary one and it requires no retrofitting. They already have their special locked units that they need. They already have the facilities necessary to take care of these patients.

We also have an abiding disdain for the lack of staff training, the chronic staffing shortages, and more importantly, the overuse, overreliance of temporary staff. That's very, very dangerous in this population. If you look at many of your problems here at Greystone, many of the situations that occurred here occurred not with longtime State employees, not that sometimes it didn't occur, but more often than not, you were looking at temporary employees, part-time nurses. They came in and didn't know what they were supposed to look for. They get a textbook education, and the textbook does not apply in this population. That's the problem.

Finally, the spin doctors have created an illusion that this is an ideological battle of labor versus management, democrat versus republican, but it's neither. The issue is about morality. It is about a primal notion of good

ethical conduct. It is not about who is right or wrong, but about what is right or wrong. It's a human issue. Let us not fall short in that regard.

I thank you.

SENATOR MARTIN: Councilman Rotando.

MR. ROTANDO: Tom, I have a specific question. You made a statement that the Greystone Police force has been reduced in numbers.

MR. BRUNO: The entire department had gone through some staffing layoffs. Now apparently since there have been increases as well, still not to the levels that they were prior to the original layoffs-- I'm talking '92, '94 again, '95. We had several layoffs where they were directly impacted. They recently had, and I say recently within the year I guess, increases through the entire GHS police department, but they're still sharing police. They don't have enough to go around. That's the problem.

MR. ROTANDO: We are aware that they do perform other duties than just at the confines of Greystone. But in the past years, the reports have indicated that the force has gone somewhat in size.

MR. BRUNO: Yes.

MR. ROTANDO: I just want to clarify that.

MR. BRUNO: Right. That's correct.

MR. ROTANDO: Thank you.

MR. BRUNO: Okay.

SENATOR MARTIN: Thank you.

Liz Bitterman, the Liaison for the Puddingstone Community Organization followed by Joseph Ragno, Esq., Trustee of the Greystone Park Psychiatric Hospital.

ELIZABETH BITTERMAN: Thank you, Senator.

I speak today on behalf of the Board of Directors of the Puddingstone Community Club. Our neighborhood's been referred to earlier today. It adjoins the grounds of the Hospital. And because we live where we do, our interest in security issues is apparent.

Greystone has a long and noteworthy history of being incapable of keeping track of patients. The number of walk aways, elopements, and escapes has ranged as high as one a day. Although the number had declined somewhat recently, we believe that zero tolerance should be the goal. Why? First of all, the criteria for involuntary commitment, the status of most of the patients at Greystone, is that the patient is a danger to self or others. A psychiatric hospital charged with the care of such patients should be aware of their whereabouts at all times. This was brought home earlier this year when a patient was rewarded with a grounds pass, did not return as scheduled, and was found dead on the grounds of the Hospital, a suicide by hanging, a danger to self. I could also list the cases of patients who have gone off the grounds of the Hospital and have gone on to commit crimes in other areas, but I'm sure that the members of this Task Force are well aware of these incidents, a danger to others.

There are two other recent developments which had added to our concerns. The strong pressure to place patients in less costly community settings has resulted in a hospitalized patient caseload which is overall more severely impaired than it was several years ago. The per patient staffing levels have not changed to reflect this fact. Any enhancements to security at the Hospital have been inadequate as shown by several escapes from the only

building claimed to be secure by the administration. This is the Ellis Building, referred to earlier, where people have gotten out by probably getting keys from the pizza man, by popping windows-- And I'd like to comment that Krol patients -- although the people in this building are Krol patients, Krol patients exist in the Hospital outside this building. We had a multiple arsonist who walked away from the cottages and was a Krol patient just last year.

The second development is the passage of Megan's law, and that was referred to only in passing by Senator Martin earlier and is of grave concern to me and I don't think has been addressed adequately by the other people who appeared before me. A little publicized section of that law calls for the involuntary commitment of any violent criminal who serves his or her entire criminal sentence and is deemed an imminent threat to society. These people are eligible for involuntary commitment without evidence of psychosis. And in fact what we're doing is calling them mentally ill because they're dangerous.

So where do we send these brutal criminals who are deemed an imminent threat and have previously evidenced no sign of mental illness? To a psychiatric hospital with no security. To a psychiatric hospital with a staff untrained in the handling of violent criminal offenders. To a psychiatric hospital full of the most vulnerable members of society. We take these unrehabilitated prisoners from a completely secure facility, a jail, with highly trained and deservedly well-paid corrections officers, and then send them to an unsecure hospital with a staff inadequately trained and inadequately paid to control them.

I'd like each one of you to think for a minute. If you had a family member who was placed at Greystone to regulate their medications, perhaps schizophrenic, perhaps bipolar with bipolar problems, and they were placed in a coed cottage with a man who had served a 20-year sentence in a jail, time to get out, and they were so afraid to put him in with the rest of New Jersey that they put him in Greystone, where does he end up? In the cottages with your daughter, your mother, your father, your sister. It's outrageous.

How many patients have been placed in the psychiatric system as a result of Megan's law? I don't know. My assistant chief of police, he doesn't know. These criminals are now patients and are entitled to patient confidentiality. This law, passed with the intent of informing residents of New Jersey about criminal offenders in their midst, has the result of making this information impossible to obtain for the most severe criminal offenders, those deemed an imminent risk to society. As a result, the residents of neighborhoods near the Hospital have no right to know which patients are the greatest potential threat. We don't even have the right to know how many are at Greystone and the nature of the crimes they have committed. Although, at open hearings such as this, when directly asked questions, sometimes we get a response.

What happens when these patients leave Greystone? Because of patient confidentiality, community notification will be impossible. What if these "patients" go on to further crimes of violence, either of a sexual nature or otherwise? I propose to you that a good defending attorney would have an easy time of showing that the patient was not guilty because of his status as a patient.

Although no information has been provided by the Greystone administration, I do have access to the one case reported by the media. We only learned of this because of leaks to the press. Gary Alston was convicted of a particularly brutal rape and assault. He served 17 years as a jail sentence. At the end of his criminal sentence, he was considered unrehabilitated and involuntarily committed. Where was he sent? To Greystone, a facility that doesn't even have a fence around the outside, put in a building that you say is secure because he's on the third floor and, if he jumps out, he'll probably get hurt. It's a joke. I don't believe that Greystone has the capacity to treat this type of patient.

This situation places other patients, and I have sympathy for the mentally ill and their families-- It places them in danger. It places the staff in danger. It places the neighborhood and the residents of New Jersey at risk, and it has to be changed. Patients with a violent criminal past must be housed at a different, completely secure facility. The staff must be adequately trained to deal with these patients. All the residents of New Jersey must be protected against anyone with a violent criminal history.

I made a couple of notes in addition to my prepared statement to things that were said earlier. I'd like to emphasize the fact that although there might have been a walk away a day in the '80s, the patient population was very different then. So that even though we have a smaller number of escapes, walk aways, etc., today, we feel that it poses a very strong risk to everyone.

I'd like to reiterate Mr. Kritchley's statement, and I think that now might be the time to think about it, and that's to change the State law -- I know that's a big deal but -- to not guilty but insane. We've talked to you in

the past, Senator Martin, about this, and it has worked well in states where it's been put into effect.

I'd like to reiterate Mayor Letts' statement about this not being a NIMBY issue. Indeed, when the discussion was which psychiatric hospital should be closed, members of all the local governing bodies went and testified in support of keeping Greystone the one that's open. So that the neighbors of this facility have been very supportive of it. However, we see a real increasing problem with the type of patients that are housed there and the way they are intermingled with the other patients.

I'd like you, if possible, somebody might answer the question about how overcrowded Trenton Forensic is. I'd like to end by saying that if you keep people there, it's really critical to have an independent evaluation of the security of this facility by a security expert, possibly not even somebody not even from this State. Because I'm not convinced, when I hear somebody say, "Yes, it's real secure," and I know that just last month three got out. Finally, this is a hospital, not a jail.

Thank you.

SENATOR MARTIN: It was powerful testimony with a lot of attention and time put into it. I thank you very much.

MR. THOMAS: Thank you.

SENATOR MARTIN: Questions for Ms. Bitterman? (no response)

Thank you.

Mr. Ragno is a Trustee of the Greystone Park Psychiatric Hospital and a practicing attorney in Riverdale, New Jersey.

JOSEPH J. RAGNO JR, ESQ.: That's correct. Thank you very much.

Good afternoon. I am in fact Joe Ragno. I'm an attorney in Riverdale, and I'm a member of the Board of Trustees with Ruth Riker, whom you've already heard speak. And to some degree, as a result of that, my remarks may be reflective of some of the things she's already said and hopefully reflective of some of the feelings of the Hospital. I promise you I will keep them very short.

I've been involved with Greystone Hospital for the better part of the last nine years in this capacity. I thank the Task Force for providing me with an opportunity to speak on the issue of caring for patients with a history of involvement with the criminal justice system. And I thank you for generously using your valuable time to address an issue which is important to the patients, the institution, and the community.

I said to some degree my remarks would be reflective by what Ruth had already said, but I think that to some degree, also, my remarks will be addressing the community relations aspect of where we stand at Greystone.

During the last nine years, one of the more constant issues that arises with respect to the Hospital is the commitment of criminally involved patients to the Hospital. Both the perceptions and realities of this procedure strain the relationship of the Hospital with its neighbors, to the breaking point at some times. This is an obviously uncomfortable and unhealthy situation for the Hospital, its staff and patients, and the surrounding community. While the facts are that there is not a significant interaction between the patients about whom we are presently concerned and the community, the perception

is different and just as important. One cannot reasonably criticize too fervently the feelings of the community which may justifiably harbor fears of the unknown and, perhaps, unjustifiably harbor fears of the essentially nonexistent. Nonetheless, this Task Force has the opportunity to recommend a solution which, despite reality or perception, will benefit both the Hospital and its patients and the community at large, its neighbors.

The population of patients with criminal justice involvement remains remarkably constant. There are essentially three categories: long-term criminally insane, or those which we generally refer to as Krol patients, those who are incompetent to stand trial, and the detainers. The long-term patients for the better part have been diagnosed and are being treated in some fashion. Their position in the Greystone community, or their level of privilege, is dictated in large part by the court system after input from the Hospital. Each of these individuals requires individual treatment and individual decision making. The law and a civilized society demand that.

I would suggest, and believe that the Hospital would suggest, that when considering the placement of these patients, and I prefer to refer to them as patients rather than consumers or clients as we sometimes hear them called, they be considered on an individual basis. The other two categories are distinct however. To this end, I reflect what Ruth has already said. Those who are judged incompetent to stand trial or who are on detainer are still more directly involved with the criminal justice system. These patients should be placed in a secure, separate, and distinct facility while this is their status.

As I understand it, Greystone houses, at this time, 78 of the long-term patients with criminal justice history, 10 incompetent to stand trial

patients, and 13 detainees. As I also understand it, we have the facility to secure approximately 60 patients effectively. When making your recommendation, I would suggest that what is needed is a blend of treatment facilities, a facility for those who are incompetent to stand trial, detainees, and those long-term patients deemed inappropriate for other State hospitals by the hospitals and/or the courts; that is, a secure and distinct facility is needed. With your input, perhaps, one will be provided, alleviating much of the public relation problem that we have and the negative perception suffered by the Hospital leading to even better treatment for those patients remaining within our facility.

SENATOR MARTIN: Joe, I just want to stop you right there. The question about the incompetent to stand trial, the ISTs as you and most people refer to them, in the community, is it a matter of convenience? That was my understanding. The reason that they're sent to Greystone is because it's courts in Morris, Passaic, Essex, and so this is the easiest place to send them. It's not the question necessarily of the best choice, but this is giving the criminal justice system the closest place they could be to their courtroom setting. Do you understand it differently? Why would they be placed at Greystone as opposed to a more secure setting?

MR. RAGNO: Well, first off, let me say I'm not in a position to answer that factually because I don't know what is in the minds of those jurists who are involved in the criminal justice system who place people where they do. But I will say this, that it probably is a matter of convenience. And I understand your perception. That's probably exactly correct. If you're going through the Morris County--

SENATOR MARTIN: I mean, if we designated one place in Trenton, would that create some kind of huge logistical problem?

MR. RAGNO: It will create logistical problems, but I thought the issue before this Task Force was not convenience, but rather what to do about the treatment of levels of people who are involved in the--

SENATOR MARTIN: Trying to understand a problem, so--

MR. RAGNO: --criminal-- I'm not arguing with you, I'm suggesting that the issue before you is: what do we do with people who are in the criminal justice system and at the same time in the psychiatric care system. There are those in that system, from our perspective on the Board of Trustees and from the Hospital, who don't belong in our Hospital no matter whether it's an issue of convenience or not and no matter whether there will be logistical problems or not. We may be trading one set of problems for another. The issue is: which problems are worse.

I only had one more sentence actually. The important side benefits -- and then one brief thing to say beyond that -- derived by transition, the nature of which I have suggested to you, will be a better feeling in the community, a feeling of safety that is now frequently missing, and the creation of a hospital, we hope, where more effort can be turned to healing than to jailing, which we hope is a win/win situation.

I'm pleased to have followed the previous speaker, and that's by pure happenstance I suspect, because I elected to look at things from a hospital community relations point of view, and clearly that speaker, as she has always had a significant interest in what's going on at Greystone because of her proximity to it-- You know that what I say about public relations is real when

you've just heard her speak, because she has a justifiable, as I said, basis for having concerns about the population which is sometimes placed in Greystone. If you have the opportunity to recommend a change in that, then that would be a good change. I'm pleased as a Trustee and I'm pleased as a citizen to see the bills already passed. This bill, if it can be passed, will also be beneficial to the society from my perspective and I believe from the perspective of the Hospital.

SENATOR MARTIN: Questions for Mr. Ragno? (no response)

Thank you.

MR. RAGNO: Thank you.

SENATOR MARTIN: I might note that I'm an active member of a church which I think is as close to Greystone as possible. My sense is, and we've been involved with a number of programs at St. Paul's in Morris Plains with some programs at Greystone-- I think there is an undercurrent that discourages more involvement. You were talking about the amount of community interaction because of an increased sense that there may be some danger as to at least some of the patients, which I think is unfortunate, but I'm not going to deny there may be some realness to that problem. There's always been a tradition of trying to work with Greystone among the churches and other civic groups, but the more the perception exists that there may be some persons there who are in fact a security risk discourages that activity.

MR. RAGNO: I agree with you. And that's why I used the distinction between perception and reality. They're rarely ever the same thing. And reality frequently doesn't matter when you're dealing with a situation in which we're dealing. The perception is just as important, especially to the

surrounding community, to our Hospital. And that leaves a negative inference on the Hospital which has been there for as long as I can remember and certainly as long as I've been on the Board of Trustees. It's an inference which needs to go away not only for the community, but for the Hospital and for the people who work there and for the people who have to live there. That's something that may be accomplished if the perception can be changed by moving the types of individuals who are of most concern to the Hospital and the community.

SENATOR MARTIN: Thank you again.

Valerie Fox to be followed by Rachel Parsio. Is she here? I see her in the back. Captain Loughman is here.

Do you have a time constraint?

CAPTAIN MICHAEL LOUGHMAN: (speaking from audience) No, I can wait. The time constraint has been taken care of.

SENATOR MARTIN: Thank you.

VALERIE FOX: Thank you very much for inviting me to give testimony. My name is Valerie Fox, and I am a person who suffers from serious mental illness.

I had met a person during my struggle with mental illness who was a patient at an institution and who had ground privileges. This part would be regarding the right. This person has confided to me he had murdered someone and had been transferred to an institution because he was deemed criminally insane. This person further stated he had to adhere to rules given to him by the Hospital administration, that if he infringed on these rules, his privileges

would immediately be taken away. I did ask this person if he liked being at this institution, and he said, "Yes, it was very nice being at the Hospital."

I felt fear being face to face with a murderer. Yet another reaction I had was that this person had human rights also and could not be confined 24 hours a day on a ward and in a courtyard for recreation. This person is a criminal because of mental illness, not through willful intent to commit a crime.

I brought closure to this experience, my fear versus human rights, by thinking that this person's rights had to be respected also, that I would go about my business and not dwell that I was walking and interacting with a criminally insane murderer. I have had occasion to go back to this institution and have seen this person, who still has ground privileges, therefore, is still keeping the rules set down for him.

Regarding security in institutions and human rights, I think the psychiatrist is the most important key. The psychiatrist must assess very carefully the state of health of the criminally insane person at the institution before allowing any freedoms. I believe this is critical regarding human rights versus security. Again, a criminally insane person is a criminal because of illness, not intent.

To go a step further and to my relief other people touched on it, I believe a deterrent to criminal activity of the mentally ill would be possibly to have patients leaving hospitals sign a contract that: they will continue in the community to take the medicines that have been prescribed for them which had made them well; if a person does not feel well on a particular medicine, to

work with a doctor; and not on his or her own to stop taking a medication. If the person breaks this contract, guidelines should be in place to follow.

Mentally ill persons want rights. We want respect. But I think we have to also show a willingness to do our best to stay well. I think the time has come to be held accountable for our actions regarding medication. Medications for the mentally ill can be the difference of living in reality or living in a fantasy world where imaginary persons and things can instruct the patient to steal, act in violence, even murder.

I have not originated this idea. I saw a television movie where a person had committed a murder. The prosecutors were trying to prove, because the patient willingly stopped taking his medication, medication he knew he needed to live in reality, he was to be held accountable for the act of violence he committed.

I think patients being held accountable regarding medication decisions after clear understanding of the patient's responsibilities is fair. I think this would be a positive deterrent for mental patients committing while ill. I think this would in the long run be very cost-effective because of less recidivism. And I think it is giving patients responsibility which goes hand in hand with respect. I would not object to be given this responsibility.

SENATOR MARTIN: Valerie, in your testimony, and I know you've had experience that none of us or at least many of us have not fortunately shared, do you think with some of these persons, for example, the incompetent to stand trials, the ISTs, if there were a number of them sent to an institution that you had been at, would that have troubled you? Do you think there should be separation is what I'm getting at.

MS. FOX: Well--

SENATOR MARTIN: I know you talked about the fact that some people deserve rights. But in terms of security, where do you draw the line as far as protecting patients and employees versus allowing some people who would seemingly be more dangerous at least based upon their past behavior?

MS. FOX: I am not a professional, and the technical terms I've heard today, the IST or whatever it is for evaluation, I don't think they're deemed mentally ill at that point for an evaluation. I would have-- I don't think there's any reason they have to go to an institution for an evaluation. They could go to a community hospital also, a psych ward. But a person who has to go to an institution because they've committed a crime and they're mentally insane, they are different. They are mentally ill, and they belong in an institution if they've been deemed committing a crime because of mental illness. But an evaluation, that has not been determined that the person is mentally ill, right, I think.

SENATOR MARTIN: Questions? (no response)

Thank you very much.

Rachel Parsio, New Jersey Protection and Advocacy, Inc.

RACHEL PARSIO: Senator Martin and members of the Task Force, we're happy to be able to present our position. Our agency is addressing this very, very broad issue on a statewide basis and has prepared a written statement.

My name is Rachel Parsio. I am a longtime advocate for the rights of persons with mental illness. I am here today representing New Jersey Protection and Advocacy, Inc., also called NJP and A. NJP and A is a private,

nonprofit, consumer-driven corporation with the responsibility for protecting the civil, human, and legal rights of New Jersey's citizens with disabilities. NJP and A derives its responsibilities from a series of Federal statutes and Governor Whitman's designation as part of the privatization of some of the functions of the former Department of the Public Advocate. And I have listed on your copies the statutes.

NJP and A welcomes the opportunity to testify here today but regrets that we did not receive notice of this hearing in sufficient time to prepare specific recommendations. We would appreciate the opportunity to submit a supplemental statement at a later date, if possible.

SENATOR MARTIN: If I could just interject, we have a six-month period in which to make recommendations. We plan to hold forth to that. We actually set our time clock at a specific time, and I think it ends around August.

MS. PARSIO: So we have time.

SENATOR MARTIN: So we would appreciate-- We will shortly, after the next meeting, which we will have a visit at Greystone, be getting into recommendations. But there is clearly--

MS. PARSIO: We have plenty of time.

SENATOR MARTIN: --I would say a two-month window--

MS. PARSIO: Two months, okay. Very good, thank you.

SENATOR MARTIN: --in which we would appreciate your recommendations, specific or general.

MS. PARSIO: Good.

The unfortunate label criminally insane can include a very disparate collection of individuals from the new mother with postpartum depression to an individual with persistent and uncontrollable auditory hallucinations. I think it is safe to say that the clinical treatment for these two individuals would be very different. Similarly, it is unlikely that the same terms and conditions of confinement would be appropriate for both individuals. NJP and A opposes the establishment of segregated facilities. Behavior, not labels, should be the guide. NJP and A does not oppose the development of specialized programs, but these programs should be organized around treatment programs, not offender status.

NJP and A recognizes that an honest effort to balance the rights of persons with serious mental illness who have a history of criminal behavior, other residents and employees of the facility, and residents of neighboring communities is a difficult task. And while our overriding objective is to encourage that individuals be treated individually, we also recognize that predicting individual behavior is far from reliable. Our concern is that too many decisions will be based upon labels rather than the individual and his or her treatment needs.

Finally, confinement without more is an incomplete response. All individuals in our State psychiatric facilities must receive adequate and appropriate mental health services. This includes a requirement for adequate and appropriately trained staff, which we've heard many times here today, multiple treatment modalities and interventions responsive to the individuals' needs, intensive discharge planning, community education, and adequate community resources, which include intensive case management services,

substance abuse counseling and rehabilitation programs, vocational training, supportive employment, and supportive housing.

NJP and A would welcome the Task Force's review of whether the resources available to the mental health system are adequate to complete its mission.

Thank you.

Do you have any questions?

SENATOR MARTIN: Questions? (no response)

Thank you very much.

MS. PARSIO: Thanks.

SENATOR MARTIN: Captain Loughman, from Morris Township.

Is there anyone else who wishes to testify today? If so, see the good-looking woman in the back with the pretty yellow jacket on, who's blushing.

CAPTAIN LOUGHMAN: I have been the Morris Township Police Department representative of the Greystone Park Security Council for about four years. I would like to take a few minutes to discuss several concerns I have regarding the future of Greystone Park and the proposed closure of Marlboro.

From our recent Security Council meetings, it is my understanding that the Department of Human Services plans to close Marlboro and transfer its patients to a variety of other facilities. This will include the transfer of Essex County patients to Greystone. In addition, the Department plans to

reduce the population of both Hospitals by placing many patients in community group homes.

There is a critical time line regarding this plan since both the closing of Marlboro and the transfer of patients to the community programs are sure to have an impact on the patient census at Greystone. Being a firm believer in Murphy's law, I am somewhat skeptical of the time line working as planned. When will the community-based beds be available to accept the population? When is Marlboro going to close? Is the existing facility at Greystone capable of housing extra patients? Does Greystone have sufficient staff to manage additional patients without a loss of security?

My second concern is related to the first. The population transferred in from Marlboro and later received from Essex County will include those deemed unfit for the community programs, Krol patients, IST patients, and detainers being my chief concern. While I have no numbers, adding Essex County to the mix will certainly increase the total number of these types of patients at Greystone. The two concerns come together at this point.

At present, Greystone is having difficulty in securely housing the existing population of criminal patients. The existing facility has several secure wards, but as recent events demonstrate, criminal patients have been able to escape and have done so for a variety of reasons, including security lapses by employees and housing criminal patients in facilities with insufficient security.

Unless there is some major change to the existing facilities and staffing at Greystone, we have the potential for a disaster. Greystone will have a smaller but collectively more dangerous population housed in a facility not designed, staffed, or equipped to handle that population. I suggest that the

Department of Human Services make certain that all housing, staffing, and equipment needs are met before any additional criminal population is transferred to Greystone.

SENATOR MARTIN: Questions for Captain Loughman?

Thank you.

MR. KAUFMAN: Maybe, Senator, it's just an opportunity to clarify some of your concerns at least in terms of planning. Marlboro is scheduled to close, and the date would be on or about the summer of 1998, about 14 or 15 months from now. But there are a large number of programs being built and phased in across the State in all 21 counties, and so part of the plan is basically a realignment of the counties and programs served by each of the remaining hospitals including another 100 new beds -- replacement beds -- that are actually under construction at Hagadorn in Hunterdon County. So it's a systemwide kind of change.

I want to assure you that the Department's plan will not be adding people to Greystone until all these parts are in place before that occurs, but it is a 21-county plan. Your concerns are well noted.

CAPTAIN LOUGHMAN: Okay. The one that really bothers me is transferring in roughly, say, 50 additional Krol, IST, or detainer patients to Greystone, and where are they going to put them?

MR. KAUFMAN: Well, let me clarify one part. There were at Marlboro 64 Krol patients. Fifty-one of them have been transferred to Ancora in Camden County. The others are planned to be discharged between now and the closing of Marlboro. There are no Krol transfers from Marlboro intended to come to Greystone.

CAPTAIN LOUGHMAN: Thank you.

SENATOR MARTIN: Do we have further testimony? (no response) No.

So I have a couple of announcements.

Mrs. Thaller will submit a written testimony by next Monday because she didn't get the information soon enough to prepare it, which is our fault. She represents the Greystone families, and we do very much want their testimony.

I want to note to the Task Force members that we will be meeting on May 21, which isn't too far away. That will include the opportunity to have a site inspection of Greystone, as we also had an inspection of Trenton Forensic, as also Ancora. At that time, we'll take up primarily the issue that was sort of left dangling the last time, which is the question of the legal issues involved as far as separations and, also, having completed the observation in different facilities, some of your thoughts about whether the current system is okay or whether it deserves some changes, assuming that it could meet whatever legal hurdles there will be.

I've had some preliminary indication from a friend of mine who's a law professor and an expert in this area, Kip Cornwell's (phonetic spelling) mother, who used to head the system in Connecticut, that he will come-- I've asked him to lend some input. He's someone I know who has written a great deal and is very knowledgeable about some of the legal issues. We will hope that the Attorney General and/or his representative, Jane Grall, will be here next week having dealt with her emergency, which was not explained to me,

but, hopefully, it will be resolved. I'm not so sure it will be by next week, but still I would hope that she will be in attendance.

I found this useful today. I really appreciate the opportunity for those of you who participated. I know it had a Greystone sort of context, but I think many of the issues of Greystone are generic in terms of the system as a whole.

I would offer anyone an opportunity to make some comments before we adjourn today. (no response) Not seeing any, I mentioned at the outset I think the two issues that I mentioned earlier, the Governor's veto of the bill that dealt with testing for AIDS and hepatitis, in my view is that's unfortunate. Senator Codey and I will be issuing a press release. We may have some further comments about tomorrow. Also, I think the issue involving the accreditation of Greystone, from indications that I've had directly from the Division, although it's somewhat -- it's not clear because I haven't seen a report, but it seems to be based in part on the security lapses, not necessarily the day-to-day performance of Greystone. The security unfortunately has spilled over in a way which is very troubling to Greystone's very operational ability to perform. So I think that we should bear that in mind when we meet next week.

I want to thank Irene McCarthy for coming up from Trenton, and our OLS staffer who's written the legislation before and may probably be asked to write any recommendations that this Task Force has to come up with in the future.

Thank you all for being here.

(HEARING CONCLUDED)