PUBLIC HEARING

before

ASSEMBLY CORRECTIONS, HEALTH AND HUMAN SERVICES COMMITTEE

on

ASSEMBLY BILL 114

(Civil commitment to mental institutions)

June 5, 1985
Room 348
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman George Otlowski, Chairman
Assemblyman Nicholas Felice

ALSO PRESENT:

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

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ASSEMBLY, No. 114

STATE OF NEW JERSEY

PRE-FILED FOR INTRODUCTION IN THE 1984 SESSION

By Assemblymen OTLOWSKI, FORTUNATO, DEVERIN, Assemblywoman GARVIN, Assemblymen ZANGARI and KARCHER

AN ACT concerning the commitment of persons to mental institutions and amending and repealing parts of the statutory law.

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

1. R. S. 30:4–23 is amended to read as follows:

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

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

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

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

"Medical director" means the physician charged with the over-all professional responsibility for [the operation of] *patient care in* a mental [or tubercular] hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Mental illness" shall mean [mental disease to such an extent that a person so afflicted requires care and treatment for his own

welfare, or the welfare of others, or of the community] *a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life. It shall not include mental retardation, simple drug or alcohol intoxication, or behavior or personality disorders manifested only by social maladaptation, assaultive, or other aggressive behavior. "Mental illness" shall be synonymous with "mental disorder."*

"Mentally ill and in need of hospitalization" means suffering from mental illness and requiring involuntary commitment because of (1) an attempt or threat to commit suicide or to do bodily harm to oneself as manifested by an attempt, suicidal preoccupation, or significant depression, (2) a homicidal or assaultive preoccupation or the inflicting or threatening of serious bodily harm against another person or the inflicting or threatening of serious property damage, (3) the serious impairment of familial financial stability or (4) the significant impairment of one's physical or mental health or the infliction upon oneself of substantial bodily injury, or serious physical or mental disease, from lack of self-control or judgment in caring for personal need such as shelter, nutrition or medical attention.

"Psychiatrist" means a licensed physician who is either certified or eligible for certification in psychiatry by the American Board of Neurology and Psychiatry or who is a resident in a program approved for certification.

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

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

Class A. [Where immediate temporary confinement in an institution is not necessary before making final order of commitment.] *Emergency commitment for immediate evaluation and treatment.*

Class B. [Where immediate temporary confinement is necessary, owing to the condition of the patient, and where an order of temporary confinement can be obtained before the patient is taken into such institution.] *Temporary commitment for evaluation and treatment of a person who is a patient in a mental hospital or other hospital or health facility.*

Class C. [Where immediate confinement in an institution before making the temporary order hereinafter referred to is necessary, owing to the condition of the patient, and where an order of temporary commitment cannot be obtained before the patient is taken into such institution.] *Indeterminate commitment for a person under temporary commitment who is determined to be in need of continued treatment by court order.*

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

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

Emergency commitment of a person shall require the certification of one physician that the person has been evaluated by the physician within five days of the request for admission and that the physician believes the person to be mentally ill and in need of hospitalization. The certification shall serve as authorization for law enforcement or health services personnel to transport the person to the institution for admission. The institution shall retain discretion as to whether or not to admit the person and shall notify the physician of its decision. No person shall be detained under an emergency commitment for more than five business days, during which time the institution shall evaluate the person and provide treatment, except for electroencephalotherapy (electroconvulsive or electroshock therapy) or psychosurgical procedures. The person may be discharged prior to the expiration of the five days upon a finding by the institution that evaluation or treatment is no longer necessary.

Temporary commitment of a person shall require certification by two physicians, at least one of whom shall be a psychiatrist, that the physicians believe the person to be mentally ill and in need of hospitalization. The certification shall serve as authorization to detain the person in the institution or mental hospital in which he is a patient or for law enforcement or health services personnel to transport the person to another institution. No person shall be detained under a temporary commitment for more than seven business days, during which time the institution or mental hospital shall evaluate the person and provide treatment, except for electroencephalotherapy (electroconvulsive or electroshock therapy) or psychosurgical procedures. The person may be discharged prior to the expiration of the seven days upon a finding by the institution or mental hospital that evaluation or treatment is no longer necessary.

Indeterminate commitment of a person shall require a judicial order, after application by the institution or mental hospital filed while the person is detained under temporary commitment and

following a finding that the person is mentally ill and in need of hospitalization by clear and convincing evidence. The court may grant an extension of temporary commitment while proceedings for the indeterminate commitment are in process. The initial order for indeterminate commitment shall authorize hospitalization for not more than three months. Upon review at the end of this period, the court may continue indeterminate commitment with review hearings at least every 12 months for adults and six months for minors.

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

30:4–30. Every certificate or written statement of a practicing physician shall set forth the date of the making of the personal examination of the subject of the action, which must be made in every case by the physician signing the certificate or written statement not more than [10] *five* days prior to the *request for* admission of such person to the hospital and [in Class A cases] not more than [10] *five* days prior to the date of the commencement of [the] *other* action.

Every certificate or signed statement shall contain the following information: name and address of physician, a report of the physician's medical findings concerning the person whose admission or detention is sought; the date of the latest examination of the patient by the physician; the physician's relationship, if any, to the person for whom application is being made; the physician's staff appointment, if any, to the mental hospital in which care is sought; and the number and issuing State of the physician's valid license to practice medicine.

Each certificate or signed statement shall set forth any additional facts and circumstances upon which the judgment of such physician is based, and shall include a precise personal description sufficient to identify the patient, and previous mental illness if any, and shall set forth that the condition of the patient is such as to require care and treatment in a mental hospital and such other information as may be required to be furnished.

4. R. S. 30:4–39 is amended to read as follows:

30:4–39. When the medical director or the chief of service at the time of admission to an institution of a [class "B" or a class "C"] patient or any time before final hearing, shall be satisfied in his discretion, that the patient is not suffering from mental illness, he shall, discharge the patient forthwith, and at the same time mail to the county adjuster of the county whence the patient was admitted a certificate signed by him setting forth that the patient is not suffering from mental illness, and has been discharged from the

hospital to which he was presented for admission. If, however, at any time before final hearing, the medical director or the chief of service shall have reason to doubt the mental illness of the patient, it shall be his duty to certify forthwith his reasons therefor to the county adjuster of the county from which the admission of such patient has been requested, and the county adjuster shall forthwith bring the certificate of doubt to the attention of the court for consideration at the final hearing.

5. R. S. 30:4–46 is amended to read as follows:

30:4–46. A person resident of the State 18 years of age or older believing himself to be mentally ill, and being desirous of obtaining treatment for the betterment of his mental condition, or a minor under the age of [21] *18* in whose behalf an application for voluntary admission has been made by a parent or guardian [or by a grandparent or adult brother or sister], may be admitted to any public or private mental hospital by filing, or having filed in his behalf, with the chief executive officer, at the time of his admission; an application in writing to be approved and furnished by the board of managers or the board of chosen freeholders or the private mental hospital, as the case may be, setting forth his name, place of residence for 10 years, preceding the application, and a full statement of his financial ability to support himself or the financial ability of the person or persons chargeable by law with his support, together with such other information as may be required on the approved forms. *A minor 16 years of age or older may apply for voluntary admission and may be admitted in the same manner as other patients. A court shall review the admission within seven days to determine that the application was voluntary. No minor, whether admitted on application of a parent, guardian or the minor, shall be detained in the hospital for more than 30 days, except upon initiation of the procedures for involuntary commitment pursuant to R. S. 30:4–25.*

If arrangements are made which are satisfactory to the institution for payment of the cost of care and treatment of the patient and if the chief executive officer or his designated admitting physician is satisfied that the patient requires hospitalization and should be admitted then he shall be so admitted without reference of the matter to the county adjuster for presentation to the court. However if such financial arrangements are not made then the chief executive officer shall forward forthwith a certified copy of the application to the county adjuster of the county from which the patient is admitted, who shall investigate the matter of legal settlement and indigence of the patient and the persons chargeable

with his support, and report the facts to the court in a proceeding therein. The court shall make a finding as to legal settlement and financial ability of the patient of the person chargeable with his support and may direct the payment of the whole or any part of the expense of care and maintenance of such patient as in the case of involuntary commitments. Such finding and direction shall be filed in the same manner as final judgments of commitment are filed.

A voluntary patient shall not be provided any form or method of treatment without the consent of the patient or parent if the patient is a minor hospitalized on application by the parent, or the guardian. A voluntary patient who has refused treatment may be treated in nonemergency situations only upon transfer of the patient to involuntary status pursuant to R. S. 30:4–25.

6. (New section) No person shall be civilly or criminally liable for action taken in accordance with any provision of this Title regarding voluntary and involuntary commitment, provided that the action was not malicious or in willful disregard of any provision of this Title.

7. (New section) The following laws or sections of laws are repealed:

Section 21 of P. L. 1965, c. 59 (C. 30:4–26.3), section 2 of P. L. 1971, c. 450 (C. 30:4–26.3a), R. S. 30:4–29, R. S. 30:4–36 through R. S. 30:4–38, P. L. 1953, c. 418 (C. 30:4–46.1 et seq.).

8. This act shall take effect 180 days after enactment.

STATEMENT

This bill revises the existing statutes relating to the involuntary and voluntary commitment of persons to mental hospitals. The primary purpose of commitment is to provide for the appropriate care, treatment and rehabilitation of a person who is mentally ill and in danger of doing harm to himself or herself or others. A secondary purpose is to protect the individual and society from potential harm. Because commitment necessarily requires the abrogation of fundamental legal rights, the commitment process must include certain safeguards to insure that commitment—and continued hospitalization—is appropriate and necessary.

This bill establishes new standards governing the commitment process to balance the interests of both the individual and society.

This bill repeals section 21 of P. L. 1965, c. 59 (C. 30:4–26.3) providing for the designation of one or more mental hospitals to which a magistrate or judge may issue an order for examination or

temporary hospitalization and providing for the arrest, summary hearing and court order of any person whose behavior suggests mental illness. The bill also repeals section 2 of P. L. 1971, c. 450 (C. 30:4–26.3a) relating to the treatment of persons attempting suicide; R. S. 30:4–29 relating to the submission of physicians' certificates on the institution of an action for commitment; R. S. 30:4–36 through R. S. 30:4–38 relating to the commitment of persons designated in class "A", class "B" and class "C" categories; and P. L. 1953, c. 418 (C. 30:4–46.1 et seq.) relating to the admission and discharge of persons to and from institutions, who are suffering from mental or nervous illness or from psychosis caused by drugs or alcohol.

ASSEMBLYMAN GEORGE J. OTLOWSKI (Chairman): May we come to order, please?

First of all, I want to apologize for being late. It is not my fault; it is the fault of the Department of Transportation and the work they are doing on Rt. 1. In any event, I hope you will forgive me.

Now we will get on with the business at hand. Let me just -- David Price prepared a written statement. Let's just go over it.

The purpose of this hearing, of course, is to review Assembly Bill 114. This is an act concerning the commitment of persons to mental institutions and repealing parts of statutory law. We want to focus today on various considerations that underlie the issue of standards and procedures for committing a person to a mental hospital. This is a very complex issue, as we all understand, that needs to be put before the public to allow all points of view to be heard. This Committee wants to be certain that it has carefully examined all of the factors, and we think, of course, that A-114 balances all of the interests, and as a matter of fact, is primarily geared to serve the patient.

What we are going to do at this hearing today is listen to testimony as it relates to 114. If you have a written statement, I suggest you submit that written statement; and rather than reading it, just comment on it. This way, the written statement will be part of the record in any event, and all of those written statements will be reviewed by our staff people so we will get the benefit of any written testimony that you may have.

With those simple rules, we are going to begin. We are going to first hear Linda Rosenzweig, Director, Division of Mental Health Advocacy, New Jersey Department of Public Advocate.

LINDA ROSENZWEIG: Good morning, Mr. Chairman.

ASSEMBLYMAN OTLOWSKI: Good morning.

MS. ROSENZWEIG: I would like to first give you the copies of my written testimony.

Good morning, Mr. Chairman and members of the Committee. My name is Linda Rosenzweig, and I am, as you know, the Director of the Division of Mental Health Advocacy, of the Department of the Public Advocate.

My Division represents annually over 7,200 patients at commitment hearings throughout the State, but principally in nine counties. Since our inception 11 years ago, we have represented 50,000 clients all together.

Our experience in representing individual clients at commitment hearings has taught us several things. One thing that we have learned very plainly is that commitment entails a very massive deprivation of liberty. The individual is taken from the comfort of family, friends, and job, and moved into a highly structured institutional setting. Every detail of his daily life is regimented once he is there. It is difficult to think of a deprivation of liberty more massive than that for someone who has not committed a crime or broken any law. For that reason, the New Jersey Supreme Court has made it plain that commitment can only be undertaken in a very limited set of circumstances, and that is a matter of constitutional law in this State. Those circumstances are when an individual is dangerous to himself or to others.

The Supreme Court of New Jersey was urged, in 1983, to broaden the commitment standard, and to allow people to be committed simply because they were unable to care for themselves without some level of aid or supervision. The Supreme Court stated very plainly its opinion in re S.L., 94 N.J. 128 (1983). The court said: "We respectfully refuse this invitation to expand the commitment standard to include people who are simply unable to care for themselves without supervision." The courts said that the commitment process must be "narrowly circumscribed because of the extraordinary degree of State control it exerts over a citizen's autonomy," and it is for that reason, because of the State Supreme Court's clear emphasis on a dangerousness standard, and because of our experience in looking at the degree to which liberty is restricted and curtailed in the commitment process -- it is for that reason that we, as a Department, oppose any legislation that would incorporate a gravely disabled standard, or a standard which would allow somebody to be committed simply because he or she is unable to meet his basic needs for shelter.

It would seem to me that when an individual needs assistance with his shelter or living needs, an institution is not the place for him. He needs community support and assistance, and I think that is the trend and the direction in which our mental health system has been moving over the past decade. It has been moving toward community care for those people who are mentally ill. We have been trying to reduce the populations at the State hospitals; by reducing the population, we have saved the taxpayers millions of dollars over the past decade.

Also, by reducing the population, we have reduced the ratio of patient to staff. It would seem to me that if we include a gravely disabled standard in our law, what we are going to do is see a rise once again in the number of patients involuntarily hospitalized in the State hospitals. When our division opened in 1974, it was not uncommon for the four State hospitals to have in excess of 1,000 patients per hospital. We are fortunate today that because of screening and because of the dangerousness standard, the State hospital populations have been reduced to 700 or below in some of the hospitals, and it is our firm contention that if a gravely disabled standard were to be added to the existing dangerousness standard, that the state hospital population would rise again back to over 1,000. And I would like to specifically point out to you the experience of the State of Washington.

In 1979, the State of Washington changed its commitment laws. Prior to that year, they had only a dangerousness standard. In 1979, they added something akin to a gravely disabled standard, which allowed people to be institutionalized simply because they could not meet their shelter or daily living needs. Subsequently, they saw an enormous rise in the number of people committed.

In the six-month period of July-December, 1978, 618 people were involuntarily committed in the state of Washington. In the same six-month period a year later -- in other words, after the gravely disabled standard was enacted -- the number rose to 1,143. To summarize, the increase from 618 to 1,143, simply because of the gravely disabled standard, is a rise of 85%. I certainly don't think my Department would like to see a rise in the number of admissions; nor do I think the Division of Mental Health and Hospitals would really want

that, either. And I do not think the Legislature would want to see a reversal of the beneficial trends that have allowed community care of the formerly mentally ill.

The other thing that I would point out to you is that current inpatient treatment costs are $100 a day. For caring for that same person in the community, the costs is approximately $20-$30 per day. So it would seem to me that as a matter of constitutional law, only a dangerousness standard should be in our law in the State of New Jersey. And from the point of view of the entire mental health delivery system, and from the point of view of expenditures for taxpayers, it would seem to me that a gravely disabled standard is ill-advised. The Department of the Public Advocate could not support any legislation which contains such a standard.

Thus we favor --

ASSEMBLYMAN OTLOWSKI: Could not support what?

MS. ROSENZWEIG: We could not support any legislation which contained a gravely disabled standard, and that I think is the point at which we depart from any of the other groups that favor legislative change. There are many, many points on which our Department agrees with other departments in the State and with other interest groups. The gravely disabled standard, however, is certainly one point where we diverge; and I am very grateful for the opportunity to be here today and to have public discussion on the issue of gravely disabled standards. I think that is --

ASSEMBLYMAN OTLOWSKI: Excuse me. Do I understand that your Department is satisfied with the way the present system is working, where people are out in the street, where people are neglected and don't have any treatment -- where people are in substandard homes? Are you saying that the Department is satisfied with that?

MS. ROSENZWEIG: No, certainly not.

ASSEMBLYMAN OTLOWSKI: What are you saying?

MS. ROSENZWEIG: What I am saying is this: better community care needs to be provided for people who are not dangerous to themselves or others. If they are not dangerous to themselves or others, they should be treated in the community. There should be better

housing options, there should be expanded community mental health services, there should be better outreach, there should be drop-in centers -- there is a whole variety of things that should be done. And I know that this Committee has introduced a number of bills that would make significant improvements in the care offered in the community and in the quality of housing available. We intend to support many of those initiatives.

So I am not satisfied, and our Department would not be satisfied, if our clients were left to live in substandard housing without adequate community mental health services. What I am saying is that the current inadequacies in the community's delivery system should not be used as a justification to insitutionalize people. I think what we need to do is increase the availability of community services.

ASSEMBLYMAN OTLOWSKI: What position is the Department taking where a person is a danger to himself, and a danger to his family, a danger to the community -- what position are they taking about having such a person involuntarily committed?

MS. ROSENZWEIG: For someone who would meet the commitment standard, that he is dangerous to himself or others? He should be committed, there is not a question in my mind about that.

ASSEMBLYMAN OTLOWSKI: And what position is your Department taking about the mechanism of that commitment? How should that be worked; should that be worked by having him committed by a fortune teller or by a psychiatrist or by doctors? How would he be committed?

MS. ROSENZWEIG: What we would prefer is a screening system be instituted. That is one of the ways in which we agree with --

ASSEMBLYMAN OTLOWSKI: And that screening system would consist of what?

MS. ROSENZWEIG: We favor the retention of the physician model. The screening should be, in our opinion...Presently, as you know, two physicians -- they need not be psychiatrists -- can do the screening. We would prefer a move toward having at least one of those two certificates filled out by a psychiatrist. I recognize that in some rural areas of the state, at odd hours of the day or night, it may not

be possible to have two psychiatrists, so we would recommend that any legislation enacted contain a provision that at minimum, one psychiatrist fill out a commitment certificate, and that the other one could be filled out by a physician, not a psychiatrist.

ASSEMBLYMAN OTLOWSKI: Good.

MS. ROSENZWEIG: We certainly favor screening centers, and I think that screening centers have contributed to the drop in admissions. When our Department first opened in 1974, and there were no screening centers, I can remember that people were admitted for a variety of inappropriate reasons. Substance abusers were admitted even if they were not mentally ill; people that could have survived in the community with some assistance were admitted even though screening service now would divert that person --

ASSEMBLYMAN OTLOWSKI: The screening center -- excuse me -- the screening center would be under the direction of whom?

MS. ROSENZWEIG: The Department of Human Services would contract that out. Or could run -- We do not take a firm position on that, as long as the screening functions effectively and the people are well trained and understand their function.

ASSEMBLYMAN OTLOWSKI: But the screening services would consist of the physicians.

MS. ROSENZWEIG: Yes. There could be other personnel of related health-care disciplines there, but I feel that the actual screening certificates should be completed by physicians, by a psychiatrist and one physician. But there should be a multi-disciplinary approach there in terms of taking the history, and of investigating the background of the individual.

ASSEMBLYMAN OTLOWSKI: Assemblyman Felice came in later than I did, and he probably wound up with the same problem that I did, and I asked to be excused on that basis, so we have similar excuses. Assemblyman, did you have any questions you wanted to ask?

ASSEMBLYMAN FELICE: Yes, I do. First of all, I have been involved with the mental health board and the handicapped for over 20 years in Fair Lawn and the Bergen County area. One question, which is most important and one which I see in the bill, pertains to the fact

that many times, late in the evening or in the middle of the night when there is a problem with a patient, naturally they would have to have a judge's order and the doctor and so forth. Do you see any objection to this bill correcting some of that? Specifically, eliminating the need to have the judge's certificate where there is an immediate need, when the person is a danger to himself and his family or other people? That is in this bill now.

MS. ROSENZWEIG: We feel, as a Department, that there needs to be judicial intervention and that the screening function is certainly performed by physicians but we feel that judicial intervention is needed at an early opportunity. We feel that way because -- you may have missed the first few minutes of my statement -- but I indicated that involuntary civil commitment entails the most massive deprivation of liberty in New Jersey or any other state for someone who has not committed a crime. Because of that, we feel that early judicial involvement is essential.

To be more specific about what we are proposing: We recognize that the individual needing screening, and possibly needing commitment, would be brought to a screening center. And I believe that any screening legislation should specifically authorize a law enforcement officer, if necessary, to bring the person in the center without criminalizing that person; in other words, without being forced to file criminal charges. Unfortunately, right now, because of the gap in our law, that is often the practice.

The person would be brought to the screening center where the certificates would be completed. I would think that a 72-hour period for holding the person at the screening center is an acceptable period of time; however, our Department believes that it is essential to get a judge's signature or temporary order at the 24-hour juncture, at the latest. That way, you would not be forced to get a judge's signature in the middle of the night.

ASSEMBLYMAN FELICE: Excuse me. I understand, and I heard most of your statement as I came in, but what we are saying is, they are a danger and a hazard to themselves and to those in their family and community. We are talking about proceeding to, instead of a

screening center, a designated hospital or area where they could be held at least 24 hours to 72 hours -- naturally, they could not be held any longer than that temporary period. In that time, the screening or medical staff would determine if there was a need for anything further, and recommend to the judicial end for a longer involuntary stay.

What we are saying is, it is very difficult to do something of this sort in the middle of the night. If you have ever been involved in a community service where you have a policeman and other people involved, such as local doctors, and, naturally, the family of the person in question. You can not just say, "We are going to take them to a center where there is not any facility to help that person," at least during that screening period.

I think that is one of the big problems, and I see the purpose of this bill answers the many, many calls from the people involved in mental health centers, government, and community service who are trying to help those people that need it. To me it is not a criminal offense, when someone is mentally sick.

MS. ROSENZWEIG: No, it certainly is not.

ASSEMBLYMAN FELICE: And I think that to tie that in is absolutely wrong. These people are trying to be helpful to us -- they are local doctors, police departments, a medical center, or the family. My question addresses one of the problems that I think actually caused this bill to come forth -- the immediate need, sometimes, during an interim period, to be able to involuntarily commit someone for his own safety and the safety of those around.

MS. ROSENZWEIG: Okay. We certainly --

ASSEMBLYMAN FELICE: It is very difficult sometimes to get a judge's order when you really need it, for a very important or dangerous situation.

MS. ROSENZWEIG: Okay, I have a few things to say about that. Number one, the system that I am proposing on behalf of our Department would meet the immediate need of the family. We recognize that when a patient or a person in the community is in crisis, it can be a very destructive, threatening, difficult situation for the family, and we certainly do not want to see that happen. We feel that if

somebody is in crisis, they should be removed from the family situation, evaluated and treated. Hopefully, that would avoid an ultimate transfer to the State hospitals. So we favor taking the person out of the situation and putting him into a screening center.

The screening center that I would envision would be a unit which would be set up to do not only screening but short-term treatment as well, which is why I favor a 72-hour stay there. If it were simply screening and nothing more, I would not favor keeping somebody 72 hours, because you can screen them in less time than that. The screening center that I envision would conceivably be one that was attached to an emergency room of a hospital in a community. There, you already have a physical facility, there is no construction involved, a psychiatrist is readily on call -- in other words, there already is an on-call system for a psychiatrist built in -- you have a physician in the emergency room, so you could easily get the one certificate there and the psychiatrist could be the person on call. If it is a well-developed, well-staffed unit, it could do several things: it could get the person out of the home, if necessary, and it could immediately start to stabilize them.

The situation with the judge's signature -- The system that I am recommending to you is not one where the judge's signature would be needed before the person is removed from the home. If I were recommending that, then I think your concern would be --

ASSEMBLYMAN OTLOWSKI: The judge's signature would be needed to continue --

MS. ROSENZWEIG: To continue, but not to justify taking the person out of the home at the outset, because I agree with you. If you have to get the judge's signature to initially remove the person from the home, everyone is at risk. The patient could be harmed as well, and things could escalate in the home, I think, as we all know.

The concern that I have with A-114 is that it would allow somebody to be removed from a family situation on the certificate of one doctor, and taken to the hospital. The screening would, in effect, take place at the hospital under that system.

ASSEMBLYMAN OTLOWSKI: I don't understand what you are saying.

MS. ROSENZWEIG: The A-114 has two routes for getting into the hospital: there is an emergency commitment and a temporary. The emergency is the one that would be used when an individual is presently in a home situation or in the community. To get that person out of the home, they would only need the certificate of either the physician or the psychiatrist. And based upon that certificate, they go to the hospital.

The system that I am describing would allow somebody to be taken out of the home and transferred to a screening service in the community, who would be screened in the community before getting to the mental health -- to the hospital.

ASSEMBLYMAN OTLOWSKI: Supposing that the community does not have a screening service?

MS. ROSENZWEIG: I think that every -- well, I believe that most of the counties now have screening services. Some work more effectively than others; I think that certainly, our Department encourages the expansion of screening services into each county. And I would urge the Legislature to consider that.

ASSEMBLYMAN OTLOWSKI: Some have more effective screening services than others? How about those that do not have more effective -- they would be bogged down with --

MS. ROSENZWEIG: Well, I think a number of things could be done. One is that the effective date of any bill that is enacted could be deferred a year, which is not an uncommon practice when you are dealing with a momentous change.

I know the Department of Human Services has already been to the JAC [Joint Appropriations Committee], and its budget is probably finalized, but that could conceivably be a priority for the next funding year.

ASSEMBLYMAN FELICE: I would rather see those facilities that are available -- in Bergen County, we have Bergen Pines, and it is a county hospital -- have the opportunity to utilize, and given up to a year for the new areas that do not have the facilities to put it into effect, because I think we should do whatever we can to help any of them, in as short a time as possible.

MS. ROSENZWEIG: Okay. I know that following me will be Steve Haimowitz, from the Division of Mental Health and Hospitals, and he is in a better position than I am to indicate the posture, funding and number of screening services.

I have also included in the balance of my written statement the elements that we feel are necessary in any commitment bill, in addition to the dangerousness standard which I outlined before. We believe that there should be a clear Legislative statement that voluntary admission should be preferred over involuntary admission, wheneever possible. That is not now part of our law, and I believe that it should be.

Another deficiency in the present statutory system, and the way in which the existing practice differs from the law, is that right now you can be committed to a community hospital for 10 days, on an involuntary basis. The law does not allow that, and as a result what happens is that --

ASSEMBLYMAN OTLOWSKI: That developed by practice --

MS. ROSENZWEIG: -- By practice. And I think that is a very beneficial trend. For one thing, it allows people to be treated closer to home; it preserves community ties. It also saves the limited resources of the State for those patients that are the most difficult to treat, and it keeps the numbers down.

So I think that any bill that is enacted by the Legislature should contain a provision for short-term, involuntary treatment in a community-based hospital.

Another thing that the law should include, which it does not right now, is a provision that involuntary hospitalization should be sought only when no less restrictive community option is available. I think that is implicit in the notion of screening, but I think it should be made explicit in the legislation.

The other thing that we would like to see contained in a legislation that is enacted is a set of rights for what happens to the individual at the screening center. Right now, the practices vary in the State and county hospitals as to what is told to the person when they arrive at that State hospital. I am referring now to a situation

in which that person has not been to a screening center. If they have never been to a psychiatric hospital before, we can only imagine that would be a frightening experience, and I think there are things that can be done when the person is first admitted, or first brought to the screening service, to make that stay there less traumatic.

ASSEMBLYMAN OTLOWSKI: What would some of those things be?

MS. ROSENZWEIG: Some of those things would be, first of all, the right by statute and by law, to have examinations and services provided to him or to her and his primary means of communication. There are people that do not speak English as a native tongue; there are people who are hearing-impaired or deaf. I believe that certainly the main thing to do is to make sure they are evaluated by someone who speaks their language.

I believe also that our laws should contain a mandatory provision requiring that the people doing the screening explain to the patient why he has been there, what the screening is for, how long he is likely to stay there, and what would happen if he is not discharged and returned home from the screening service. I do not think that would be unduly difficult, and I think it would be wise to make that a uniform practice throughout the State.

We also believe that there should be a provision for a judicial hearing within 20 days. Right now, as you know, that is provided principally in the court rules of the State of New Jersey. That should be in the --

ASSEMBLYMAN OTLOWSKI: Do you have a mandate that a hearing would have to be held in 20 days?

MS. ROSENZWEIG: Within 20 days of the time that the person first arrives at the screening center; in other words, within 20 days of the time that his liberty is first curtailed, not 20 days from the end of the 72 hours.

The other thing that the law should make explicit, which actually occurs right now in practice, is the right to counsel. That is a part of the court rule, and I believe that the Legislature should make that --

ASSEMBLYMAN OTLOWSKI: The right to counsel at what point?

MS. ROSENZWEIG: Certainly at the point of the commitment hearing.

ASSEMBLYMAN OTLOWSKI: When they appear in court?

MS. ROSENZWEIG: When they appear in court, yes.

ASSEMBLYMAN OTLOWSKI: Oh.

MS. ROSENZWEIG: Right. I think we all take that as a given, because that has been the practice now for almost a decade, but it is not a part of our law, and certainly if there is going to be a significant and wide-ranging change in the law, I think that the right to counsel should certainly be incorporated into it.

The other item that I believe should be incorporated in tne law is the right to be present at the hearing. Right now, the only pronouncement on that subject is the court rule, which says that the patient can be excluded from the hearing if the doctor's testimony can adversely affect that patient-physician relationship. I would prefer-- our Department prefers a different standard, and that is, the patient has a right to be present, unless his conduct is so disruptive--

ASSEMBLYMAN OTLOWSKI: Wouldn't it be better left to the discretion of the court, so that the patient's health or emotions would not be further impaired? Wouldn't that be better left to the discretion of the court, whether or not the patient should be present at that very moment?

MS. ROSENZWEIG: Yes, it should be left up to the discretion of the court, but I think that there should be standards to guide that judge's discretion. I have appeared before a number of different commitment judges in the 10 years that I have been praticing law, and some almost always let the patient in, some are very much inclined to keep them out, although there has been a softening of that in the past couple of years.

In other words, it would depend-- If we leave it completely up to the judge without any standards, a patient's presence or exclusion from the hearing might depend upon the whim or the point of view of the particular judge. I think we need to have some standards.

The other things that are presently a matter of practice, but are not included in the law, are the right to present evidence, to

cross-examine witnesses, and the right to have a court-appointed expert witness, paid for by the patient if the patient is not indigent.

ASSEMBLYMAN OTLOWSKI: The United States Supreme Court ruled in that area just awhile ago, didn't it?

MS. ROSENZWEIG: Yes, in the context of somebody facing an insanity defense. It would seem to me that if the hospital doctor is recommending the commitment, it would be very hard for the patient to defend himself against that without the services of an expert of his own choosing. Very often, I would say in 95% of the cases, the patient is indigent, so without the right to an expert witness at public expense, that patient is going to be ill-equipped to defend himself.

We also believe that any commitment bill that is enacted should contain a provision that the testimony to support the involuntary commitment, at that commitment hearing, must be the testimony of a psychiatrist -- not a physician, not another mental health professional.

We also believe that the evidence of dangerousness must be clear and convincing. As you know, there are several evidentiary standards. Clear and convincing is the most restrictive civil standard that presently exists. We are not recommending "beyond a reasonable doubt," but we do feel that the evidence should be by clear and and convincing evidence.

The other thing that is presently a matter of practice but is not incorporated in any statute is the review hearing schedule. We are satisfied with the present schedule that exists in the courtroom. That is, an initial hearing in 20 days, three months later, six months after that, and annually thereafter. That is set forth on page 7 of my written testimony.

There are only a few other elements which we feel are necessary, and they are: Number one, we feel that treatment issues should be able to be raised at the commitment hearing. In other words, the hearing should not be limited to the issue of whether or not the patient is a danger to himself or others. It is plain that the patient should get treatment in accordance with accepted professional standards, and if the patient feels that his treatment is deviating

from those standards, we feel the judge should be in a position to hear testimony on that. However, in fairness to the hospital and in keeping with the existing law, we believe that it should be the patient's responsibility to notify, in advance, the hospital and its attorney in advance before raising the issue at the hearing. In other words, the patient should not be able to raise it on the spur of the moment.

ASSEMBLYMAN OTLOWSKI: Don't we have to be careful that we don't start treatment right in the courtroom; that the treatment really belongs in the hospital? Don't we have to be careful about how far we go with that?

MS. ROSENZWEIG: Yes, I agree that we do. And I think we have to be mindful that there are sometimes, in some of the hospitals, as many as 50 or 60 cases per day.

That is on the one hand. On the other hand, though, I think it is essential that patients receive the care and treatment that is going to get them out of the hospital at the earliest possible opportunity. Some balance needs to be struck there, and I am not prepared at this moment to say exactly what language should be incorporated.

ASSEMBLYMAN OTLOWSKI: What bothers me about that is that we would get involved in very complex legal procedures that supposedly would be for the benefit of the patient, actually delaying the whole process of his treatment so the legal procedure would take the form of treatment then and there. Treatment, of course, in many instances is difficult to arrive at, and sometimes only after extensive evaluation of the patient's condition can real treatment be --

MS. ROSENZWEIG: That is certainly true. But bear in mind this hearing would occur at the 20 day juncture.

I can say from my own experience, having represented thousands of patients myself at commitment hearings, it is rare that a treatment issue is raised. It seems to only be raised in a fairly extreme situation. When it is raised, it seems to be something that is susceptible to quick resolution. You might not think so unless you have seen it happen, but it is usually a fairly narrow issue. The judge poses a question to the doctor, who is right there anyway, the doctor

answers it and the judge rules. There is not that much colloquy back and forth; at least, that has not been my experience.

ASSEMBLYMAN FELICE: Excuse me. Don't you think that there is a lot more behind the scenes, that the judge has reports from the psychiatrist and the medical profession that he must also evaluate?

In other words, if he asked if you feel that the condition of the patient warrants additional treatment, it may be a simple question that is directed to the medical people but I am sure, in most medical cases, there is a backlog of reports on his desk beforehand, so he can evaluate the information. When he does ask that question, basically, it is just for the purpose of the courts. He already has in his hand a pretty heavy medical report.

So it is not just that they are asking questions, it is a resolution and he makes a decision on the question that he is asked. But the preliminary reports and the final reports, I think, make up the final determination in most cases I have followed. And I think what Chairman Otlowski is saying is that this is not just a snap judgment by the judiciary; this is a combined evaluation of the medical team and a report, and the judge's evaluation and determination of what he shall do. I don't want you--

MS. ROSENZWEIG: I am not suggesting that--

ASSEMBLYMAN FELICE: --to think it was sort of a snap question-and-answer.

MS. ROSENZWEIG: Certainly, the liberty question is much more involved, whether somebody is committable or not committable. You are right; there is an extensive written report submitted to the judge in advance of the hearing, or certainly, when he arrives that morning. We need to be very careful about committing someone and that should involve extensive discussion. I don't want my answer to the other question to confuse you in any way.

When I am talking about a treatment issue --I will give you an example of something that comes up fairly often that I am calling a treatment issue, such as, Christmas may be approaching. The doctor may have been equivocal with the patient about whether the patient can go home for Christmas day -- not overnight, but just for the day to see

his family. The patient may pose that question to the doctor, or to the judge, and the judge may ask the doctor about it. That is the kind of treatment issue I am talking about. We would suggest to you that kind of issue should be raised on notice to the hospital so the doctor is not presented with it for the first time at the hearing.

That is why I say that it can be answered fairly quickly. That is something that the doctor ought to be able to tell the judge right on the spot, based upon his 20-day knowledge and experience with that patient. If it were anything more involved than that, I think there would need to be some guidelines.

I don't want to spend too much time on this, because it is really a collateral issue. And if the Committee is interested in it, perhaps I could submit material to you later.

The other element that I think should be contained in any commitment bill is a provision that if the court finds the patient to be not a danger to himself or others, then he should be discharged immediately. I understand that there are suggestions from other interest groups in the state that the court would not order the discharge for 24 more hours -- that would give the hospital more time to do the discharge planning. It is our position that if that person does not meet the standard for commitment, is not a danger to himself or others, and has a place to go, the discharge should be effective immediately.

The discharge planning is really something that hospitals should be initiating almost from the time the patient comes in, and that is why there are "liaisons" from the community. Those are people that come from the community mental health centers that the patient will return to upon his discharge. They are involved with the patient, as they should be, from practically day one that the patient is admitted. So, discharge planning is an ongoing process that begins at the time of admission, and I don't see that it should take 24 more hours to accomplish it.

The other element we believe should be included in any commitment bill is a status of discharge pending placement if a patient is not dangerous to himself or others, and should be discharged but

there is no place for him in the community. Presently, that is the practice; it has been the practice for, I believe, eight or 10 years, but it is not contained in our law. It is contained in the decisional law in the State, and in the Supreme Court opinion, but I believe it should be a legislative pronouncement, not Supreme Court opinion.

There should be periodic reviews of the degree to which the hospital is making an effort to place somebody. In other words, an order should be entered discharging someone pending placement and three months later, if that patient is still there, the court should be entitled to an explanation as to why that patient is still there, and what the hospital is doing to release the patient.

That is the list of things I would urge this Committee to consider during its deliberations concerning the enactment of a commitment law. I thank you for the opportunity to appear before you and to contribute to the public discussion, which we feel is very essential to this topic.

ASSEMBLYMAN OTLOWSKI: Thank you. You have been very, very helpful. As a matter of fact, I am sure that your testimony will be scrutinized by the staff and by the Committee, and there are many, many things you suggested that have great merit. Thank you very, very much.

MS. ROSENZWEIG: Thank you very much.

ASSEMBLYMAN OTLOWSKI: Can we hear from Steven Haimowitz, please?

Would you tell us where you are coming from, please?

STEVEN HAIMOWITZ: Mr. Chairman, I am with the Division of Mental Health and Hospitals and my title, for what it is worth, is Special Assistant to the Director for Legal Affairs. I am essentially in-house counsel for the Director of the Division within the Department of Human Services.

ASSEMBLYMAN OTLOWSKI: For the Department of Human Services.

MR. HAIMOWITZ: That is correct.

First of all, let me say that we are grateful for the opportunity to address you this morning, and, more importantly, for the hearing to be scheduled. We very much would like to see the issues of

the needs of the mentally ill and their families, and the system that tries to provide them, placed high on the agenda of this Legislature. We feel that legislation is necessary, and I am about to try to describe for you, in clear and simple terms, how I think the questions need to be addressed.

As I am sure you know, and as I am sure you will hear from the following witnesses, there is precious little that people can grow with, or reach unanimity on, in the mental health system. It is very difficult to balance the individual's interest in liberty or the individual's interest in treatment with the community's interest in safety. No one -- no one, I think, in this room or no system in this country -- has found a perfect way of accommodating these interests. I think we are building upon the experience in this State, and building upon the experience elsewhere; trying to push the system forward, recognizing that there is no panacea or simplistic answer, but there are some basic principles we think we can articulate. I think you will find some degree of consensus among most people in the room and in the State who are interested in this subject.

Let me first phrase the two questions: why is the legislation needed and what should the legislation provide? I think it is fairly simple to explain why the legislation is needed. Current commitment throughout New Jersey is scattered; it is outdated, it is contradictory, it does not reflect the current public policy in terms of the treatment of the mentally ill, it does not reflect the current clinical practices, it does not integrate commitment with the entire mental health system, and it does not focus upon the primary objective that there is in a mental health system, which is to provide to the individual treatment in the least restrictive conditions consistent with that individual's clinical needs. We often hear the expression, "the least restrictive conditions," but there is an important part of the phrase of that sentence which is often omitted. That is the "least restrictive circumstances consistent with that person's clinical need." It is obviously a relative concept and in our view, the judgment is best exercised by clinicians.

Present law does not address the very practical and operational questions which have arisen over the last 10 years, as we have attempted to move the system forward. So, having focused upon why legislation is needed, let me try and describe for you the basic elements of the legislation we support, and what it would provide. Those would be three:

We want clear standards for the voluntary and involuntary commitment of individuals, we wish to see workable procedures, and most importantly, we need to see the legislation provide for a comprehensive system of mental health care, admission, treatment and discharge. The questions of commitment cannot adequately be addressed in a vacuum. They must be considered in contemplation of the entire mental health system, both where it is and where it needs to be.

Back to the question of clear standards for the voluntary and involuntary commitment of individuals. We believe it is very important to define, finally, in New Jersey, what mental illness is for the purposes of civil commitment. We believe the definition can not address the very difficult questions of, what about people who are or appear to be developmentally disabled? Suffering from drug or alcohol intoxication? Suffering from organic brain syndrome, or senility? There is tremendous controversy, both within the clinical profession as well as the systems in the state and elsewhere, over where those individuals ought to be served. We think that one of the elements of the answer is defining in a civil commitment statute, that as a general proposition, people suffering from developmental disabilities or organic brain syndrome, or drug and alcohol intoxication, are not mentally ill for the purposes of commitment. They may also be mentally ill, but it is not synonymous with the concept of mental illness for the purposes of commitment.

Moreover, we think the definition of involuntary commitment ought to be mentally ill, causing a person to be dangerous or gravely disabled. We think the concept of "dangerous" needs to be refined much more clearly and specifically than it presently is in the law. It is nowhere in the statutes; it is made reference to in a court rule and it is made reference to in a couple of Supreme Court cases. We think the

standard of dangerousness needs to be made very clear. We think that the clinicians, the judicial personnel, the patient and the family ought to know what it is we need to focus on when these very, very difficult decisions have to be made, often in crisis. We think we need to talk about, in the dangerousness standard, dangerousness to who and to what, and dangerousness when. We believe that dangerousness ought to be something that can be anticipated in the relatively immediate future. We believe that the dangerousness ought to be of a significant kind.

Furthermore, and the reason why we support the concept of gravely disabled, is that we find that it is, in fact, inaccurate to assert that the vast majority of people who are even severely mentally ill are dangerous. None of the research indicates that there is a higher degree of dangerousness among the mentally ill than amongst many other groups in our society. Therefore, we talked about the concept of gravely disabled, certainly not with the idea of expanding the number of people who would be committed to institutions, but to allow the clinicians to have more flexibility in deciding when, in the oftentimes cyclical nature of mental illness, a person can be provided with the kind of care to prevent the suffering and deterioration that often occurs. We believe gravely disabled, again, has to be very narrowly drawn, very specifically drawn. We believe, most importantly, that the decisions that are made with regard to involuntary commitment or the person being mentally ill, which cause him to be dangerous or gravely disabled, also have to be made with the idea that there is no alternative available to the mentally ill, the gravely disabled, the dangerous. Again, we believe very strongly, as do, I think most people in the room this morning; that hospitalization which may well have a valid purpose in a mental health treatment system is not the place where all mental health care occurs, as did in fact most of it did 20 years ago. We are talking about treatment, and we are talking about treatment which is least intrusive upon the individual's liberty, and most clinically and cost effective. So we talk about the standard being linked to this treatment, and explicit findings by the clinicians making the judgment that the person is mentally ill and dangerous, or

mentally ill and gravely disabled, and there is no present alternative available to that person.

Having defined the standards, we think that the legislation also has to provide for workable procedures, as described a moment ago. We feel very strongly about the idea of community screening. We believe that in community screening, where clinicians make judgments, those clinicians should be affiliated with and part of the entire community mental health system, which is expanding in this State and which the Legislature has indicated its interest in seeing expanded, as evidenced by the increase of the per capita rates increased a few years ago. We believe that community-based screening has to be available, and available 24 hours a day. We think it has to be capable of providing outreach, going to the situation if the person can not or will not come to the center. We believe people have to be afforded a degree-- The mental health staff involved has to be afforded a degree of immunity to enable them to intervene and make those very difficult judgments. We believe that the treatment has to be provided in the most normalized setting possible, with perhaps the abrasive condition being removed. We believe that transportation has to be provided and therefore, the police may need to be involved. We think, however, that there continues to be a problem with the police filing criminal charges against people who are otherwise simply mentally ill, because the police do not have any other way of functioning under the present law. We think the law should make explicit their authority to intervene not for the purposes of taking someone and incarcerating them, but for the purpose of taking that person to a facility where they can be clinically evaluated.

We believe that the individual's interest should be protected but again, we perhaps differ from the Public Advocate in that we believe the individual's primary interest, and his community's primary interest, is in treatment. We think liberty is a critical issue; it is simply not the paramount issue to us. We believe the issue is that treatment has to be provided as quickly as possible to enable the person to return to the highest level of functioning and the greatest degree of independence as quickly as possible. It is for that reason

we suggest the initial clinical decision be made in the screening center, and that there be a new generation of facilities which are already evolving naturally in what we call short-term care facilities. Those are inpatient units in general hospitals where acute care, like other forms of medical care, can be provided and where, hopefully, the person can be stabilized and discharged as quickly as possible. Again, we talk about the system, including the discharge planning, all being done in a continuing fashion so that it is not simply an all-or-nothing question -- you are mentally ill and dangerous one day, the next day, after stabilization, you are not, and you simply go back into the community. We are talking about a system that provides follow-up care.

We believe there ought to be a standard of probable cause that has to be established within the first 72 hours, if a person is going to be involuntarily committed. We believe that matters should be presented to a judge to insure the individual clinical judgment has been provided within the terms of the statute. We believe that there should be a court hearing for 20 days and periodically thereafter, if further involuntary commitment is provided. Our sense is that with the kind of system we are talking about, perhaps people would remain in the hospital short-term care facility as a voluntary patient, whereas now they are forced to become involuntary or remain involuntary in the State hospital system.

Thirdly, we are talking about clear standards, and workable procedures -- and again, a comprehensive system, which I have made reference to. We believe that screening has to be linked to the entire range of community mental health services, so inappropriate admissions can be diverted. So, if there is another combination of services -- partial care, day programing, supervised group homes, supervised apartments -- that whole cohort of services can be evaluated first, so that hospitalization is only used when really necessary. Other available services which we hope to be able to expand will be the primary source of treatment for people suffering from mental illness, and hospitalization will only be used when necessary, and only to the extent of bringing the person back to the level at which they can function as independently as possible.

That is why we focus on this concept of screening centers, short-term care facilities, inpatient units in general hospitals, and county and State hospitals that provide the more long-term or the more structured or rehabilitative services that some people will need, at least in the foreseeable future.

We believe the system has to be able to respond rapidly, and that is why we agree with some of the points raised earlier about not requiring judicial supervision at the moment of crisis, although not long thereafter. Again, not for the lawyers and judges to dispute with clinicians, psychiatrists and other mental health professionals what's going on, but to insure that individual clinical judgments have been made for this individual person -- what their assessed need is, and to insure those needs are being met.

We also believe the comprehensive system we are talking about -- making sure that the discharges considered as part of the same series of questions as when we talk about admission-- We think that a commitment bill that just talks about commitment, and does not talk about the system, or does not talk about discharge, really does not move our system forward.

Finally, I would again assert that we believe legislation is needed. We believe that the legislation that is needed must provide three things: clear standards, workable procedures, and a comprehensive system. We believe that the mentally ill in the State, their families, and the people that work with the mentally ill are looking to the Legislature for leadership as they did with the per capita funding issue, and we at the Division -- at the Department -- are ready to work with this Committee, other committees and their staff members to come up with a bill which will move the system forward and which garners the greatest degree of consensus possible.

But as I am sure you understand, it is unlikely that any bill is going to garner any sort of unanimity with a series of issues that are as complex and, at this point in time, as unsolvable as I think the mental health issues are. I think they can be solved better than they are being solved right now. I would be happy to attempt to address any questions that you might have.

ASSEMBLYMAN OTLOWSKI: Thank you very, very much. Your testimony has been very comprehensive and I am sure it is going to be very, very helpful to us. Thank you very, very much.

We would like to call on Wayne Young, please. Would you tell us -- give us your name and the organization which you are representing, please?

DR. WAYNE YOUNG: Yes. Good morning, Mr. Chairman. I am here this morning as a representative of the New Jersey Association for the Advancement of Psychology, of which I am on the Executive Board. I also serve on the Executive Board of the New Jersey Psychological Association.

However, I am also someone who, regarding the issue of the commitment of mental patients, has been, so to speak, in the trenches. Over the past 14 years I have served as the psychologist at the Essex County Hospital Center in Cedar Grove, where I am currently the Chief Clinical Psychologist. I have also served as Director of Training, and as the senior psychologist on its admissions unit for over four years, during a time when there were over 1,400 annual admissions to our facility. During that time, I personally participated in the screening and evaluation of over 500 newly-admitted patients, and on the basis of that experience, have authored and co-edited articles on the subject. As the Chief Psychologist, I have also conducted numerous in-services and training sessions for nurses, physicians, and other mental health professionals, and have recently completed serving on the New Jersey Supreme Court Task Force on the commitment of mental patients.

I would like to thank the Committee for the opportunity to speak this morning. While I think there are many issues on which the subject of commitment of mental patients brings before the public eye and the public attention -- and this bill does also -- I would like to focus, if I may, on one of those issues in some depth this morning. Mainly, it is the issue of having some kind of a multi-disciplinary approach as part of the entire screening and/or commitment process for patients.

As this bill is presented, it appears as though physicians, some of whom, of course, would be psychiatrists, are the only

practitioners who are vested with the powers of commitment at several different levels during the patient's course of treatment. Certainly, while practitioners who are in the sub-specialty of psychiatry are justifiably qualified to perform such evaluations, some of the other medical people who are called on to make judgments regarding the issues of mental disorders and mental illness, as they appear in your bill, may not have had the commensurate training to qualify them for this experience.

I think it is important for this Committee to be keenly aware of what is the current national trend with regards to assessments of psychiatric patients. For example, in the 1985 Standards for the Joint Commission on the Accreditation of Hospitals, this nationally recognized group has set forth certain standards which require "an assessment which shall include, but not necessarily be limited to, the physical, emotional, behavioral, recreational; when appropriate, legal, vocational, and nutritional needs of patients," and not only do they recommend that with regards to assessments, but also with regards to treatments. I was interested in hearing this morning, as the representative of the Department of the Public Advocate noted, it would be their hope that as a patient is considered for assessment and commitability, that some treatment take place, for example, within the first 72 hours. Members of the psychological profession and psychologists are uniquely qualified to perform some of those treatment functions. I also think that as a basis of my experience as the Chief Psychologist at Essex County Hospital Center, it is often the case where psychiatrists and/or physicians are seeking out additional opinions to help them in making these very difficult decisions regarding the level of the patient's pathology and also the kind of care needed.

It therefore seems important that for the purpose of any patient's comprehensive assessment and treatment, that a multi-disciplinary assessment be performed as it pertains to the certifiability. I would like to bring to this Committee's attention the factual evidence which supports the use of psychologists in the commitment process.

According to our last review, a minimum of 29 states now include psychologists in one manner or another in the commitment procedure. The mode of their inclusion varies from state to state, and 60% of these laws have been enacted since 1975. This statistic, I think, speaks to the current trend on a nationwide level, which is a forward-looking pattern towards including as many mental health professionals as possible in these very difficult decisions. In 23 of these 29 state laws, psychologists are included not only in the commitment certification but in the judicial procedure as well. Six states allow psychologists to independently certify, that is, without medical counterparts, and screen or evaluate a potential patient in an emergency. In those states, the emergency commitment must then be reviewed by a psychiatrist or physician within 48 hours.

We feel that these collaborative efforts insure a fair system of checks and balances for both the system's needs and the patient's needs. As recently as 1985, North Dakota has expanded its list of providers, and psychologists there are defined as independent expert examiners and mental health professionals who are allowed to assess a patient's mental condition. Also, Virginia currently has granted parity for psychologists with psychiatrists in commitment procedures.

The desirability of a multi-disciplinary diagnosis could really be seen as analogous to what some of our medical colleagues do in some areas of the sub-specialty. For example, it is currently the trend to have second opinions, where a surgeon may be called upon to render a decision on surgery, but there is a counter-balancing, second opinion, offered perhaps by an internist or one of his other medical colleagues. Most practitioners really do want, I feel, the opinion of one specialist checked against another; and I think when an individual's personal freedom is at stake, it is our position that a second or third opinion should be mandatory, not optional.

Last year, as the Chief Psychologist at the Hospital Center, we had over 660 admissions to our facility. Seventy percent of those admissions were involuntary admissions. As a matter of unit policy and the medical director's policy, each of those patients is given a

psychological examination which includes the use of various psychological tests, and behavioral assessment. In a large percentage of those cases -- over 40% of the 70% of the involuntary patients -- psychiatrists themselves requested additional psychological screening and assessment, for example, in the way of some kinds of tests for cognitive disorders, whether or not mood states were very refractory at any one point during their admission. The assessment skills that psychologists have, I think, are geared to answering questions of whether a patient has substantial disorders of thought, mood, perception, orientation, and memory; and these are the very issues which the Committee is considering in the definition of mental illness as it is defined in this bill.

I think we are certainly very supportive of the Committee's efforts to examine this issue, and as you have heard already, it is a very difficult and complex issue to tackle. We are in favor of the concept of screening centers. We favor a multi-level and continuous assessment process occur for the patients who are severely disturbed. We are very interested in having legislation established which includes psychologists as important members of the screening center's assessment team.

Once again, I would like to thank you for the opportunity to speak before the Committee, and I do hope that the work of this Committee leads to a resolution of this very difficult problem.

ASSEMBLYMAN OTLOWSKI: Thank you very, very much.

May we hear from Dr. Irwin Perr, please? Doctor, do you want to give us your name for the record and some of your credentials please; and if you are representing anyone?

DR. IRWIN PERR: I am Dr. Irwin Perr. I am a psychiatrist and a Professor of Psychiatry at Rutgers Medical School and an Adjunct Professor of Law at Rutgers Law School in Newark. I teach law and psychiatry; I have a legal background in addition to being a psychiatrist.

I do not represent anyone. I am an academic person with an interest in the field, and have written about to these issues for a long period of time. I come here as an individual.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

DR. PERR: Should I go ahead?

ASSEMBLYMAN OTLOWSKI: Yes, would you please, Doctor? It is just a relief to know that you are not representing anyone. (Laughter)

DR. PERR: It makes me sort of unique, I think. I am also therefore responsible for everything I say, but don't hold it against any organization.

I would point out a few things that should be taken into account by the Committee. One is that there is historic cycling to the handling of the mentally ill in our society. We have varied over the last few hundred years, between cycles of treating people in terms of humanitarian principles, and what was called under the law of the parens patrae principle and the law and order principle, which was also called the police power principle.

Today, we are in a law and order period. We are in a police power period. The general orientation of the courts for the last 10-15 years have reflected this law and order, police power attitude which has permeated our treatment and handling of the mentally ill. We now are restricted in many states to viewing people only as dangerous. We use procedures which are ordinarily applied to criminals and apply them to the mentally ill. Interestingly, the liberal approach has become identified with the police power approach at this time by saying, "We are for freedom, and not for restriction." Each time in American history that this has happened, there has been a loss of view of the patient and of the mentally ill. We become involved with procedure, and that is what we have at this time.

When we had parens patrae principles operating, we were nicer; we treated people better. I think the programs were better. When we became police power, the programs deteriorated; and the people have been worse off. In the 1700s, that was a police power period. The first part of the 18th century was a parens patrae period. The last half of the 19th century was a police power period. The first half of this century, we were more humanitarian once again; and now, we are in a period of restriction. I think it affects what happens to patients, and I really have not heard much concern expressed about what really happens to patients.

However, I do agree with most of what Mr. Haimowitz had to say regarding patient care and attitudes. This has not been followed through in terms of what actually happens to people. Two of the main issues the laws have to deal with are emergency procedures, and the definitions as to who is treatable. The law has been quite vague in terms of definitions; there is no definition under New Jersey law, statutorily, and therefore, it should be clarified. There have been a number of court decisions in this regard which guide the principles today.

I might add that much of what you have been hearing today has been reflected in legislative and court decisions of the last 15 years, and is already somewhat obsolete, as there now is beginning to be a reaction to the rigidity and legalism which has affected this country. In the last few years, of those few decisions that have gone to the United States Supreme Court, the court itself has been highly critical of legal and judicial involvement and control of what happens to patients; and has indicated that it is willing, at this point in time, to return more care to the medical people who are responsible for giving such care. The Supreme Court has spoken out on few occasions. The leading case, in this regard, is the "Parum" case which dealt with commitment of children, and it has been followed through by few other cases, so that clearly is the attitude of the U.S. Supreme Court. So if anyone says you have to do this, because the Supreme Court says such and such, it is clear that the court itself is not necessarily bound to follow rigid rules of procedure and so forth.

I think there is a basic attitude. The difference in attitude between a person such as myself and the Advocate's office-- They focus on freedom, and I do not disagree with that altogether. In recent years, there has been a marked increase in procedural rights that have been given to patients, and these are already in place. They have indicated an opposition to the concept of gravely disabled. The fact is, that under the rigid dangerous criteria, we put the wrong people in hospitals. Vast numbers of mentally ill people are not being treated, they are being excluded from hospitals and they are being called not mentally ill when they clearly are.

It is said we are moving towards community care. The problem is, as almost everyone knows at this point through vast publicity, that in New York, California, New Jersey and elsewhere, what we have done is move towards community non-care. What has happened is, the mentally ill people have been either kicked out of institutions, not allowed into institutions, or never treated at all. I refer to the articles in The New York Times about the lady who was described, a few months ago, on a street corner in New York City as an example of the neglect of the mentally ill these days. Families are very acutely aware of this, because they call and say, "What can we do?" and they are frequently told that there is nothing they can do under the law. If the Advocate's office is concerned that there will be an increase in the number of people hospitalized, whether in a mental health center or a State hospital, they should be, because whatever happens, the number is going to go up. The number is already going up around the country, because we have created a larger class of chronic mentally ill patients who have been left untreated, and who are now hospitalized at a later stage in the game. That is one of the accomplishments we have had.

If it costs $100 to hospitalize a patient today, and that is a small amount of money; and it costs $20 to keep him in the community, then it is said we should do that for economic reasons, which is a major reason for what occurs today -- but I would point out the reason it is costing $20 is because we are not doing much of anything, and therefore the reason the costs are low, is nothing much is being done and then that number has no reference at all to the need. The fact is, there are large numbers of mentally ill people who are not handled under the current rules and system, and there needs to be a system for doing that; and these have some focus in the laws that have been proposed.

When it comes to legal procedures themselves, I have no particular comment; that is not a medical issue. I would point out that I do not object to legal rights being given to patients, but I would also point out that such rights do not provide care in any way, shape or form. There is no relationship whatsoever in the amount of legal representation and the quality of care that is given.

I might also point out, to be fair, that quality of care is not addressed in any commitment bill either. All of the things that the Department of Human Services say should be done, they could do right now -- mostly, if they had the staff, the will, the money, correct selection of staff, and administrative policies. They could do much more, they do not need this commitment bill for that; and much of what has been done, has been done by administrative rule and regulation, which gives them considerable flexibility. Whatever laws pass will not improve that function unless that function is changed otherwise, and we should not mislead ourselves in that regard.

As for the complexities -- Now I realize it is a delicate issue, of the different groups who wish to participate in the process. There is much inter-professional and inter-occupational rivalry these days, and everyone wants a piece of the action for a number of reasons. There is a declining economic pool out there, and people are fighting for money and power. I won't spend too much time on it, other than to say I think it has been recognized that we have the problem of psychologists, social workers, pastoral counselors, clinicians, mental health centers -- they have all kinds of names.

ASSEMBLYMAN OTLOWSKI: Hypnotists, fortune tellers -- the whole bit. (Laughter)

DR. PERR: On and on, there is a wide variety of people, some of whom have special skills and some who do not.

One point I would make is, in the last decade in particular, there has been a vast change in psychiatry in that biological psychiatry has advanced tremendously. There is an immense amount of research going on; there is much that is being done, mostly at private hospitals and medical schools. But not in the public sector, which has operated for the last two decades on a social model which is not well adapted to the needs of the mentally ill. The result has been a greater disparity of care between people with insurance and people with money, who are treated outside of government, and those who are treated within the government system where there is a rather simplified social model of people with limited backgrounds and so forth. Now, that is an issue that really can not be dealt with in terms of the commitment bill. When

the principles discussed by Mr. Haimowitz were given, I had no disagreement with practically everything that he said because I think he said things that made sense, and that we all would be for.

This is something of a background. I think some of the bills that have now been proposed deal with some of these issues, but we should not lose sight of a few things. One is that emergency hospitalization and handling of a patient require speed and should not be too complex. If you have an emergency, you need to recognize and handle it as an emergency. You need to recognize that some of the mentally ill people are not being treated adequately, or treated at all, under the current system, partly due to the rigidities of definitions.

Some of the other aspects are just a matter of degree. For example, the bill that you have indicates that we should retain an emergency hospitalization for five days. Someone else says three days; someone else says one day. Now one day is obviously not adequate to perform an evaluation -- it is in many cases, but it is pretty rigid. Whatever is chosen in number is arbitrary; the fact is, it would be shorter than -- It is seven days now, I think, under emergency. And there are other kinds of hospitalization. Whatever, it is a relatively short period of time and should not be made too rigid to deal with.

I would mention one point as an example. There are things that we like to do, but the question is, are they meaningful? For example, it was said that a person should have an absolute right to be examined in his primary language. That is very nice, and some of that comes from what is called bilingualism in our society, particularly in reference to the use of English and Spanish, as if those were the only two languages that exist in this country. New Jersey, amongst other places, is a very polyglot place. You have people from all kinds of backgrounds. You are going to say that every screening center in every place must have available, within that time period -- 24 hours -- someone who is going to speak a certain language. I recall the difficulties we had in having a man evaluated who was, say, 95% Russian-speaking, 3-4% English-speaking and one or two percent unintelligible. It is hard to find a Russian-speaking person; maybe not

impossible, but I don't know how you would do that in certain places or at certain times.

When this came up previously, I suggested that it be put in with the expression, "if feasible." It is not always feasible. You have people with Chinese dialects. You have people from Asia with Indian dialects. We have a wide variety of languages and it is not easy to come up with a person who might be suitable to do an evaluation. In some cases, you are almost as well off trying to go through an evaluation in pidgin English, than getting a person who knows the language but not the professional aspects.

So, this is something that should not be handled too rigidly, but should be used as a guide. If that were put into the law, there should be an expression that this should be done "if feasible." There should not be such rigidity to it otherwise.

These are just some random comments that I offer. I would be happy to respond to any questions.

ASSEMBLYMAN OTLOWSKI: Doctor, excuse me. In this area that you just mentioned, the language area -- Wouldn't it be a matter of common sense, when you are making an evaluation, to find out if the person has a language difficulty and what that language difficulty is, or what that major language is and then to get somebody, at that moment, to help you? You would not have to staff the center or hospitals with these multiple-language people, as you point out. Because if you did, first of all, you would have a whole institution of babble, and frankly, since we are an English-speaking nation and most of our work and reports are written in English, any other language, of course, is an auxiliary language, and that is always available.

I think what you are saying, and I can appreciate that -- if we start stressing the languages that much, we are going to find out that we have institutions of babble. We are going to have language specialists in these institutions, rather than have the kind of treatment that should be made available.

Secondly, you are pointing out -- and this is what bothers me, and what I am terribly frightened of -- the fact that you have to be careful about legal rights, you have to be careful about the

commitment. You don't stress that very much, and you don't think about that very much, and you neglect the treatment and the patient. You become so concerned with the patient's legal rights, so protective of the legal rights, that he gets no treatment at all. Specifically, how do you deal with something like that, which is frankly, such a hot political potato? When people you know are howling about their liberties -- the funny thing about it, nobody ever talks about their responsibilities -- how do you deal with something like that when you want to get to the core of the thing? You are talking about an emergency, you are talking about a patient that should have immediate treatment -- and in my years, I dealt with those, even long, long ago in the hazy, distant past, when I was the Assistant to the Mayor of Perth Amboy, which goes back centuries, I was dealing with that almost on a street level -- with emergencies. And of those patients we lost, we lost them because we were not able to deal with them on an emergency basis. How do you cope with this problem that you have just outlined, where there is such--

DR. PERR: Well actually, these have been coped with, to a degree. Fifteen to 20 years ago, there were severe, overt, and marked abuses. The legal movement would not have arisen had there not been specific problems, and through the work of lots of people and lots of litigation, changes have occurred. The fact is, therefore, that much that we screamed about, or some people screamed about, 10 or 15 years ago has been accomplished and there has been change. The courts have put in rules. The State departments have put in administrative rules. There is a bill of rights for patients under the law now. What it amounts to is, it gets harder and harder to find the same kind of abuses -- of that kind -- because they do not exist at the moment, or do to a much lesser degree.

Again, this is an example of the cycling that I spoke about. There has been much greater emphasis on the legal rights of patients, at this moment of time, that are being taken care of to a considerable degree. There is plenty of legal -- well, there now is a reasonable amount of legal help floating around the institutions to look after the legal rights of patients. You don't need, actually, more law for that.

God knows, there has been no scarcity of litigation in this regard. What I am complaining about is that the pendulum has gone, perhaps, to one degree because it always does when you start cleaning up something or making changes; and at this point in time, the treatment aspect of patients and their needs are being neglected. And that is where the focus should be, where the legal issues are not as important. It is very easy to get legal reviews now; for almost any reason you would want, you can get a court review on it. The courts have marched in and -- I could go into some of these examples in detail, on the right to refuse treatment and so forth. The courts jumped into what has been a very troublesome area, and changes have been made. New Jersey handles it administratively in a certain way; then the courts pull back, and say, "We don't want to make decisions as to mitigation treatment; we want to make sure there is a system in place that gives some type of review but now we don't want the judges to do it." And when the judges did it, they were grossly incompetent, despite their good intentions. This is one of the problems that has existed: when people jump in with good intentions, they can not deal with technical professional issues. There has been an increasing withdrawal by the judiciary, because they have seen the trouble they can get into. That is what is going on.

At the same time, for the Legislature to jump in arbitrarily when the courts are pulling back -- and the Legislature is not in much better shape than the courts are in terms of making judgment, what might be a real problem -- the whole situation is carefully reviewed. That is why, in the bill you have, it only deals with a few essential elements to clarify procedures in the handling of patients, and it does not have long statements of principle. It does not say, "be nice," it does not say, "be good," it does not say, "you should do things, preferably this, and we encourage people to do that." A law should not encourage people to do anything; the law should mandate what has to be done, clearly and understandably, so that everyone knows where he or she stands under that law.

ASSEMBLYMAN OTLOWSKI: Doctor, one other -- Excuse me. (brief pause)

One other thing, Doctor. People are not only sleeping out in the streets of New York City, they are sleeping out in the streets in New Jersey. Let me ask you this question, because you are in that whole realm at the present time: The person who is out in the street, and who refuses any kind of help or any kind of treatment -- Have you any ideas how that should be handled, how they should be treated? Obviously, there is a breakdown you know, of getting away from the State hospitals; and now some of the people have found their way into the streets, and avoid all kinds of treatment. How would you deal with a situation--

DR. PERR: The recent studies would indicate we have as many as two million people now living in the streets of this country. Of the two million, at least 70%, depending on the study, have some type of psychiatric disorder. Of the two million, and of the 70%, somewhere between 30-50% are grossly psychotic individuals unable to function, often with concomitant, severe medical and physical problems. Most of them are being totally ignored by the society in which they live. Not all the people who are homeless are mentally ill. Not all of the people who are on the streets would be eligible for mandatory care. But a significant percentage, and probably several hundred thousand people, are being neglected who would have either treatable conditions or improvable conditions.

Another 30-40% represent people with alcohol and drug problems, which we have not included in the mandatory group because of the special problems involved in the handling of our population. So I don't have an answer for what to do about the 30-40% who are primarily alcohol and drug disorders, because we have not traditionally required mandatory institutionalization, in addition to which mandatory institutionalization of that population solves very little. However, the other populations represent ones which are treatable. I have a short publication coming out on this matter in the American Journal of Psychiatry in a few months.

But we are increasingly aware of this large group, which exists, in part, for two reasons. One is the changes in laws and restrictions, and two, it represents political economics. The

government, in an effort to cut back on expenditures of funds, and with the loss of of Federal funds, cut back on services, and it is economic. They have justified the social policy on the basis of economics, when the social policy has been catastrophic. It is a matter of saving a buck. It is the hard times we are in, to a degree, in this country; but it is really economic and financial and has nothing to do with philosophy and medical care, otherwise.

ASSEMBLYMAN OTLOWSKI: Doctor, just to keep this in focus. As you aptly and rightly pointed out, A-114 really deals with commitment and the mechanism of that commitment and the law of that commitment, and hopefully, the treatment that would result from that commitment. And I emphasize hopefully.

One of the things I think that this Committee will do at a later date -- I don't want to mix it up with our present pursuit -- and we will look to you at that time for some additional testimony, is go into this problem that we are just talking about now -- the sick people out in the streets, and the sick people who are not getting any attention at all. We are probably going to explore what can be done to deal with that, what some of the approaches could be, and how big that problem is. What is it related to, and how is it related to some of the things that we are doing at the present time? But that is going to be for a later date, and I don't want to confuse it with this bill and I am happy that you kept the two things separate; and you did not confuse us any more than we are at the present time.

Assemblyman Felice?

ASSEMBLYMAN FELICE: Yes, I will try to make my remarks as brief as possible.

Dr. Perr, I, in no way, want to demean your professional thoughts and background. But there are so many random thoughts you put there, it was very confusing. First of all, I don't believe that it is only because of the judiciary that the problems of mental health have come forward. I think it is just a question of society realizing that mental illness is just that -- an illness. We have tremendous abuses of children and senior citizens, and certainly the judiciary is aware of it, but until society recognizes the need and works with the proper divisions to resolve those problems, they will be there.

I was a little confused over your statements. I have to disagree with some of the programs you say society has that are not working, such as taking them out of the State institutions and putting them into residential community homes. You also mentioned that the Legislature is not properly suited to deal with the problems. I have to disagree, because it is the legislators who are here today and sit in that chamber, who brought many of these problems to light and brought special legislation to the front. This bill is not a "resolve" type of bill for all problems, but it is a step in the right direction. And somehow or other, professionally, I seem to interpret that a lot of things that were and are being done, are not resolving any of the problems.

I just could not help but think that professionally, what is being done today is not a step in the right direction because I did not get from you any real positive answers of what to do. In one step, you say the professionals are debating between psychologists and psychiatrists over the professional turf; in another step, we are saying that the State institutions and the other private institutions are not the answer, community residential homes are not doing the-- You know, it is like going backwards.

The last thing I am going to say is, the police type of action-- You know, in my youth it was not uncommon for -- pardon the expression -- the old pie wagon, when people were not recognized as being mentally ill, they were actually taken, almost as criminals, put into a straight jacket, and taken to a State mental institution. We have come a long way, we have a long way to go, but that kind of action-- If you have ever gotten a call at three in the morning, as a leader in your community or a mayor, that there is a family which has a problem, and a very difficult problem, because someone is in an emotional state to the point of being dangerous -- it is not usually the doctor that they call to help bring that patient to the institution, it is the local police department. And I must say in most cases, the police are very, very compassionate. They are very considerate in the handling of someone who is very difficult to handle. It is almost the same as handling a dangerous criminal, you

might say, but they recognize the difference, that these are human beings with a mental illness problem. So, when you say that we are now in a police-type of action, well, I think yes, there is a lot of indication for law enforcement, but also, I have to say the people that I have been involved with throughout the northern part of the State -- whether they be police officers, an ambulance corps or volunteers -- that most people today recognize and treat those patients as people who are ill. This relationship between-- well, you know, society has lost that moral obligation, and now everything is a law abuse type of program. I have to disagree with you, and I did not get anything, really, from your random thoughts that told us of any other direction.

DR. PERR: I would like to respond, briefly, to that. One is, I was speaking of an overall legal principle that has guided the courts, not in terms of what people do as individuals. In general, I think people are and have been concerned, and are reviewing the problem.

I do not mean to demean the Legislature in any way. I probably came on too strongly in that regard. It is the obligation of the Legislature to deal with this matter. There is almost no one else who can. I meant merely to point out that some of the aspects are difficult for a large body like the Legislature to deal with, but this is the Legislature's responsibility. One reason I am here is that the Legislature does determine the State policy to a considerable degree, and must take this into account. It is a difficult situation.

I do not mean to criticize some of the functions, or ideas behind functions when it comes to treatment. I do not criticize residential settings. I think the problem is not with the concept of the residential settings, or the community mental health center; it is the problem of the affectuation of it. There is nothing wrong with that system. I don't say, get rid of it. I don't say it is bad. But I do say it has been inadequate to an extent, and has not reached the populations needed. Obviously, if one wished to have that work better, you would need a lot more people and money, which is a good idea except that it will cost more people and money. So I do not criticize the concept of the community mental health program, though I have

criticisms of some of the programs -- how things are done, the quality and so forth, but a lot of that has to do with the kind of people, the money, the facilities, and so forth, not the idea of it. The idea of it is a good one; it is the effectuation of it.

The same thing is true of my criticisms of the State program. I do not criticize the fact that it exists; I am concerned about the quality of what is done. I wish to make it clear that I am not against all these things-- I am not against everything. We have to do things reasonably; there has to be accommodations. I understand the political process and the disagreements; I am trying to present a point of view, obviously. I come here in an attempt to influence, to a degree. By the way, I am speaking in favor of the principles of this bill because I think it will facilitate patient care. It will not solve all of the problems, but it will facilitate things, help some patients, make it more reasonable, and give better guidelines to judges, who do not, under the current law, have very good guidelines. Therefore, you have many individual reactions from court to court, which is another thing you see. The judges operate on very much of an individualistic basis, because they are given that flexibility under the law, which is rather vague. The law could provide a better guideline; that is what a law is for.

I hope that answers some of the remarks that you made.

ASSEMBLYMAN FELICE: Yes, thank you. It is just that I have personally seen great improvement in the communities. There are community mental health centers that are doing a great job to reach both the young people in the school system and the adults and all the people in the surrounding communities.

DR. PERR: There has been -- There is extreme variance--

ASSEMBLYMAN FELICE: An extreme amount, as you say, depending on the qualities and the money available to them. I think they are a great buffer, to have these people be able to come back to their community and get the kind of care they should get on a community basis level. I think they are a great asset.

DR. PERR: There is an immense variance in the programs that have been offered. There are things that are going on -- I won't go into them -- that are really bad, and there are things going on that are quite good, and I don't think people are fully aware of some of the things that are bad. It is clear that certain classes of mental patients do not get adequate treatment under the mental health system that is quite common around the country. What has happened is that people with a wide variety of other problems are going to mental health centers, but they are being treated often for things that are not traditionally what we consider the mentally ill; or the sick or mentally ill people are being neglected in many mental health centers compared to people with adjustment and social problems. I do not object to that, because that is a reasonable function to be handled. But we have not dealt adequately with the problems of the more severely mentally ill.

ASSEMBLYMAN OTLOWSKI: Doctor, thank you very, very much.

Doctor George Wilson? Do you have any written testimony to submit?

DR. GEORGE WILSON: No, I don't.

ASSEMBLYMAN OTLOWSKI: All right, good.

DR. WILSON: I'll try to keep my comments--

ASSEMBLYMAN OTLOWSKI: Doctor, do you want to give us your name? Are you representing any particular organization or association?

DR. WILSON: Yes. I am George Wilson, M.D. I am the Immediate Past President of the New Jersey Psychiatric Association.

I would like to make some brief comments about the position of the Association on this bill and some comments about the problem of a commitment bill in general.

First, I think, one of the clear positions we have is that the criteria for commitment need to be expanded beyond dangerousness, to include the concept of gravely disabled. There has been an extensive discussion this morning about the problem of the large numbers of chronically mentally ill people who have been living in the streets or are living in inadequate boarding houses, who are uncared for by a system that simply is not well funded and not adequately coordinated to

care for a large number of these very seriously ill and seriously disabled people. I think this is a problem that we in the psychiatric profession -- both those who are in private practice and those who work in the public sector -- are acutely aware of. The American Psychiatric Association has made the problem of the homeless mentally ill one of its priorities in recent years.

One of the reasons -- certainly not the only reason, but one of the reasons -- that has contributed to the continuation of this problem is the dangerousness criteria, which makes it very difficult to commit someone who may be seriously disabled or who may have a readily treatable mental illness, but who because of the illness is refusing to cooperate with that treatment which is available. We feel that the broadening of the criteria can include -- which I think can very easily be defined -- someone suffering from a severe mental illness, with a serious disability which prevents him from being able to cooperate.This kind of criteria will allow hospitals, mental health centers, and mental health practitioners in private practice to place these people in the treatment setting.

The first speaker from the Department of the Public Advocate made a point which I think needs to be enlarged. It is possible that the use of a gravely disabled criteria may enlarge the number of people admitted to the State mental health facilities. However, it may very well be that many of these people would be far better off in terms of their own personal lives, were they living for periods of time in a hospital, rather than on the street. I think an economic concern of the difference between the $100 per day cost of the hospital and the $20 cost of the community care is, as Dr. Perr stated, a reflection of the inadequate funding of community services.

I would also agree with Mr. Haimowitz that the primary concern of a commitment bill should be to protect the mentally ill, to protect the public in those cases where it may be at risk, and finally, to obtain adequate treatment for those who are ill or unable to care for themselves. The liberty of the patient is certainly a serious concern; however, health and welfare of both the patient and the community are, to our minds, an even more weighty concern.

With regard to the question of the qualifications of the professionals who will be writing commitment papers, we believe that the process of deciding whether a person is suffering from a severe mental illness, and whether that person by reason of that illness is so severely disabled or is potentially dangerous, has historically been medical judgment. Our increasing awareness of the medical contribution to psychiatric illness, the recognition that perhaps 20-25% of those suffering from severe mental illness on the street are also suffering from serious medical illness, plus the recognition that many neurological and medical illnesses can directly cause a psychiatric illness, has, in our opinion, supported the traditional role of the physician as the person who needs to make that emergency first-line judgment. Physicians are trained in the emergency evaluation and the triage, or the disposition of patients to appropriate treatment, and we feel that this role should be continued. We would support the concept of including in legislation the requirement that whenever possible, one of the two persons writing commitment papers should be a psychiatrist. But I think we must realize that in many parts of this State, particularly in the rural areas, in the middle of the night or on the weekend, where there may not be more than four or five psychiatrists in an entire county, one of them will not be available. Likewise, in many of these situations, psychologists will not be available, and therefore, we would support the concept of the physician and commitment.

A final point relates to the question of the broader system for getting patients into the treatment process. Our Association is basically supporting the concept of the screening center as a mechanism whereby there would be 24-hour facilities available for the emergency evaluation of patients, and for the retention of the patients for a limited number of days -- three days or five days, I don't think it really matters; I don't think anything less than three days would be reasonable. The retention of patients in a local community facility, whenever possible, is to evaluate the status of that patient, and then make a careful, reasoned decision as to whether that patient should then be transferred, with a more formal court process, to a more

distant public hospital. So the concept of the screening center that Mr. Haimowitz had discussed earlier, hopefully, one of which would be located at least in every county and would be no more than a half an hour to 45 minutes from any place in the State, is an ideal.

We feel that another part of this ought to be a system of outreach, whereby the staff of a screening center can move into a community to evaluate and identify a mental patient who is gravely disabled and refusing treatment, and to bring that patient to a screening center for an emergency evaluation.

I think that is all, sir.

ASSEMBLYMAN OTLOWSKI: Doctor, just one question -- While it is not directly associated with this bill, there is a indirect relationship with it. We talked this morning here about getting people committed, either voluntarily or involuntarily, who are gravely ill and who are in absolute need of immediate hospitalization. Of course, the bill primarily deals with that situation.

There is the other thing, of course, that confuses this issue, aside from the economics everyone is talking about. That is the fact that many of the mental health centers, of course, are dealing with behavioral problems, sociological problems, and want to avoid dealing with the gravely ill person because of the fact that it is so time consuming and because they feel they don't have the facilities for that kind of treatment other than to send the person to a general hospital. How do you unravel that -- how do you bring this into better focus, that many of these community senders are dealing with community related problems, with the problem of the individual personality, behavioral problems, and they are really not dealing with the gravely ill person, giving that person the kind of time, and the kind of treatment he needs? How do you deal with that other than by commitment? Is there any other thing that you have to suggest at this point that could be helpful to the committee?

DR. WILSON: Well, I think so. There needs to be more medical and psychiatric input into the management of mental health centers, so that psychiatrists are brought into those centers who are interested and experienced in dealing with the chronically mentally ill.

Unfortunately, much of the demand for services in mental health centers, as you have said, is for young people with behavioral problems, with drug and alcohol problems; married couples with marital dysfunction, and patients with milder kinds of illness that will never need treatment. In some sense, these patients may be more attractive and easier to treat, but I think there has to be a clear mandate to the mental health centers, that they have to have psychiatric evaluation and services available for the chronically ill as the primary obligation.

I think there are certainly broader problems with the unavailability of adequate Medicaid coverage for these patients, so it is in some sense more attractive for a mental health center that may depend on third-party reimbursement to treat someone who is not chronically ill, and may be employed and therefore will have adequate third-party reimbursement. I do feel that efforts have been made by the State to provide funding for mental health centers, to insure that the chronically mentally ill are adequately treated. I believe there needs to be clear regulations about the adequacy of the psychiatric supervision for these patients, and there needs to be a reinforcement of the commitment that these are the primary obligations of the mental health centers; and a requirement that mental health centers have housing available, that they have vocational rehabilitation services available, that they have outreach services to seek out those patients who are refusing treatment. With all of those required, it is possible, perhaps even legislatively, to redefine the primary obligations of a mental health center.

ASSEMBLYMAN FELICE: Mr. Chairman, on this particular issue, many of the community mental health centers have psychiatrists, have psychologists, have people working on all phases, but they are basically an outpatient type of a community center. They do not have the facilities to treat medicinally, and have people be housed there for any length of time. They do not have the facilities for some of the other programs because of their limited use in the community, and also their attempts to attract those who will not have to stay in an institutionalized area and can get the treatment as an outpatient in their own community.

I think one of the hardest things for people who have had or are going through mental illness is the fact that they want to be able to feel they are being treated in their own community, rather than have to go a distance. Some of them can not even drive any distance to go to a clinic or a hospital or an institution. This helps resolve some of the heavy load of these same people taking the same treatment by professionals such as psychiatrists and psychologists.

Yes, there are community centers which are satellite centers. They do not have the complete facilities that they should. But they are referred to such places as mid-Bergen, or sort of a combination center within the group of the community mental health centers. That is what I think has to be elaborated so that the little satellite community centers will have the availability to go to the larger mental health centers that have a bigger staff and more facilities and programs. But it does serve a purpose, and if I said only the youngsters and the people who have marital problems, but the seniors and the other people-- So really, you are covering all when you are covering from the youngsters to the seniors. And some of those people I know personally have gone through very extensive medical treatment in the institutions, and they are now very, very happy to have a maintenance type of outpatient program, which is more comfortable for them, and more comfortable for the people who are involved with them.

Yes, there has to be more assistance given to them, both financially and administratively, on the county and the State level, even on the Federal level. But I think this is an effort that has been a tremendous benefit to the problems of mental health, certainly not those who had to be taken in off the streets that are needing both physical and medical attention. They are not there to serve that kind of purpose, and I think if anybody thinks that the community mental health center is going to take people off the street who have a mental problem and a social problem, well, they are going in the wrong direction. But I appreciate your comments on the others.

DR. WILSON: Thank you, sir. I just want to state that I think our mental health centers vary tremendously in their capacity to

handle the seriously disturbed patient. I certainly agree that those centers may be very justified in wanting to serve, and I think there is a need for services to the youth, to older people, to persons with marital problems and to persons with drug and alcohol problems. But if it is going to be public policy to deinstitutionalize patients who have been in public hospitals for many years, and who suffer from chronic and severe psychotic illnesses, to place these people in communities where housing may not be adequate, where there are no vocational rehabilitation programs-- I believe that the mental health centers are going to have to-- The concept of the mental health centers is either going to have to be expanded to be able to provide a broad range of psychiatric and social services for those patients, or many of those patients will deteriorate in the absence of that kind of care. Perhaps some of them are better off in institutions than they are living on the streets, in terribly distressed circumstances.

ASSEMBLYMAN FELICE: Doctor, one other thing. You know, society-- We are all for motherhood and apple pie, but unfortunately, if you have ever been in local government or on a Zoning Board or Planning Board, as soon as you have anything to do with the mentally ill or the retarded or handicapped, they say, "We are for it 100%, but don't put it next door to me." So, you will never, never see in our society, in a residential area, I don't think, where you have the very emotionally disturbed patients coming into a community center, because first of all, unfortunately, the society of people does not want them living or working next door to them. So that is one of the biggest problems, and you are going to have to face that. If you are going to have to have people with these problems, they are going to have to be in institutions and hospitals that take care of them. We are for senior citizens and we are for the retarded and handicapped, just as long as it is not next door to us. And that is the big problem that society has. They recognize mental illness; the next step is, how do we work around it?

DR. WILSON: And how do we pay for it.

ASSEMBLYMAN OTLOWSKI: Doctor, thank you very, very much. You have been very, very helpful.

Now, may we have Miss Carol Ann Wilson? Miss Wilson, will you tell us who you are and who you represent?

Do we have copies of this?

CAROL ANN WILSON: Yes.

ASSEMBLYMAN OTLOWSKI: Miss Wilson, you are going to summarize this, right?

MS. WILSON: Yes, I am. I realize that you want some brevity this morning.

ASSEMBLYMAN OTLOWSKI: And the clock is running against us.

MS. WILSON: Chairman Otlowski and the Committee Members, I am Carol Ann Wilson. I am President of the Mental Health Association of New Jersey. It is a statewide, voluntary citizens organization with thousands of members statewide, and chapters and offices in 11 of New Jersey's counties.

I would like to thank you for giving me the opportunity of speaking to you this morning, with regard to a comprehensive revision of the laws governing voluntary admission and the involuntary commitment to inpatient mental health facilities. The Mental Health Association of New Jersey has long supported, recognized and advocated a revision of the present commitment procedures, which have not been revised since 1965. Since that time, there have been vast changes in clinical practice, several policies, case law, and development of community-based service systems in New Jersey. My full and inclusive testimony has been distributed to each member of the Committee, and attached to my summary. I will take this opportunity to briefly and generally list some key issues which the Mental Health Association in New Jersey, as citizen advocates for the mentally ill, believes must be considered and included in a revision of the present statutes.

First, we believe there must be a sound, humane and forward-looking definition of mental illness, and also, we want a precise definition of "dangerous to self and others" included.

We also believe that the standards and procedures for involuntary commitment must be consistent with the protections afforded to patients and potential patients included in present case law. This also should apply to standards for psychiatric hospital treatment, to

limitations on certain treatment modalities, and to a broad range of patients' rights recognized nationally, as well as in New Jersey. We believe that protecting patients' rights is also essential to giving quality care.

The third point we feel should be focused on would be that throughout the screening and commitment process, a person who is being considered for involuntary holding or hospitalization should be protected by an independent system of advocacy. Advocates should be easily accessible, trained, and able to answer the client's and the family's questions.

The fourth issue we feel should be focused on is that there must be an adequate statutory procedure for providing crisis intervention, emergency outreach, and involuntary screening services, to ensure that care and treatment are made available for mentally ill persons in crisis, who are unable or unwilling to come to a facility for services. In all cases, services should be made available in the peoples' home communities, before hospitalization becomes necessary.

And for our fifth point, finally, we would want to emphasize what the Mental Health Association of New Jersey believes to be the most important concept to be included in any revised commitment legislation, that is, explicit authorization for the establishment of outpatient screening and assessment services and community-based inpatient short-term care facilities designated by the Commissioner of Human Services, to serve involuntary patients, as part of a total service continuum.

For the last five years, a whole array of community-based mental health services have been initiated and are now operational within the State. As an organization, we do, however, recognize that they are still insufficient in number and sometimes in scope.

Screening services offer a relatively independent, unbiased and comprehensive assessment of a client's needs for mental health treatment, hospitalization, or other services, and it mandates the linkage of that client to needed services in the least restrictive environment possible.

We of the Mental Health Association believe that comprehensive screening and commitment legislation would reinforce what was begun five years ago, and would push the system toward further advancement. We strongly support the continuum of care concept, which would emphasize the use of community facilities, whenever they are appropriate and available, as the preferred treatment setting for all of New Jersey's residents. A commitment bill without a screening component would ignore the progress that has been made in offering community based care.

Our full testimony goes into greater detail on each one of these issues, and you have that before you. Let me end by saying that New Jersey's mental health care system has evolved during the last decade from a primarily institutionalized base system, to one which emphasizes community care close to home.

The enactment of legislation which provides a comprehensive revision of the laws governing voluntary admission and involuntary commitment to inpatient mental health facilities, including a community-based screening component, would be another giant step forward. We must replace a faulty, at best, commitment procedure with a new law that insures that people in need of mental health services can obtain those services quickly, in appropriate settings, and without forfeiting their constitutional rights and protection.

Our Association is confident that with the leadership presented by you this morning, such legislation and the funding needed -- and I have to use the word funding -- to implement such services can and will become a reality in the State of New Jersey.

ASSEMBLYMAN OTLOWSKI: I don't have any questions. Thank you very, very much.

May we have Joseph Rogers, please? Do you want to tell us who you represent, and give us your name for the record?

JOSEPH ROGERS: Primarily, I am representing myself, but my name is Joseph Rogers, and I am a member of the New Jersey State Mental Health Consumer Advisory Committee. I have been active on several county, State, mental health advisory committees; and I am a formerly an employee of the New Jersey Self-Help Clearinghouse, where I organized

16 self-help and advocacy groups of former mental patients. I am also an advisor to the National Institute of Mental Health Community Support Program, and last month I was a presenter at the NIMH National Learning Community Conference on the issue of involuntary treatment in State hospitals. I am presently Associate Director of the Mental Health Association of Southeastern Pennsylvania, and I live in Camden County, New Jersey.

Primarily, my greatest interest in this issue comes out of the fact that I have suffered involuntary commitment to a State hospital. I am a former mental patient. Included in my treatment, as some of the people talked about, was being isolated in a room, strapped in four-point restraints for over three days, where I ended up defecating in my own clothes, was not fed adequately, and was abused by staff. I emphasize these issues because I have felt that--

ASSEMBLYMAN OTLOWSKI: Excuse me. Was that in an institution in New Jersey?

MR. ROGERS: I was in an institution in Florida at the time, but I have also experienced similar problems in New Jersey institutions.

ASSEMBLYMAN OTLOWSKI: Okay.

MR. ROGERS: I come also as a Chairperson of the New Jersey Mental Patients Association, where many cases involving these kinds of things have been documented.

I am deeply concerned about the efforts to change the commitment law in New Jersey. Many people are now saying that it is time to swing the pendulum backwards, away from the issue of rights to the issue of treatment-- In fact, we heard that from several people today. I believe they are trying to move backwards, to the time when it was easier to lock someone away because of his problems.

I am worried about these efforts to use the law to move people into services against their will. It is true that people do not seem to be able to get the services they need to support them in the community. Often, people are opposed to participating in their local community mental health services and, at times, it seems that their refusal to participate is the problem. This leads some people to think

that if they can tinker with the law a little bit and say, "For 72 hours, we'll bring them in and medicate them and force them into a treatment situation," they will see the light and somehow, move on to get the care they so badly need.

This is a dangerous premise. The failure is not in the individual's refusal of services, but in the services themselves. Much of what passes for mental health services in New Jersey is not much more than baby-sitting, time-wasting, bureaucratic number games that do not begin to meet the needs of the individual.

We need to develop a broad based system of alternatives, with a vigorous outreach capability that involves the consumer as an equal partner in his own treatment. Forcing people into treatment has been proven worthless time and time again as a way to help them.

Many of the people you will hear today come from provider organizations that blame the client for failure to engage in their services. They rarely analyze their own failure to engage the client. I have often worked with people who have sought help and have been denied help by bureaucratic programs structured for the convenience of administration and staff, where the needs of the client run a poor third. Until services are structured for the benefit of the client, there will always be a huge failure to engage people in services.

But the answer is not to lock them up against their will. If we are changing our commitment laws, I call for the addition of a strong advocacy focus. We as mental health consumers do not automatically believe that the providers of mental health services have our best interests at heart when they propose to "beef up" the commitment law. Instead, we feel they are primarily out to protect their own interests. We call on you as legislators to be our friends and to advocate for us, and not for the providers, in this effort.

We haven't even begun to look at the alternatives. What about respite care? What about the development of places of sanctuary for individuals? We give people no alternatives, and when they are unable to function, we offer only the most restrictive methodologies. This is a denial of their basic human rights.

A comprehensive program of rights protection and advocacy must be developed and included in any effort to change the commitment law. If there are no guarantees that people will be allowed to find alternative help in a least restrictive setting, we will return to the days of warehousing people, whether that is in the community and boarding homes or whether that is in the State hospitals. Changing the commitment laws to expand the areas in which we can move people involuntarily into services is taking a giant step backward. Instead, let's move forward to develop services that will help people grow and prosper, and break the cycle of institutionalization.

Thank you.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

At this point, I would just like to make one thing very clear. I think I am speaking for the whole Committee. In the legislative process, and particularly this Committee process, I think it has been evident, as long as this Committee has been sitting, that whether we are dealing with providers, who obviously could be called special interest groups, whether we are dealing with lobbyists, who actually can be called special interest groups; whether we are dealing with the whole range of people that have special interests that come before us-- Why we extend every courtesy to them, and why we listen to everything that they have to say -- maybe we shorten it sometimes, but in any event, we listen to what they have to say-- Our final judgment is usually based upon what we think is good for the patient, and what we think is good for the community. So, obviously, in any kind of legislation, the first people to come forward would be the people who have a special interest. But, the Legislature, of course-- Thank the Lord for that, the Lord has given the Legislature at least some intelligence; it may be small but it is enough that they are able to perceive the differences.

I just wanted to make that known at this point because I thought it was the opportune time to say that, and I hope that in the restricted area that we are operating with this bill, that we are going to come up with a good bill. Frankly, we are not going to cure all of the evils and all of the ills that we see out there with this hearing.

But I think that this hearing may lead us into other areas at a later date. Thank you very, very much.

MR. ROGERS: Thank you very much.

ASSEMBLYMAN OTLOWSKI: May we hear from Marilyn Goldstein, please?

Marilyn, give us your name and tell us who you are representing, please.

MARILYN GOLDSTEIN: My name is Marilyn Goldstein, and I am here today representing the New Jersey Alliance for the Mentally Ill. I would like to thank Assemblyman Otlowski and Assemblyman Felice for being able to speak here today.

The New Jersey Alliance for the Mentally Ill is a coalition of family advocacy and self-help organizations which incorporated in February, 1985. The coalition represents groups from 18 counties and is part of the growing family movement in the mental health field in this State. We are an affiliate of the National Alliance of the Mentally Ill, and we are privileged to have Carmela Spadola, who is the founder of the first family organization in this State, as our member. She was on the Steering Committee of the National Alliance of the Mentally Ill.

For too long, families of the mentally ill have been passive and ashamed due to the stigma of mental illness. The time has come for us to become actively involved in saying what our family members need, and advocating these needs. It is for this reason that I am here to testify today on the screening and commitment process.

First of all, members of the Alliance, who are family members, have painfully experienced many of the problems and issues with our current laws in this area and believe that new legislation is needed. We feel that the process of involuntary commitment can not be looked at apart from the needed services in the community. Involuntary commitment has, in the past, been seen as an alternative because other services did not exist. We feel that this is not a productive or useful process for the individual or the family. A variety of community mental health services need to be in place so that whenever possible, a person can be helped in a fashion which does not deprive them of their liberty.

Family members are frequently faced with the need for help with their family members, and the current law does not provide this help. There should be services in the community which can evaluate a person and provide information on a range of possible things which can be done to help. This currently exists in some emergency screening services in the State, but it needs to be expanded so that it is available to all persons and their families.

Currently, mental health professionals will not intervene unless a person is willing to come for service. The current law does not provide them with any protection. The result of this is that family members frequently have to sign a criminal complaint against their family members before some intervention takes place, and frequently the intervention will be jail. This is not what the family wants or needs. It can be a very traumatic experience for the family as well as the person who needs to be hospitalized. Any new legislation must provide for outreach and home visits, and give mental health professionals the authority and legal protection to carry out those functions.

We also feel that language needs to be broadened so that a person does not have to be dangerous in order to receive treatment. It is our hope that in many instances, even persons who need involuntary treatment can remain in general hospitals in the community to receive their care. Removing a person to a State hospital far from their home is not helpful in terms of allowing that person to stabilize and return quickly to his family and community.

Lastly, we feel that positive family involvement needs to be supported by everyone in the mental health system. The family has valuable information about their family member, and also needs to be given support and information during this time of high stress.

The experience of families can be extremely helpful in developing any legislation dealing with mental health services. The New Jersey Alliance for the Mentally Ill stands ready to assist you in any way we can. What the mental health system in the State looks like affects us very directly. Our goal is for a better quality of life for our loved ones. Your contribution in passing this needed, new

screening and commitment bill to replace our present commitment law would not only save lives, family trauma and financial depletion, but ultimately, taxpayer dollars. Thank you.

ASSEMBLYMAN OTLOWSKI: Thank you very, very much.

May we have Dr. Stanley Kern, please?

DR. STANLEY KERN: I am Dr. Kern. I have been practicing psychiatry in New Jersey now for 25 years as of this month. I am a Clinical Associate Professor of Psychiatry and the New Jersey Medical School in Newark, and an Adjunct Associate Professor of Law at Rutgers Law School. I am member of the Board of the Mental Health Association of Essex County, and I am President-elect of the New Jersey Psychiatric Association. I am here representing the New Jersey Psychiatric Association.

I am not going to waste your time reiterating the things that Dr. Wilson has told you. He has presented the position of the New Jersey Psychiatric Association in regard to the general concept of commitment and mental health treatment in New Jersey. The bill, Assembly Bill 114, we think is a good bill. It is a vast improvement over what we have today. It is the kind of bill that we can support. We do think that there are a few weaknesses in it. It does not mention screening centers, and it has no mention of an outreach program.

Now, in Essex County, where I come from, we do have screening centers in operation now, and we do have an outreach program. I know from speaking to families of mental health patients that this is something that they found extremely useful, extremely valuable, and I think it is something that should be included in the commitment bill, so that people don't have to be brought in by the police. I know that--

ASSEMBLYMAN OTLOWSKI: Doctor, excuse me. Would you do the Committee a favor? This point that you just made now-- Would you please give us that in a separate memorandum? Just give us that in a separate memorandum so we have it directly from you. The things that you mention that you think this bill ought to incorporate-- Would you let us have that, please?

DR. KERN: I just wanted to mention -- I know that the Department of Human Services has a proposed bill that includes these things and that something like this--

ASSEMBLYMAN OTLOWSKI: I just want what you said, a memorandum coming from you as the head of the Psychiatric Association. I would want that for the record. All right?

DR. KERN: Yes, surely.

As I was saying, I know that the Department of Human Services has a proposed bill that includes these things and some amalgamation of Assembly Bill 114, and the proposed bill from the Department of Human Services is something, I think, that would be a tremendous improvement--

ASSEMBLYMAN OTLOWSKI: We are going to take a good look at that, no question about it. That is why I am asking you for the memorandum.

DR. KERN: Surely. And I think that this is something that would really put together all the kinds of improvements that we would like to see in a commitment bill. This is really all I want to say.

ASSEMBLYMAN OTLOWSKI: Doctor, thank you very, very much.

DR. KERN: Thank you.

ASSEMBLYMAN OTLOWSKI: May we have Joan Mechlin, please?

Thank you very much.

JOAN MECHLIN: I am Joan Mechlin. I am President-elect of the New Jersey Association of Mental Health Agencies, but I have also worked in crisis programs for 16 years in Pennsylvania and, for the past eight years, in the State of New Jersey. I am presently the Program Director of the Crisis Service Guidance Center in Camden County. By working in the field for 16 years, I have had much experience in doing screening and in working in emergency services.

The Association represents agencies who are committed to developing a comprehensive system for the care of the mentally ill. In building the community based programs, there has been an increase in the availability of crisis emergency services, crisis beds in general hospitals, out-patient programs, partial care, residential and case management and family support groups that are designed to help maintain

the client and the community, and improve their quality of life. As a result of these programs, the number of people receiving community-based care has increased, decreasing the number that are committed to State and county hospitals.

The mental health agencies in New Jersey see themselves as part of the continuum of care. This continuum of care begins with the least restrictive involvement to the most restrictive setting, from self-help groups, outpatient, partial care, residential, screening programs, and involuntary hospitalizations, both in general hospitals and State and county hospitals. The continuum also includes involving the clients, families, caretakers, and agencies in treatment. The New Jersey Association of Mental Health Agencies agrees that there needs to be a new statute that establishes clear commitment criteria and streamlines procedures. We feel that legislative changes should not only clarify and streamline the process, but should also give legislative support to the system providing the care and treatment for the client. This includes crisis programs, caretakers, criminal justice systems, and facilities providing voluntary and involuntary treatment. The changes should focus on what is needed to provide the client with treatment in the community, and also to provide the community-based care system with the means to provide treatment for the client when it is needed.

As a person who has worked in crisis programs, I personally support the need for outreach and having legislative backup to be able to bring somebody from the community back to the screening process, when that person is exhibiting behavior that is dangerous. We need to have clear criteria and definitions so there is not the conflict between the disciplines as to who needs to be committed and who does not need to be committed. The screening centers -- and I have worked in two in the State-- We have decreased the hospitalizations to the State and county hospitals by providing options in the community, and not "streeting" people. Thank you very much for this opportunity.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

I just want to take the liberty at this point to particularly thank two people who are here, for the help that they have been to this

Committee over a long period of time. I just want them to know that we appreciate everything that they have done for this Committee, and the fact that they have made their talents and their time available to us over a long period of time. One, of course, is Dr. Perr, whose testimony we heard. Doctor, we are very grateful to you for all of the services you have rendered to this Committee over a long period of time. We hope, of course, that you are going to continue your interest, and we are going to be leaning on you as we finalize this bill.

The other person is Professor Meyer Schreiber, who has been of exceptional help to this Committee in many, many areas, and we are delighted that he is here this morning. As a matter of fact, before we finalize this bill, we will probably be talking to him and just asking him to talk to our staff, if he has any ideas that will be helpful to us. So to both of you gentlemen -- this is an opportunity, and I am sure that I am speaking for the whole Committee, for us to express our deep thanks to you for all of the time you have given us, and as a matter of fact, even for the patience that you have had with us. Thank you very, very much, both of you.

Now we are going to hear Jill Hoffenberg, please.

JILL HOFFENBERG: My name is Jill Hoffenberg, and I am here representing the ACLU -- the American Civil Liberties Union of New Jersey. However, I bring what I believe is a unique perspective to this problem, in that I am a psychiatric nurse -- I have a Master's degree in psychiatric nursing -- and I have been practicing for the past 23 years in the field.

I have worked in State hospitals, I have worked in private hospitals, and I am currently working in the mental health unit of a community mental health center in a general hospital. I have also taught psychiatric nursing in the past.

Instead of just reviewing what I have written in my comments, what I prefer to do is make a couple of points that I think--

ASSEMBLYMAN OTLOWSKI: Let your written testimony speak for itself, all right?

MS. HOFFENBERG: Right. I will just make a couple of comments that I think should be included in a commitment bill.

I agree with many of the other speakers that have spoken already. I feel, along with Dr. Perr, that a commitment bill should deal specifically with commitment and not get clouded with other issues, such as screening centers, discharge planning, or other kinds of things. I think a commitment bill that is simple would be the easiest one for people to comment on and to agree on.

The ACLU believes that whenever possible, voluntary hospitalization -- voluntary treatment -- is the preferred route. We would encourage people to remember that this is always an option. If somebody is mentally ill and dangerous to themselves or others, then there are reasons for commitment. But we would like to see the standard for commitment stay with a dangerous standard. We are concerned that people who are not dangerous should not have their liberty taken away from them unneccessarily, and we feel that more emphasis should be put on community programs and support services in the person's locale.

We need to remember that when somebody is involuntarily committed, their liberty is taken away from them. As much as possible, we need to ensure that due process takes place. We would like to see that the person is hospitalized when they must be involuntarily committed for the briefest time possible before a judicial review or court review. We believe, along with the Division of Mental Health Advocacy, that certain rights need to take place during this court procedure. The person should have an attorney or an appointed attorney, the person should have the right to be present unless he is disruptive, and the person should have the right to have his own witnesses.

We also believe that the time period should be as brief as possible prior to this court review. Three to five days seems more than adequate; 20 or more days seems very disruptive to us, since there may be a difference of opinion as to whether or not this person needs to be treated.

We believe in a right to refuse treatment, and I was very glad to see this included in your bill. However, we very strongly believe that in addition to voluntary patients having the right to

refuse treatment, patients who are in the involuntary commitment process, prior to a court hearing, should also have a right to refuse treatment. We feel that certain types of treatment that you have spelled out, such as electroconvulsive therapy or psychosurgery, are automatically not allowed for involuntary patients. But sometimes people forget about the adverse effect of psychiatric medication, and when we are talking about treatment, frequently, this is the method of treatment that we are talking about. Certain patients have had very adverse effects to psychiatric medication, and I would be very opposed to having somebody forcibly treated with medication prior to the court hearing. If they are forcibly medicated, sometimes they are less able to present their case in court and in fact they may appear sicker than they are. That concerns us greatly.

I also would like to encourage that, whenever possible, commitment should be done in the least restrictive setting, for example, an outpatient program rather than an inpatient program, or a community hospital rather than a State hospital. I agree that the closer the person is kept to the community, the better chance of integration that person has. I also feel that the community mental health centers are evolving, and are doing more outreach and more community services. I would like to see that process continue also, on a voluntary basis whenever possible.

There are other points that I have, but in lieu of time, I would be very happy to answer questions.

ASSEMBLYMAN OTLOWSKI: Thank you. Let me just say this, so we all know where we go from here. I am going to ask the staff people that if they need any help, to call for it, and to review all of the testimony that was submitted today. After they review the testimony, I want to know that they have reviewed it, and then I would want some suggestions from the staff people. Then I am going to call an Executive Session of the Committee to go over the staff committee's examination and recommendations. We will then meet in Executive Session to determine what, if any, changes we are going to make in this bill before we finally submit it for release. Hopefully, I would like to see that done in the next couple of months.

In the meantime, I want to give the staff the opportunity to go over this testimony. Some of the Committee members will want to go over the testimony, they will want to talk to staff people, and after that is done we will need an Executive Session to determine the date for the release of the bill.

Thank you very much. You have been very, very helpful.

MS. HOFFENBERG: You are very welcome. Thank you for letting me talk.

ASSEMBLYMAN OTLOWSKI: Thank you.

(HEARING CONCLUDED)

APPENDIX

State of New Jersey
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TESTIMONY OF LINDA G. ROSENZWEIG, DIRECTOR
DIVISION OF MENTAL HEALTH ADVOCACY
DEPARTMENT OF THE PUBLIC ADVOCATE

Before the Assembly Committee on
Corrections, Health and Human Services
Relating to the Voluntary and Involuntary
Commitment of Persons to Mental Hospitals

June 5, 1985

Mr. Chairman and Members of the Committee:

The Department of the Public Advocate, as you know, represents involuntarily confined patients from nine counties at a total of 7,200 commitment and review hearings annually. Based upon that experience, we suggest to you that revision of the commitment laws of this State is both necessary and desirable. We say that because the New Jersey statutes which govern admission and commitment to inpatient mental health facilities were written in 1918 and last amended in 1965. Since that time, there have been vast changes in:

(1) Judicial mandates governing the standards and procedures for involuntary commitment.

(2) Clinical practice, specifically the availability of involuntary, short-term treatment in local general hospitals, as a supplement and alternative to treatment at state and county psychiatric facilities.

(3) Federal and state policies regarding the provision of mental health services, such as community mental health service systems and community-based screening systems.

Because of these changes, three things have happened:

(1) Our statutes do not reflect the stringent due process guarantees that our Supreme Court has found to be constitutionally mandated. (I will indicate what those are in a few minutes.)

(2) The actual governing standards are not found any longer in these outdated statutes, but are scattered throughout a dozen Supreme Court cases and the Court Rules. For that reason, the applicable law is not readily accessible to courts, attorneys, mental health providers and consumers.

(3) There is a gap between the law and the existing practices.

But before any legislative change is made, it is essential that certain key considerations be kept in mind. The first of these is that involuntary commitment entails a massive deprivation of liberty. The patient is moved against his will from his home, his spouse, children and job, and faced with locked wards and regimentation of the details of his daily life. It is difficult to think of any deprivation of liberty more massive than this facing a person who has broken no law and committed no crime.

It is for that reason that the New Jersey Supreme Court has clearly indicated, as recently as 1983,[1] that the scope of the commitment power itself is limited. The State cannot constitutionally commit individuals to mental hospitals solely on the basis of mental illness. Nor can persons be committed against their will simply

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1. In re S.L., 94 N.J. 128 (1983).

because they are unable to care for their basic needs. In New Jersey, an individual cannot be committed unless he poses a "danger to himself, others or property by reason of mental illness," and the risk of such dangerous conduct must be substantial within the reasonably foreseeable future.[2]

It is for that reason that we oppose adding a "gravely disabled" standard to the commitment laws. That standard would allow an individual to be committed due to "inability to provide for basic needs such as food, clothing, shelter or safety."

It is readily apparent that such a standard would not be constitutional. When urged by a Supreme Court Task Force to adopt such a definition, the Supreme Court declined to do so because such a standard would not comply with the New Jersey or Federal Constitution, and I will quote the Supreme Court:

> The Task Force on Mental Commitments encourages us to expand the Krol standards of commitment to cover "an individual who by reason of mental illness is unable to care for himself without some level of aid or supervision." We respectfully refuse this invitation. The civil commitment process must be narrowly circumscribed because of the extraordinary degree of state control it exerts over a citizen's autonomy. To widen the net cast by the civil commitment process in the manner suggested by the Task Force is inconsistent with the central purposes of the commitment process. It would permit the State to commit individuals to mental institutions solely to provide custodial care. This authority cannot be justified as a measure to safeguard the citizenry under the police

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2. In re S.L., supra, 94 N.J. at 138.

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> power. Nor is it a proper exercise of the State's parens patriae power because confinement in a mental hospital is not necessary to provide the care needed by individuals who are simply incapable of living independently.

The Court also specifically stated that when a person needs assistance with his shelter or daily living needs, involuntary commitment is not an acceptable answer. When an individual is mentally ill, and if he is incompetent and in need of assistance with his shelter or living needs, a court-appointed guardian can transfer the individual to a boarding home or residential health care facility, and can manage his money and provide for his care, comfort and maintenance. Such an approach is not only more humane in that it avoids institutionalization but is consistent with recent national and New Jersey trends favoring community-based care and the preservation of family and community ties.

Moreover, I suggest to you that if a gravely disabled standard is instituted, recent positive trends toward reducing the size of in-patient psychiatric populations will come to a screeching halt. State hospitals that eight years ago held 1,000 patients, and now hold 700, will again hold 1,000 patients or more if a gravely disabled standard is enacted. In fact, the State of Washington in 1979 changed its commitment laws to add a gravely disabled standard. They experienced an 85% rise in involuntary commitments in the six-month period after the law was changed, compared to the same six-month period a year earlier.[3] Such a rise in New

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3. The number of involuntary commitments rose from 618 to 1,143, comparing July-Dec., 1978 with July-Dec., 1979. The law went into effect on Sept. 1, 1979.

Jersey would needlessly cost New Jersey taxpayers millions of dollars. In-patient treatment costs over $100 a day in each of the state hospitals, while community-based care costs $20 to $30 per day. Changing the standard to include "gravely disabled" would also adversely affect patient-staff ratios and the quality of care. We would see a return to overcrowded and understaffed facilities.

Thus, the Department of the Public Advocate favors retention of the existing dangerousness standard because it is the only standard which makes sense legally, fiscally or systemically.

Having said that, I would like to outline for you briefly the other elements which should be contained in any revised commitment bill:

1. A provision for the establishment of screening centers so that screening takes place in the community and not in the state or county psychiatric hospitals. We favor screening centers, and regard them as a vital component of any mental health delivery system. It is important that a 72-hour maximum be established as the amount of time that an individual may be involuntarily detained at a screening center.

2. Mandatory provision for obtaining a judicial order within the first 24 hours after arrival at the screening center, authorizing the 72-hour detention and establishing a commitment hearing.

3. There should be two screening certificates. One should be of a psychiatrist, and the other by a psychologist, physician or psychiatrist. There should be no immunity from liability for such persons.

4. Voluntary admission should be preferred over involuntary admission.

5. A person should be able to be committed to a short-term care hospital, which is a general hospital with an in-patient psychiatric service, and not just to a state or county psychiatric hospital. If there is to be a transfer from there to a state or county hospital, there must be a hearing.

6. The law should specify that involuntary hospitalization shall be sought only when no less restrictive alternatives are available.

7. Upon arrival at the screening service, the person should have the following rights and should be provided with them in writing:

(a) The right to have examinations and services provided in his primary means of communication or with the aid of an interpreter, if the person is of limited English-speaking ability or suffers from a speech or hearing impairment;

(b) The right to a verbal explanation of the reasons for admission, the availability of an attorney and the rights provided in the act.

8. A patient committed pursuant to a temporary judicial order signed within the first 24 hours must receive a hearing with respect to the issue of his continuing danger to self or others within twenty days.

9. The patient must have the following rights at the hearing:

(a) The right to counsel or appointed counsel; a patient shall not be permitted to appear without counsel.

(b) The right to be present, unless the court determines that the patient's conduct at the hearing is so disruptive that the proceeding cannot reasonably continue while he is present;

(c) The right to present evidence;

(d) The right to cross examine witnesses;

(e) The right to a court-appointed psychiatrist, psychologist, nurse, social worker or other relevant expert witness acceptable to the patient as to profession and credentials. The cost of the witnesses, if any, shall be borne by the person or public body charged with the patient's legal settlement;

(f) Testimony in support of commitment must be by a psychiatrist who has examined the patient within the past five days.

10. The evidence of dangerousness must be by clear and convincing evidence, and the burden of establishing that must be upon the State at all times.

11. If the court is satisfied that the commitment standard is met, it shall order a review hearing three months, nine months and annually from the date of the first hearing; however, the court should specifically be empowered to accelerate those intervals for good cause.

12. If the court is not satisfied that the patient constitutes a danger, it should order his immediate discharge. It is not acceptable to delay the discharge for 24 hours to do discharge planning. That must be done in advance.

13. Treatment issues should be able to be raised at the hearing, on notice to the hospital and to the State.

14. If the court finds that the patient is not a danger but is in need of placement in the community not presently available, it should order him discharged pending placement with review hearings assessing the adequacy of placement efforts every three months. These should be full hearings, with the patient present.

15. Minors should be able to voluntarily admit themselves at age 14 or older. A court hearing should be held to determine whether the admission is voluntary and informed.

I thank you for the opportunity to appear before you today and to contribute to the public discussion which is so essential to reform of our State's commitment laws.

The Division of Mental Health and Hospitals is pleased to be here today to discuss with the Committee the entire range of issues surrounding admissions and commitment to inpatient mental health facilities and the role our comprehensive system of mental health services plays. For the purpose of our discussion, we will make our remarks on the issue in general, rather than commenting on A-114 line-by-line. We ask the Committee's indulgence with our method of testimony; the Division believes the importance of the issue is such that we are taking the broadest possible look at it.

At the outset, we must commend the Chairman for his foresight in introducing A-114 and for holding this hearing. The laws of New Jersey that govern admission and commitment to mental health facilities originated in the early 1900's. Even the most recent statutory revisions date back 20 years. Current Law is confusing, inconsistent and outdated.

Clinical practice has made giant steps in the treatment of mental illness in the last 20 years. Further, public policy on both the state and federal level has changed dramatically and there are a myriad of judicial decisions affecting the screening and commitment process, and during this period there has been a rapid expansion in the community mental health system. We applaud the committee and particularly the chairman for being willing to wrestle with these confusing and sometimes competing changes and for attempting to effect legal and legislative order.

The Division of Mental Health and Hospitals has been giving serious consideration to all the legal revisions we believe are necessary to bring this particular body of law into the 1980's. It is our position that the first and guiding principal is that commitment for the mentally ill must focus on treatment as near to the person's home as possible, and not simply custody. Following this premise, then several others follow in logical order: 1) the description of behavior, as evidence of mental illness, dangerousness and grave disability must be clear and concise; 2) the process of screening candidates for commitment must be thorough, expeditious, and appropriate; 3) treatments, whether voluntary or involuntary should be readily accessable, preferably in close proximity to the patient's natural environment; and 4) all the elements in the process must mesh and there must be close coordination and linkage between all the facilities that are or might be involved.

At the risk of redundancy, we would like to discuss each of these elements in detail.

By clarifying what precisely is meant by "mental illness", "dangerous", and "gravely disabled", the Division takes the position that a clear picture must be drawn so that commitment, especially involuntary commitment, is not inappropriate. Involuntary commitment by nature interferes with an individual's liberty. Every precaution must be taken to insure that when commitment does occur, no other course of treatment seems

possible. With clarification of these terms, patients, families, mental health professionals, and court personnel will be given a clear picture of the patterns of behavior that would indicate the need for commitment.

The Division has developed a set of working definitions that we believe should be included in any bill the committee releases. They are:

> Mental Illness: A current and substantial disturbance of thought, mood, perception or orientation which significantly impairs judgement, behavior or the capacity to recognize reality. Simple alcohol intoxication, transitory reaction to drug ingestion, ordinary senility or developmental disability constitute mental illness for the purpose of this act only when such substantial impairments result.
>
> Dangerous: A recent act or threat indicating a substantial likelihood in the reasonably foreseeable future that the person will: (1) inflict serious physical harm upon himself or herself; or (2) inflict serious physical harm on another person; or (3) cause serious damage to property.
>
> Gravely Disabled: A recent failure or inablility to provide for basic needs such as food, clothing, shelter or safety, indicating a substantial likelihood in the reasonably foreseeable future that the person will experience serious physical harm.

Any commitment decision would be based upon not only the professional diagnosis of mental illness but also the evidence of dangerousness and/or grave disablilty.

The screening process, with the attendant possibly of commitment, must be exhaustive. Such screening must sometimes be performed in an emergency atmosphere, but must always keep the welfare and rights of the patients uppermost. Prevention of inappropriate commitment, especially to a long-term facility such as a state hospital is difficult, but in an atmosphere of crisis, with proper screening, is possible.

Over the past several years, the Division has put a great deal of emphasis in the building of a community-based mental health care services. We envision the screening process under this bill taking place in such a location. The professionals in such a setting must be thoroughly familiar with all the agencies, facilities and programs available within the community and must view involuntary commitment as absolutely the last resort.

Closely related to the well refined and smoothly functioning screening process, mentioned above, the treatment elements to which the client is referred should be as close to that person's natural environment as possible.

Among the community-based mental health care systems the Division has supported and encouraged is the establishment of short-term acute care units, usually located in general hospitals. These are not screening facilities, nor long-term residential hospitals, but are acute care, short-term facilities. They are intended for crisis treatment and

any bill on this issue should, we believe, stipulate the use of such acute care units whenever possible as the alternative to commitment to a state facility. Commitment to such an acute care unit allows for emergency treatments and stems public hospital admissions and judicial involvement. Most importantly, though, use of short-term care, voluntary or involuntary, in the patient's community prevents dislocation and disruption of the natural, familial support system. Further, placement in a general hospital is cost effective and provides the sort of treatment the Legislature envisioned when S-81 was passed.

Finally, all the elements of the mental health care system must work virtually as a unit to insure systematic care for the client or inpatient. The lines of communication must be firmly established and open at all times. At the first clinical indication that a patient is ready for a less restrictive setting, the system should, ideally, be prepared to accomodate the patient. The entire purpose of the whole system is to maximize independent functioning and we must never lose sight of this goal.

The Division has, over the past several years, worked closely with representatives and practioners of all the mental health care fields in an effort to reach consensus on these points. We believe we have been successful in formulating these principles to govern the commitment process and are confident that a bill incorporating these points will go far toward meeting the need for improvement and update of the laws governing the system.

We appreciate the opportunity to appear before the committee. The Division is, of course, prepared to help in any way we can to assist the Committee in drafting the best possible legislation addressing this sensitive issue and to insure that all the mental health disciplines are comfortable with the bill.

Thank you for your consideration.

LC/jd/18

T E S T I M O N Y

NEW JERSEY PSYCHOLOGICAL ASSOCIATION

Re: Assembly Bill A-114

June 5, 1985

I want to thank the Committee for this opportunity to testify on this Bill which attempts to address the needs of many of the involuntary and voluntary patients committed to mental hospitals. On behalf of the New Jersey Psychological Association, I wish to support the attention that this Committee is giving to the health and welfare of the many distressed persons who are in need of substantial mental health care. In reviewing the legislation as offered, we find several of its provisions as insufficient and limiting in the quantity and quality of services that these patients would receive and too restrictive when it comes to the backgrounds of the professionals that are called upon to make the very difficult and multifaceted decisions which surround these patients' institutionalization.

The particular issue which I would like to bring into focus for the Committee this morning centers around the value of including a multidisciplinary assessment in the commitment procedure. As the Bill is currently presented, physicians (some of whom may not even be psychiatrists) are the only practioners invested with the powers of issuing certifications

for emergency, temporary or indeterminate commitment procedures. While medical practioners who have entered into the sub-specialty of psychiatry are justifiably qualified to perform such certifications, many of the other physicians may not have the experience or commensurate training that qualify them for the particularly weighty decision which may involve a patient being subjected to involuntary commitment. It is important that this Committee be keenly aware of the most current treatment in mental health services, which endorse a multidisciplinary approach to the decisions and treatment of persons suffering from a mental disorder. For example, in the 1985 Standards for the Joint Commission on the Accreditation of Hospitals, this nationally recognized group has issued Consolidated Standards for Psychiatric Facilities which address the importance of interdisciplinary assessment and treatment. These Standards (Chapter 17, Article 17.1.1,) require that "an assessment shall include, but shall not necessarily be limited to, physical, emotional, behavioral, social recreational, and, when appropriate, legal, vocational and nutritional needs." Furthermore (Chapter 17.4) the assessment shall include, but not necessarily be limited to, the following: (A) a history of previous emotional, behavioral, and substance abuse problems and treatment; (B) the patient's current emotional and behavioral functioning;

(C) when indicated, a direct psychiatric evaluation; (D) when indicated, a mental status examination appropriate to the age of the patient; (E) when indicated, psychological assessments, including intellectual, projective, and personality testing; and (F) when indicated, other functional evaluations of language, self-care, and social-affective and visual-motor functioning. Further, in its section regarding treatment (Chapter 18.1.3.2) the Consolidated Standards suggest that "...a multidisciplinary team shall develop a master treatment plan that is based on a comprehensive assessment of the patients' needs."

It therefore seems important that for the purpose of any patient's comprehensive assessment and treatment, a similar, multidisciplinary assessment be performed as it pertains to the certifiability of someone who is thought to be in need of care in a psychiatric facility and placed there on an involuntary basis. Other mental health disciplines may also have much to contribute to a relevant assessment of a patient in the midst of a commitment process, but I would like to briefly address the issue as it pertains to the participation of licensed clinical psychologists in the State of New Jersey.

First I would like to bring to the Committee's attention, factual evidence which supports the use of psychologists in the commitment process. At our last review, a minimum of 29 states now include psychologists in one manner or another in the commitment procedure. The mode of their inclusion varies somewhat from state to state, and 60% of the laws were enacted since 1975. This statistic speaks to the current trend throughout the country and New Jersey can well follow this forward looking pattern. Some of the laws refer to the examiners as mental health professionals in general. In 23 of the 29 State laws psychologists are defined as those licensed or certified by a process similar to N.J.Statute. 22 of the states include psychologists in not only the commitment certification but in the judicial procedure as well. Six states allow psychologists to independently (i.e. without medical counterparts) screen or evaluate a potential patient in an emergency. In those 6 states the commitment must then be later reviewed by psychiatrists or physicians. Ohio State law also mandates that if a physician commits alone, his diagnosis must then be reviewed by a psychologist or psychiatrist within 48 hours. We feel these collaborative efforts insure a fair system of checks and balances for both the patient's needs and the clinical viewpoints offered.

More recently, N. Dakota law (H.B. 1446, 1985), provides for the expansion of the list of providers who may participate in and conduct commitment proceedings. Psychologists in that Bill are defined as "independent expert examiners and mental health professionals) who are allowed to assess a patient's mental condition." And most recently, Virginia psychologists gained parity with psychiatrists in commitment proceedings. Texas and several other states have introduced similar proposals. Many of these states passed these laws in the belief that psychologists' participation in the civil commitment process enhances the quality of the commitment decisions and the fairness of the process for the patient and his/her community. The desirability of multidisciplinary diagnosis could be viewed as analogous to what the medical profession is subjecting itself to in a somewhat different context. For example, second opinions are often required before undergoing major surgery. As a result, the number of patients being surgically treated has decreased significantly. Most practitioners want the opinion of one specialist, say the surgeon, checked against the opinion of another,for example an internist, before major surgery. When an individual's personal freedom is at stake it is our position a second or third opinion should be mandatory, not even optional.

As the Chief Clinical Psychologist at Essex County Hospital Center, my staff and I are intimately involved in the psychological assessment of the over 600 admissions we have each year. This assessment is mandated by Unit and Medical Director policy. 70% of these patients have been committed to our facility. In a large percentage of the cases we receive formalized requests from psychiatrists for additional psychological assessments to substantiate or refute the recommendation for continued commitment. The assessment skills we have are geared to answering the questions of whether the patient has a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgement, behavior, or a capacity to recognize reality, or the ability to meet the ordinary demands of life. As you probably recognize, the referrals we get for additional assessments are for precisely those conditions included under the definition of "mental illness" proposed in the Bill which is presented here for consideration. This definition ironically clearly stresses the functional or psychological processes in mental disorder without alleging organic or medical causes.

Psychologists are highly trained to conduct these psychodiagnoses. Psychiatrists are quite willing to have non-

psychiatric physicians participate in the examination for mental disorder, and some suggest that clinical psychologists are not competent to do so. But, paradoxically, medical students in New Jersey receive minimum training in Behavioral Sciences when compared to psychologists, and much of the training which psychiatrists do receive in the behavioral sciences and psychodiagnosis is provided by psychologists. Psychologists are uniquely trained in specialized intervention skills (for example behavioral intervention), crisis management skills, and knowledge in dynamics, all of which are crucial in gaining access to the dangerous and disordered patient. This training affords a psychologist a broader and comprehensive view, which helps to understand the level or the seriousness of the problems which a patient presents, not only the patient's transient behavior which can vary so dramatically in such disturbed patients.

I strongly suggest you do not support this legislation for the above cited reasons. Our organization prefers the establishment of "screening centers" to assist in the commitment process. The centers act as an intermediary step in the treatment process before the level of restriction which institutionalization implies takes place. Such screening centers and

their implementation are spelled out in careful detail in legislation offered in N.J.Senate Bill 2159. A system such as the one outlined there is much more attuned to patient needs and in the long run, more cost effective.

Once again thank you very much for the opportunity to have you hear our point of view on this Bill.

Wayne T. Young, Ph.D.
New Jersey Psychological Association

The American Civil Liberties Union of New Jersey is encouraged by the modifications that appear in the printed version of Assembly Bill 114, a bill to revise the commitment laws, and we would like to recommend additional changes to address civil liberties issues. This position paper will highlight our major concerns. The points are addressed in the sequence that they appear in the bill.

1. Definitions

a. A bill to commit mentally ill persons to institutions does not need six definitions referring to mental retardation. We recommend deleting these references since they tend to confuse the distinction between the two mental conditions. (Page 1, lines 10 and 19; page 2, lines 31 to 40 and 59 to 60; page 3 lines 85, and 89 to 104)

b. "Family care" concept is defined on page 3, lines 80 to 88 and referred to on page 2, line 57 but not referred to in the body of the bill. It seems out of place in a commitment bill. The concept may have merit and should be considered, along with other alternatives to continued involuntary commitment, in another forum. It should, however, be deleted from this bill.

c. We recommend changing the definition of "Mental Illness" by adding "current and" to "substantial disorder" on page 4, lines 107 to 114, and by eliminating "or ability to meet the ordinary demands of life" on line 110. Gross impairment of "judgment, behavior or capacity to recognize reality" are sufficient standards. Inability to meet ordinary demands of life is too vague a standard and is open to a variety of interpretations.

d. Involuntary commitment to an institution entails deprivation of liberty and should be used only as a last resort. Before the state takes action against citizens, no matter how seriously disturbed, it should be certain that the harm caused to job, family life, and reputation by involuntary commitment is not going to be more disruptive than the mental illness itself.

The definition of "Mental illness and in need of hospitalization" poses grave concerns to the American Civil Liberties Union of New Jersey. It encompasses so many conditions that anyone, at some time during their life, could be involuntarily commited using its standards. A narrower definition would serve the purpose of involuntary commitment and yet not limit the types of individuals who could seek

voluntary hospitalization. The phrase should be changed from "in need of hospitalization" to "in need of involuntary commitment" to make the definition clearer.

We recommend the following definition:

> "Mentally ill and in need of involuntary commitment" means that the person is suffering from mental illness and (1) is a danger to self as a result of an attempt to inflict serious bodily harm against oneself or an attempt to commit suicide, or (2) is a danger to others as a result of an attempt to inflict serious bodily harm against another person.

2. Provisions for Commitment

a. Under the provision for Emergency Commitments, since one physician initiates commitment, we support the sentence: "The institution shall retain discretion as to whether or not to admit the person and shall notify the physician of its decision." This ensures that commitment is a decision by more than one individual. (Page 5, lines 35 to 37)

b. The time limits as described in the bill for Emergency Commitments (5 business days) and Temporary Commitments (7 business days) are more than sufficient to evaluate and decide if court-ordered commitment should be sought or if the person should be discharged. (Page 5, lines 38 and 52 to 53)

When these two types of commitment are applied to the same individual, the time prior to a court hearing becomes 12 business days which could be as much as 19 calendar days. We believe that this is too long a deprivation of liberty without due process. The total time prior to the initiation of a court hearing should not exceed 7 business days. The court can grant an extension while the proceedings are in process (page 6, lines 64 to 66). The maximum length of time for the extension should be specified in the bill. One week extensions should be more than adequate.

c. During the evaluation process and prior to court review, the bill provides that "the institution shall evaluate the person and provide treatment." We believe that the institution should only provide treatment if the individual gives informed consent or if an emergency exists where the person would harm self or others if not treated. (Page 5, lines 39 and 54) People have the right to self determination unless courts order involuntary treatment. Forced medication,

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prior to the court hearing, can have serious medically adverse effects as well as impede the person's ability to defend himself during the court hearing.

The right for the person to be present in court, the right to counsel or appointed counsel and the right to be informed of the hearing date should be explicitly stated in the bill in the section on court hearings for involuntary commitment. Otherwise, a significant loss of liberty could occur without due process. The name "Indeterminate commitment" could be more clearly called "Court-ordered commitment" since indeterminate is a vague and unsettling phrase.

A second court review, when needed, should take place 3 months after commitment as stated in the bill. Subsequent reviews should be at 6 months, 9 months and then annually. Patients should also have the right to petition the court more frequently.

3. Voluntary Admissions

Although the bill addresses voluntary admissions to public hospitals, a commitment bill should not make references to voluntary admissions to private hospitals. (Page 7, lines 11 and 12) These admissions are between the individual and the hospital and should be treated no differently than any other voluntary medical admission to a private hospital.

4. Minors

a. The bill provides for minors between the ages of 16 and 18 to be able to apply for voluntary admission with an automatic court review within 7 days. This allows minors who know they need help to get it even if their parents are unable or unwilling to accept the severity of their illness (page 7, lines 17 to 20). We agree with this provision but believe that the age should be lowered to 14.

b. When a parent "voluntarily" admits a minor ages 14 to 18 to an institution, the bill provides for an automatic court review after 30 days. We believe that the review should occur after 7 days. (Page 7, lines 20 to 24) If the minor agrees with the parent on the need for voluntary hospitalization, this hearing could be waived by the court.

5. Informed Consent

Generally, in mental illnesses, there is more than one treatment approach

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that would be effective. When patients are given treatment choices which define the risks and benefits of treatment as well as the risks and benefits of no treatment other than confinement, patients are more likely to accept medical decisions. When patients are forcedly treated, the anger and loss of self-esteem that occurs, impedes treatment. When differences of opinion occur in the treatment approach, an arbitrator should help make treatment decisions, unless a patient is declared incompetent by a court and a guardian makes the treatment choices.

The right that a voluntary patient has to refuse treatment is included in this bill (page 8, lines 44 to 49). However, involuntary patients should also have rights in this area.

Coersion has no place in the treatment decision. Threatening a voluntary patient with involuntary commitment or an involuntary patient with additional restrictions, makes a mockery of the principle of informed consent. With this in mind, we recommend the rewording of this section of the bill as follows:

> A patient shall not be provided any form or method of treatment without the consent of the patient or parent if the patient is a minor hospitalized on the application by the parent, or the guardian. Patients who have refused treatment may be treated only in emergency situations. Court-ordered involuntary patients may only be treated in nonemergency situations after arbitration proceedures have been completed and the situation resolved.

Statement of Support

The American Civil Liberties Union of New Jersey agrees that New Jersey needs a new commitment bill. We hope that Assembly Bill 114 will address the civil liberties concerns expressed in this position paper. If the bill is modified as suggested, we would support this version of the commitment bill.

My name is Joan Mechlin. I am president-elect of the New Jersey Association of Mental Health Agencies. I have worked in crisis programs for 16 years. I have worked in New Jersey for the past 8 years and I am presently Program Director of the Crisis Service of the Camden County Guidance Center. I have worked on the task force convened by NJAMA that developed a model of a comprehensive system for crisis stabilization and this model is being used in developing crisis programs in New Jersey.

the Assoc. represents Agencies

In New Jersey, we have been working toward developing a comprehensive system of care for the mentally ill. In building the community-based programs, there has been an increase in the availability of crisis/emergency services, crisis beds in general hospital, outpatient programs, partial care, residential and case management, and family support groups that are designed to help maintain the client in the community and improve their quality of life by teaching life skills. As a result of these programs, the number of people receiving community-based care has increased, decreasing the number in state and county hospitals. People are no longer sent to state or county hospitals without planning for their discharge. The mental health agencies in New Jersey see themselves as part of a continuum of care. This continuum of care begins with the least restrictive involvement to the most restrictive setting/self-help groups to involuntary hospitalization in general hospitals, state and county hospitals. The continuum includes involving the clients, families, caretakers, and agencies in treatment.

We agree that there needs to be a new statute that establishes commitment criteria and streamlines procedures. We feel that legislative changes should not only clarify and streamline the commitment process but should also give legislative support to the system providing care and treatment for the client. This includes crisis programs, caretakers, criminal justice system, and facilities providing voluntary and involuntary treatment.

TREAT

The changes should focus on what is needed to provide the client with supports in the community, and also to provide the community-based care system with the means to provide treatment for the client when it is needed.

the mental health association in new jersey
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Detailed Attachment

Testimony on Screening/Commitment Legislation

Presented June 5, 1985

To the Assembly Corrections, Health & Human Services Committee

by

Caron Ann Wilson

It is essential to revise our present psychiatric commitment laws because:

A. The New Jersey statutes that govern voluntary admission and involuntary commitment to inpatient psychiatric facilities were written in 1918 and last amended in 1965. Since that time, there have been vast changes in:

1) clinical pratice;

2) federal and state policies regarding the provision of mental health services; e.g. the development of community mental health service systems; and

3) case law governing standards and procedures for involuntary commitment, standards for psychiatric hospital treatment, limitations on treatment modalities, and patients' rights.

B. Because of these changes:

1) Our statutes do not describe the standards and procedures that are required by "law" or utilized in practice. Therefore, the content of our "laws" are not accessible to mental health providers, attorneys, courts or consumers of services. They must be gleaned from incomplete descriptions in statutes, court rules and case law.

2) Our statutes do not contain constitutionally required procedural protections for persons facing involuntary commitment.

3) Our existing "laws" do not address many issues that have arisen in practice and need to be resolved in order for the hospital and community mental health systems to operate cooperatively and effectively.

C. Finally:

1) The existing statutory procedures for providing (involuntary) emergency services are not adequate to ensure that care and treatment are made available to mentally ill persons in crisis.

Because these procedures do not address the needs of persons in crisis or the concerns of service providers, they are not followed in practice. One of the most unfortunate consequences of the inadequacies of our statutes is the criminalization of mentally ill persons as a vehicle for obtaining mental health services. (Families have to call the police and press charges to get emergency services.)

2) The existing procedures for providing (involuntary) non-emergency services are cumbersome, duplicative, irrational and sometimes inhumane. In many cases, it is too difficult to obtain initial assessments of mentally ill persons and too easy to commit persons to long term care facilities which should be used only as a last resort.

II. The major objectives in a revised Commitment/Screening Bill should be:

1) To update, codify, rationalize and clarify, in our statutes, the laws governing admission and commitment to inpatient mental health facilities.

2) To address and resolve issues that arise in practice within the mental health system and between the mental health and judicial systems;

3) To provide explicit authorization and a role for a broader spectrum of mental health services, including screening services and involuntary units in general hospitals.

III. The bill should provide explicit authorization for the three tiered system of mental health services - which are basic types of service that should be available statewide:

1) Screening services, which are public or private out-patient services, so designated by the Commissioner of Human Services, which may be free standing or part of a mental health center or hospital;

2) Short term care facilities, which are public or private inpatient or residential facilities (but usually, general hospitals with either voluntary psychiatric units or voluntary and involuntary units;

3) Mental hospitals, which are public or private inpatient facilities, which are licensed by the Department of Health. Although under the Health Care Facilities and Planning Act, N.J.S.A.26: 2H, the Department of Health has the authority to license all health care facilities, a bill should give the Commissioner of the Department of Human Services the power to determine which facilities may accept involuntary patients.

IV. A Commitment/Screening Bill should address the following and include:

a. Explicit definitions of standards for voluntary admission and involuntary commitment. Involuntary commitment requires a determination that the patient be dangerous to himself or others because of mental illness.

b. The bill should define dangerousness, which by case law, is a necessary component of a standard for involuntary commitment. A person is dangerous only if there is a substantial risk of serious harm to persons in the immediately forseeable future, as evidenced by recent behavior. The risk of danger must exist "if the patient is not committed" or "if his commitment is not continued," as in the Civil Commitment Court Rule. i.e. a patient might not be dangerous in the hospital but would be dangerous if released.

c. Persons who have in the past been considered dangerous to themselves only because they cannot care for themselves due to mental illness, can be termed gravely disabled. Like dangerousness, grave disability requires a substantial risk of serious harm in the immediately forseeable future, as evidenced by recent behavior.

d. The bill should clarify the circumstances under which public facilities may exercise discretion regarding admission and give screening services referral responsibilities for persons who are not admitted. State and county facilities and involuntary units of general hospitals must admit involuntary patients referred by screening services or commited by court order. General hospitals have discretion with respect to all voluntary patients, but State and county hospitals must accept voluntary patients referred by screening services. Private hospitals have discretion with respect to all admissions.

e. The bill should give specific protections and "rights" to persons admitted to short or long term facilities and give facilities the responsibility to provide assessment, personal care, treatment, and rehabilitation (as permitted by law).

f. Screening services and courts should be given guidance with respect to determination of which facility to specify in their certificate, and orders, in order to ensure that patients are committed to the least restrictive, appropriate, available facility.

g. Community agencies designated by the Commissioner of DHS should be given explicit responsibilities for discharge planning for hospital patients from their service area.

h. In both emergency and non-emergency situations, the bill should make it easier to get assessment at a screening service, but ensure that the decision to commit a person to a long term care facility is made carefully, by experienced persons.

i. Emergency procedures must assign responsibilities to screening service and law enforcement officers for assessment and assistance, respectively, and make it possible to get a psychiatric assessment of an unwilling person without resorting to the criminal laws. The bill also should provide explicit authority for detention and transportation during the commitment process.

j. The bill should codify the procedural protections in the existing Civil Commitment Court Rule and incorporate the additional requirements of case law.

In Summary:

The Public Policy Committee of the Mental Health Association has spent many months dealing with recommendations for specific issues and areas that should be included in comprehensive Commitment/Screen Legislation. They include the following points,

I. In any definition of "dangerous" and "gravely disabled" to add the following:

For an order of commitment, at the time of admission to a psychiatric facility, substantial likelihood shall be evidenced by a recent threat or behavior attempting or causing harm.

b) re: "gravely disabled"

For an order of commitment, at the time of admission to a psychiatric facility, substantial likelihood shall be evidenced by recent behavior indicating a failure or inability to provide for his or her basic needs.

II. ~~Family members should be notified about pending discharge~~. The position of MHANJ is that any adult individual who was the object of dangerous behavior on the part of a patient, prior to his or her hospitalization, should be notified of that patient's discharge.

This would apply to family members and non-family members. The family should not be notified if they were not victimized, and the adult patient objects to their being notified. Where minors have been the previous object of the patient's dangerous behavior, a guardian or other responsible adult or public agency should be notified of the adult patient's discharge.

There needs to be a way to insure the actual receipt of the notification prior to the patient's discharge. Several working days' notice should be given.

III. The person being considered for involuntary commitment needs to be protected by an independent advocate at all times during the process.

MHANJ rationale for this position is that there may be potential for serious abuse of a patient's rights during the detention/evaluation process. An individual in a screening center, who is being considered for involuntary detention or commitment, even during the initial 72 hour period, should have access to an independent advocate, to obtain information concerning, and to assure compliance with, the individual's rights. A Bill should include general language to insure that occurs. This would allow flexibility as to delivery models (lawyers or trained lay people, paid or volunteer).

Conceptually, the Committee favored funded, recognized, and independent advocates available in each County, who would be notified about the detention of any County resident because of Mental Illness.

MHANJ's recommendation is:

A. Within Screening/Commitment legislation, the "72 hour" holding period should begin at the initial moment that it is determined that the person will need involuntary detainment and/or eventual involuntary commitment. There should not be a "dangling" time period in which a person can be "detained" for transportation and/or evaluation, with no time limit set.

B. There should be independent advocates (lay or legal, paid or trained volunteers) in every County, available when appropriate, throughout the screening and commitment process. The Administration should determine the specifics of implementation.

C. In addition to advocating for the inclusion of "B" above into the screening/commitment process, ways to expand the Department of the Public Advocate's (AP) Division of Mental Health Advocacy, to cover all 21 counties should be explored. Currently, given that the PA has field staff only in several Counties, there does not seem to be equal protection under the law.

IV. With regard to the question of who should sign certificates for commitment; our position is as follows:

A. The Public Policy Committee voted to approve the concept of non-physicians, with appropriate training and/or experience, being able to sign certificates.

B. If mental health professionals, such as psychologists, nurses, or social workers are included in any bill, the definitions need to be explicit and stringent, to include clinical experience with psychiatric emergencies and evaluation.

C. Both commitment routes (Screening route and court route) should have at least 1 psychiatrist signing a certificate.

1. In the screening route, a second "Mental health professional" certificate could include a second psychiatrist, although that should not be mandated.

2. The court route should be consistent with "C1" above. The second certificate should be executed by any other "mental health professional", including a second psychiatrist.

V. Notice of Final Hearing

Current law allows for 10 days notice.

The MHANJ's position is that the parties involved, particularly the patient's lawyer, should continue to have the 10 days' notice. If the patient improves and is discharged prior to that time, or in the interim, the hearing can be cancelled, and notification of the cancellation can be made.

VI. MHANJ favors the policy of conditional discharge for the following reasons:

A. It is important for people who are rehospitalized over and over again, (the "revolving door" population,) if they have repeatedly ignored the discharge plan re: treatment support services and/medication, etc. and need an incentive.

B. It would be the clinical decision of the hospital's discharge team, with the community liaison's input.

C. It seems to be a favored approach of families and clinicians, so that discharges can occur, but there are certain conditions.

D. There are protections that must be built into conditional discharge:

1. Specific language to assure that the status is not abused by landlords or facilities to intimidate residents into compliance.

2. A specific time limit should be set.

3. Specific clinical conditions for use should be spelled out.

4. Procedures should be set for when conditions are broken. The MHANJ's position is that the patient after breaking the guidelines should be screened first before being re-admitted or committed through the court process, to determine what his/her most current needs are.

VII. Special provision for minors should be included in the bill which will take into account and be consistent with current court rules.

The Public Policy Committee and the Board of MHANJ recognizes that given the complexity of the issues involved, there can be no perfect piece of legislation which will satisfy all of the various interest groups: patients, families, legal advocates, different professional groups, and provider agencies.

We believe that many of the existing problems within our current statutes would be positively addressed by the inclusion of the recommendations we have made.

Thank you for this opportunity to appear at this hearing and to present the result of our deliberations on this most important issue. We, as a citizen's voluntary organization, agree with you that a comprehensive commitment/screening bill is of primary importance at this time and applaud your decision to hold a hearing on these issues.

Thank you.

A STATEMENT REGARDING VOLUNTARY AND INVOLUNTARY COMMITMENT

OF PERSONS TO MENTAL HOSPITALS

Meyer S. Schreiber, D.S.W.
Associate Professor, Social Welfare
Kean College of N.J., Union, N.J.

My name is Meyer Schreiber. I am an Associate Professor, Social Welfare, at Kean College of New Jersey in Union. I am presenting this statement as an individual citizen speaking in the public interest.

For many years the State of New Jersey, and many counties, have subjected any individual who was committed, or voluntarily opted for admission, to a state or county psychiatric hospital to both fingerprinting and mug shots at the point of admission.

I urge this committee, in considering Assembly Bill No. 114, to include a clear and unambiguous prohibition against such practices.

This practice dates back to 1918, or earlier, when superintendents of such facilities were mandated to set up procedures for identifying all patients. Fingerprinting was one of these methods utilized and while the records were not to be open to the public the institutions were empowered to cooperate with law enforcement agencies.

The 1966 state gun control law amended the 1918 one and required the superintendents to to fingerprint, and to cooperate with the state and local law enforcement agencies that requested such records.

The gun control law requires state police to check applicants for firearms for any history of mental illness. The public mental hospital was given the option of checking these applicants or turning over the fingerprints to the state police. The system of making them available to the state police was adopted. These prints are mixed with all the other ones in the state police files, but are on special cards to identify them as fingerprints taken from mental hospital patients.

Mental illness is no predictor of violent or criminal behavior. Most social scientists and law enforcement experts and officials agree that such behavior cannot be accurately predicted by any means.

Mental illness is the only health problem that a person seeking treatment is labeled in undesirable ways; that of being different and a deviant and possibly dangerous.

There are several objections to such practices. These include:

1. The individual needs treatment, and help, rather than the harsh judgement of being considered dangerous because that is what fingerprinting symbolizes in our culture.

2. Consequently instead of there being a therapeutic approach to the individual right at the start instead he or she is confronted with fingerprinting and a mug shot.

3. It is a denial of the person's right to privacy, and the confidentiality of the records..

4. It is an affront the the person's civil liberties in that he or she seems to treated as he or she is harmful to others.

5. Finally, it is discriminating in that the practice applied only to patients in public facilities, and not private, proprietary ones in the state. As persons who are generally poor and of minority status tend to end up in public facilities it extends the nature of that discrimination against such persons.

Currently there is an informal agreement between an Assistant Attorney General and the N.J. American Civil Liberties Union regarding a kind of temporary halt to these practices. But this is not enough.

The 1966 gun control law providing mandating such fingerprinting needs to be eliminated by an effective provision in Assembly Bill No. 114. Such an act on the committee's part would go a long way in sending out the word to people who are mentally ill that the Legislature of The State of New Jersey is interested in hastening their recovery and well-being.

Meyer S. Schreiber, D.S.W.
June 6, 1985

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