
Public Hearing

before

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

SENATE BILL No. 2760

(An Act concerning involuntary commitment to treatment and amending and supplementing chapter 4 of Title 30 of the Revised Statutes. Establishes involuntary outpatient commitment to treatment for persons in need of involuntary commitment)

LOCATION: Committee Room 1
State House Annex
Trenton, New Jersey

DATE: August 11, 2005
10:00 a.m.

MEMBERS OF COMMITTEE PRESENT:

Senator Joseph F. Vitale, Chair
Senator Ellen Karcher, Vice Chair
Senator Ronald L. Rice



ALSO PRESENT:

Eleanor H. Seel
Elizabeth Boyd
*Office of Legislative Services
Committee Aides*

Jillian Hudspeth
*Senate Majority
Committee Aide*

Victoria Brogan
*Senate Republican
Committee Aide*

***Hearing Recorded and Transcribed by
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SENATOR JOSEPH F. VITALE (Chair): Good morning, everyone, and I thank everyone for coming out today, this morning, for this hearing. Today's hearing will be just for the purpose of receiving testimony for the Committee and an opportunity for the members to ask questions of those who are here to testify today.

S-2760, sponsored by Senators Codey and Cardinale, established involuntary outpatient commitment to treatment for persons in need of involuntary commitment. The bill would amend the State's current civil commitment laws to allow for the involuntary commitment to outpatient treatment of persons who are in need of involuntary commitment to treatment. The bill will also provide an alternative uniform standard commitment treatment option, other than just the current inpatient treatment.

I just want to, first, take a moment to recognize and to thank Bob Davison, and Kim Ricketts, and Governor Codey's Task Force for the great work they have done over the past many months in identifying and establishing ways in which we can care for those who suffer from mental illness throughout the state, and any number of illnesses, not limited to just a few. I just want to thank them for their work.

First, to testify today--

First, I want to just also note that Senator Buono will not be here today. She is-- Her stepfather passed away, and today is the funeral.

And Senator Madden is at a bill signing today. The Senator expresses his wishes and looks forward to reading the testimony.

Our Republican members are unable to be here today. I believe that there's a Wayne Newton concert someplace. (laughter) But we'll be

able to provide that information. We have great representation from the minority office here, today, as well.

So I'd like to, first, call Bob Davison, the Chairman of Governor Codey's Mental Health Task Force, to come forward and also introduce one or two of your members.

Thanks, Bob.

ROBERT N. DAVISON: Good morning, Mr. Chairman.

SENATOR VITALE: Good morning, sir.

MR. DAVISON: Thanks for having us. Thanks for your kind words. How's that? (referring to PA microphone)

SENATOR VITALE: Perfect.

MR. DAVISON: I'll say it again. Good morning, Mr. Chairman.

SENATOR VITALE: Good morning.

MR. DAVISON: Thanks for having us. Thanks for your kind words.

If I could just bring up John Jacobi, from Seton Hall Law School, and John Monahan.

I'm just going to say a few introductory remarks and then turn it over to them to make the testimony on behalf of the Task Force. At the end of the day, sir, Senator Karcher, Senator Rice, we are recommending this legislation in involuntary outpatient commitment in the State of New Jersey. I would like to say we did not do so lightly. We recognize it's a controversial and an emotional issue for many people. We did so after three public hearings with over 600 people attending and over 200 people testifying -- many family members, consumers, and professionals testifying

in favor of involuntary outpatient commitment, as well as some, quite frankly, family members -- not so much family members, but consumers and providers testifying against it.

We had over 20 meetings as a Task Force. We probably deliberated on involuntary outpatient commitment for about 60 hours. We had 20 advisory committees that also gave a lot of thought to this topic. And in the final analysis, we are recommending it, and we think it's in the best interest of the citizens of the State of New Jersey, of the consumers who suffer from mental illness in the State of New Jersey, and their families.

And to talk about some of the particulars of the legislation and why we support it, as well as what we believe to be the impact on consumers and their families, is, first, John Jacobi, from Seton Hall Law School, and John Monahan, from Greater Trenton Behavioral Healthcare.

So Professor Jacobi will start first.

JOHN V. JACOBI, ESQ.: Good morning,

SENATOR VITALE: Good morning.

MR. JACOBI: I have distributed my testimony. My name is John Jacobi. I am a Professor at Seton Hall Law School, and the Associate Director of the Institute of Law and Mental Health. Now, as a member -- I guess I still am -- of the Governor's Task Force on Mental Health, my testimony will describe the analysis of the Task Force on the issues of involuntary outpatient commitment that supports the central principles of S-2760. I'll describe the conflicting arguments considered by the Task Force and the principles on which the majority settled, which are fully consistent with S-2760.

These are genuinely very difficult issues. IOC raises fundamental issues of individual liberty, social responsibility, and public safety. IOC, as it has been applied in other states, has expanded the coercive power of the State over people with serious mental illness. In addition to the State's power to confine a person with mental illness to a hospital against his will, IOC would permit the State to require a person to comply with treatment in a community. The power to commit a person to a hospital has always been regarded as an extraordinary power, and its exercise has been accompanied by significant restrictions as a matter of constitutional right. IOC would add another level of coercion, arguably for the people whose condition would not justify involuntary hospitalization.

Those in favor of IOC argue that it is necessary for several reasons. It is argued that people with serious mental illness who are not engaged in treatment can cause themselves serious physical harm and exacerbation of their psychological illnesses. It is argued that on rare occasions people seriously harm others through acts of violence traceable to their untreated mental illness. It is argued that deprivations of liberty less severe than hospitalization are sometimes necessary to prevent deterioration of a person's psychiatric condition, and to allow them to progress towards wellness and recovery, while protecting them and others from harm. In addition, outpatient therapy, and not inpatient care, is increasingly appropriate for many with even the most serious mental illnesses.

Those opposing IOC argue that most people with serious mental illness fail to engage in treatment because community mental health services are too often simply not available. They further argue that people who are not an imminent danger to themselves or others have a

fundamental right to choose to avoid treatment, even if we disagree with the wisdom of that choice. In addition, they argue that IOC, no matter how carefully crafted the legislation, is likely to be applied in a way that improperly curtails the freedom of people with mental illness.

The Task Force majority agreed to recommend that IOC should be added to New Jersey's commitment statute pursuant to four guiding principles, which are largely reflected in S-2760. I want to go through those four principles and describe their connection with S-2760 very briefly.

The first, IOC should not be implemented unless and until appropriate community services are safely available. The availability of appropriate community services will greatly reduce the number of people for whom IOC might be suggested, as voluntary engagement will increase. Without such services, the initiation of IOC could lead persons in need of treatment to be forced to be committed to IOC in order to gain access to the limited services available. In other words, if there are too few services, IOC could be perverted into a system for jumping the queue, and people would find the only way to get access to scarce services might be through being committed. And that's a result that no one would want to have. The Legislature in this past session, and through this year's budget, has taken great strides to increase the availability of community services.

Two, the commitment standard should be clarified to permit recognition of danger arising in the reasonably foreseeable future, and the same standard should apply to inpatient and outpatient commitment.

Much of the impetus for IOC comes from dissatisfaction with the application of the general commitment standard, which some courts and screening centers have interpreted as requiring current danger to self or

others, rather than danger in the reasonably foreseeable future, as the current statutory language requires. Many health-care providers testified that this restrictive reading prevented commitment of persons who were, in the opinion of the treating clinician, within several days of becoming dangerous to self or others. S-2760 addresses this concern in Section 1, describing the general policies of the State; Section 2, providing multiple factors clarifying that predictive judgments on dangerousness are appropriate; and in the bill statement.

With this clarification, the commitment standard applies to people whose condition is not currently dangerous, but will become so in the foreseeable future without intervention. The standard, with its clarification, becomes appropriate for both inpatient and outpatient commitment, depending on the best means of stabilizing the person's condition. This clarified standard strikes the appropriate balance, allowing involuntary treatment for those in urgent need, while avoiding the introduction of a lesser standard that might lead to unintended expansion of the use of commitment powers.

Three, the choice between inpatient and outpatient treatment for committees (*sic*) should be guided by a least-restrictive alternative principle.

The clarification of the general commitment standard makes it clear that predictive judgments on dangerousness are permissible, with treatment to be provided in either inpatient or outpatient settings as appropriate. Under S-2760 then, the commitment process has two steps: First, it is determined whether a person is a danger to himself or others in the reasonably foreseeable future; and second, it is determined whether the

treatment necessary to prevent that danger is inpatient or outpatient care. This segmentation of the decision logically incorporates a least-restrictive alternative standard. S-2760 codifies the least-restrictive alternative standard in Section 5, applicable to screening centers; and Sections 9 and 13, applicable to courts.

Now, in practice, we anticipate that both assessments would occur in the same hearing -- the preparation for both assessment of dangerousness and the appropriate placement would take place in the same hearing.

Number four, the effects of IOC should be evaluated by a qualified, independent researcher two years after the effective date of the change, and again five years after the effective date, with the report submitted to the Governor and the Legislature for review.

The initiation of IOC will be controversial. I think that that's an understatement. Close monitoring of the course of its implementation will permit an assessment of its effectiveness allowing for a check against its uneven application throughout the state or other possible implementation problems. Language requiring such reports could easily be added to S-2760.

Now, in conclusion, let me say a couple of things: The benefits of the addition of IOC to New Jersey's commitment statute can be obtained by modest modifications in the current law, as provided in S-2760. These modifications will clarify the prospective nature of the judgment of dangerousness to self or others, and implement a least-restrictive alternative standard to allocate a committee between inpatient and outpatient care.

The surgical modifications of the commitment statute allows for the commitment of people with serious mental illness to treatment on

an outpatient basis in appropriate circumstances, while reducing the chances of disruptions or confusion that could arise with the institution of a completely new outpatient standard, as has been implemented in some other states. S-2760 navigates a middle path in this controversial area, permitting New Jersey to join the ranks of those states that employ IOC without risking unwarranted restrictions of the autonomy rights of people with mental illness.

Thank you.

SENATOR VITALE: Are there any comments or questions from the members? (no response)

I do have one question. Could you just further clarify the differences between the existing IOC statute and what's being proposed, just as it relates to inpatient commitment?

MR. JACOBI: With respect to inpatient commitment?

SENATOR VITALE: Yes.

MR. JACOBI: The changes in S-2760 that affect inpatient commitment deal with a definition of dangerousness to self and to others. The reconfigurations of those definitions allow-- Let me back up a second. A problem that was raised on many, many occasions to the Task Force was that in some parts of the state and before some judges and in some screening centers, there was an interpretation of the dangerousness to self or dangerousness to other standards that required a showing of current harm, rather than a showing of harm in the recently foreseeable future, which is what the statute says. The changes in the statute are intended to clarify that the standard is predictive to a certain degree. That is, that it is permissible for a judge, or a screener, to find that a person meets the

standard when the person is not dangerous as he or she sits there, but is dangerous in the reasonably foreseeable future.

So the language that was changed in the definitional sections of the statute are intended to describe a couple of the factors that should be taken into account in making that predictive judgment, such as the course of treatment that the person has received in the past, the reactions of that person to the courses of treatment that he or she has received, and the assessment of clinical professionals about where in that cyclical course of treatment the person is now, as the person is being screened. That's the principle change with respect to inpatient commitment.

SENATOR VITALE: On the issue of increasing capacity for outpatient centers, can you describe to us what currently exists in terms of existing infrastructure in the provider community for outpatient care, and what this legislation, or the Task Force, would recommend, going forward, for enhancing outpatient opportunities and access?

MR. JACOBI: I will answer that question briefly. I think John Monahan, who will be testifying next, is probably better qualified to describe what currently exists on the ground now, since he is an outpatient service provider. Our assessment is that the biggest-- Well, one of the two largest problems with respect to the treatment of people with mental illness in New Jersey is the lack of opportunities for appropriate outpatient care. Some of the steps that were taken in this past budget session added funding for screening centers and for outpatient care opportunities. It is clear that more needs to be done. It is true that many people now are simply unable to find appropriate outpatient care, and that effort -- the effort to increase

accessibility to appropriate outpatient treatment seems to me a necessary concomitant to any move towards involuntary outpatient commitment.

One of the steps that has been taken is increasing funding for the screening centers, to allow screening centers to have more resources to do a better job of referring people to those services that are available. John Monahan, I think, can give you, perhaps, a more complete answer to your question.

SENATOR VITALE: Thank you.

Senator Rice.

SENATOR RICE: Yes. You mentioned the standards of dangerousness. Does not this legislation change those standards in a subtle way that's not, maybe, easy to spot? And be honest about it.

MR. JACOBI: I will. The honest answer is, in practice, yes. I'm a lawyer. So let me say that, in fact, it doesn't change the substantive standard as the statute is written. The substantive standard has always been dangerousness in the reasonably foreseeable future. By highlighting that issue and indicating in no uncertain terms that screeners and judges ought to consider this predictive aspect of the dangerousness standard, I believe that it is inevitable that the standard will reach more people than are being reached now, at least before those judges and in those screening centers where the standard has been applied as requiring current dangerousness.

So my answer is that it was the Task Force's intent to recommend a modification of the statute to clarify that the standard is dangerousness in the reasonably foreseeable future. But I take your point. And I think it is true that if the standard has been applied more narrowly --

and this statute has the effect of encouraging judges to read the standard more broadly -- then it will reach more people. So the answer is yes.

SENATOR RICE: You're an attorney, you said, so I think you can appreciate the fact that the query is how do you -- if you're going to expand that -- that's dangerous, number one, in itself, particularly when there are issues that may not be easy to spot. So if you really lack experience in rights in mental health issues, how do you spot them?

MR. JACOBI: The standards will be employed by -- most frequently by attorneys. That is, by judges and by the attorneys representing potential committees and other attorneys operating within the mental health system. So the--

SENATOR RICE: And many who do not, right?

MR. JACOBI: Many committees who do not?

SENATOR RICE: No. Attorneys and judges who don't have expertise in the rights and issues addressing mental health.

MR. JACOBI: I'm sure that that's true. I will say, Senator, that--

SENATOR RICE: I'm sure it's true because most of the time they don't address those issues.

MR. JACOBI: I'm sorry?

SENATOR RICE: I'm sure it's true because most of the time you don't practice in those fields. Most of you practice where the big money is.

MR. JACOBI: And the attorneys who do practice in this field will be committing malpractice if they didn't read the statute before they represented someone. So the statute will describe the standard in relatively

clear terms. I think it would be an excellent idea for there to be, first of all, better education of attorneys who operate in this field so that they are better able to represent people. And secondly, as I think your comments suggested, to encourage more attorneys to become involved in these areas. I think that the legislation should be clear, and I believe that this version of the bill does lay out the standard in a clear way. That doesn't, as you suggest, get to the problem of people who don't read the statute. But if people are not going to read the statute, then writing the statute more clearly won't help those people. I think that education outside of clarification of statutory language is necessary to address the concerns that you're raising, which I agree with. I think that there are significant concerns.

SENATOR RICE: Well, my concern is one that I always have to raise. And being the lovely complexion I am, every time I raise it, people want to draw lines between racism, etc. But I have some real concerns about the impact on minorities in general, particularly blacks and Hispanics. We'll probably talk about the Kendrick (phonetic spelling) Report later, in terms of disproportionate. But aren't these decisions being made on personal interpretations, probably based out of fear of someone's possible actions?

MR. JACOBI: Our predictive--

SENATOR RICE: Or simply history, with no time limits on the history?

MR. JACOBI: Yes. The answer to that is yes. To the extent that predictive judgments are used to assess dangerousness, the literature is clear that those predictions are often imperfect, and as you suggest, often

subjective. In situations involving deprivations of liberty, the record is clear that when there are subjective standards applied that there is a disproportionate effect on people of color and poor people. And in this area, the record is no less clear.

Your concern is -- the broader concern that you're raising is that whenever there is any movement in a commitment standard that would allow for more people to be committed, we ought to be extremely concerned about it, in general, and in particular for people who are often underrepresented. And that is certainly people of color and poor people. So, yes, that is certainly a danger. There is a danger whenever a standard is even nudged a little bit, as this one is, in the direction of allowing commitments, that there will be a disproportionate effect on people of color.

SENATOR RICE: So then you would partially agree, if not totally, that there's another danger lurking out there where people who are troublesome, or basically not wanted by some families, could very well be locked into a system and forced to get treatment that's not really necessary because they still have capacity. This bill is about capacity, right? The courts were very clear about capacity. Is that correct? You're an attorney, right?

MR. JACOBI: Yes.

SENATOR RICE: All right. We're talking about people who still have capacity.

MR. JACOBI: Often, yes.

SENATOR RICE: Well, there are a lot of people who just don't want people in the family around them. Other people don't want

people in the household. They may be homeless, or they may be undergoing -- through some changes. You may feel they have these serious problems because they need a job and no one wants to hire them because they have a record. And so someone just makes an assessment with no real clinical experience, no real evaluation -- on someone's whim, based on what they think may possibly happen or because of hearsay.

MR. JACOBI: Well, let me--

SENATOR RICE: That's dangerous, particularly in my community.

MR. JACOBI: Certainly as you describe it, it's dangerous. Let me answer that in two ways. First, the people who will be making these assessments will not be untrained people who will be making their judgments on the basis of hearsay, or at least they ought not be. They ought to be mental health professionals who are making their assessments based on proper clinical indications. To that extent, I disagree with you.

Let me tell you to the extent to which I agree with you. There is possibility for error and abuse in this system. There is possibility for error and abuse in the current system. The judgment that the Legislature has the unenviable task of making is where to set the standard to minimize the level of error. Error can be made both ways. Error can be made by under applying commitment standards, and error can be made by over applying commitment standards.

This bill, in my judgment, makes an attempt to set the standard at a place that is closer to the optimal point for minimizing error than the statute as it has been interpreted in some places. Now, it's a very modest change in that standard. I think that the judgment that the Legislature has

to make is whether the changes in the commitment standard that are described in this bill will adjust the standard in a way that sufficiently reduces the possibility of the under application of the commitment standard, such that it is worth the risk that there might be abuses that over apply the commitment standard. That is a very difficult judgment to make, and one that the Task Force struggled with and, unfortunately, the Legislature now has to struggle with. But you've put your finger on exactly what is the most difficult thing about making an assessment about this bill.

SENATOR RICE: Well, for the record, Mr. Chairman -- and then I'm going to listen to the rest of the testimony -- I'm not confident -- and I've been here as long as most -- that the Legislature collectively, given the history of the Legislature, can really get the standards of error without a tremendous impact, as has been the history. And I can document that on minorities. It seems as though when we weigh things, as with health or anything else, if, in fact, the greatest impact's going to be -- or auto insurance -- on "the minority community" or women and minorities, it's like we don't care, as long as we take care of the rest. I'm not willing to take that chance right now, number one. This is too much iffy.

It kind of reminds me of grasping with problems that we need to address, but it takes me back to the mindset of needle exchange in terms of our thinking of how we should treat problems. And we know what that impact is as well. And then I'm concerned about research, in general. I have not seen a lot of research or read it, but I always dispute research. Because everything that is agreed upon can be disproven, if you will, by some other research. It depends on how you set your models up. I just want to at least start to set the stage to let you know that, and I want to

thank you for being very honest in the questions that I raised. Because it tells me that you, too, would have doubts in certain areas. And the question becomes, how do we remove the doubt or, at least, diminish it? And I'm not so sure we can do that. I think intent may be good.

But I'm a former cop, and I've been in Newark all my life. Now, I know what frustration is. Right now, I've got people that I went to see yesterday who are totally frustrated with the Schools Construction situation. I wouldn't want someone to say that they need this type of treatment and they have capacity, but it doesn't make a difference. And that's the danger in this bill. And I'm not so sure of New York -- not such a wonderful job as the documents say. I think they have done what they documented -- what they wanted to document, but somewhere you talk about the impact on African-American and Hispanics in particular in those communities.

Thank you.

MR. JACOBI: Thank you, Senator.

SENATOR VITALE: Thank you.

I do want to move on to our next speaker. But I just had, maybe, one last question. I'm sorry.

Like in most courts, we have drug courts and we have judges who are assigned to matrimonial issues, judges who are assigned to the municipal court level or even the Superior Court level -- judges that handle domestic violence cases, and where there's a certain level of expertise in some of the cases that they handle and the areas in which they're assigned. Are there courts or judges in New Jersey that -- where this is -- I wouldn't

use the word *specialty*, but in an area that they're better suited to address than perhaps other judges?

MR. JACOBI: As you know, there are no mental health courts in New Jersey. There are Superior Court judges who are more expert and more attuned to these issues than other Superior Court judges. We did discuss, in the Task Force, the issue of mental health courts. And as I'm sure you know, Senator, the Administrative Office of the Courts and some Superior Court judges have been discussing that issue for a number of years in New Jersey.

Let me just briefly say two things: One, that a problem with mental health courts in New Jersey is that many of the issues that would properly be dealt with in a mental health court are dealt with in New Jersey at the municipal court level. And it's difficult to imagine a municipal mental health court. And it would seem -- and there are problems with moving up petty disorderly offense and disorderly offense matters to Superior Court. And in that way, in some sense, is penalize people with mental health by moving them up -- mental health problems -- by moving them up to a more serious venue for adjudication. That's a problem that, maybe, could be dealt with, maybe not. But I think that one of the things the Task Force recommended, that is being piloted in three counties, that is sort of a halfway measure to address your concern, is to create offices in each of the vicinages that will provide expertise to advise judges, to advise Superior Court judges on mental health issues, both in substantive and technical ways, and also to describe referrals and alternative adjudications, alternative dispositions of cases for the benefits of judges, prosecutors, and public defenders, and other defense attorneys. It's a compromise way of

getting towards most of the benefits of a mental health court, while working around, perhaps, some of the problems of New Jersey's municipal court/Superior Court set up.

SENATOR VITALE: Thank you.

MR. JACOBI: Thank you.

SENATOR VITALE: Next.

J O H N M O N A H A N: My name is John Monahan. And I would like to make some remarks. My testimony actually presents another argument that addresses Senator Rice's concerns. There's another side to this, if we have minorities right now in the system who are experiencing harm as a result of the current system -- the fact that we don't have involuntary outpatient commitment. I think that's something that needs to be evaluated as well.

So my testimony-- My name, again, is John Monahan. I am the President and CEO of Greater Trenton Behavioral HealthCare. We provide services to people with serious mental illness, and their families. Many of our clients become hospitalized, or incarcerated, because of symptom-induced behavior caused by their refusal of treatment. My testimony focuses on how involuntary outpatient commitment, or IOC, will benefit these consumers and their families.

The overwhelming support of families for IOC is understandable. Sixty percent of those leaving public psychiatric hospitals are discharged to families. Families often shoulder an unfair, and at times, dangerous burden, when we expect them to provide shelter to a family member who refuses treatment. Such families see IOC as long overdue.

The benefit to consumers is also clear. Though some consumers oppose IOC, the vast majority of those opposing do not even meet IOC's eligibility criteria. They are too healthy. IOC focuses on a much more ill, high-risk consumer.

The proposed IOC legislation targets a very tiny segment of those with serious mental illness in New Jersey -- approximately 400 persons, or one-tenth of 1 percent of the 400,000 with schizophrenia, bipolar, or major depression. But though very small, this group consumes a vastly disproportionate share of public mental health resources, primarily in the form of high cost emergency and inpatient care. They also pose the greatest danger to themselves, to their families, and to the community.

Some argue that if the State would provide more funding for services, there would be no need for IOC. I agree there is a need for more services. But even if we had twice as many services as we need, the vast majority of those targeted for IOC would still refuse treatment. Why? Because these high-risk consumers are so ill with an untreated brain disorder, that distorts their perceptions and judgments, they do not recognize they are ill.

The IOC target population is already in crisis and, based on repeated history, is headed toward involuntary hospitalization, or incarceration, in the reasonably foreseeable future. By then, they will be beyond reach, sunk to the depths of their illness, terrified, and a danger to themselves or others. Once institutionalized, they will be physically controlled in ways that are traumatizing for those who are ill. They will also be required to take medication against their will, just like under IOC, but the outcomes and prognosis will be far worse.

By intervening before high-risk consumers reach the point of dangerousness, as the IOC legislation proposes, they will be spared an ordeal that both those in favor and those opposed to IOC agree is horrible and traumatizing. By comparison, IOC provides a much less intrusive intervention than what lies ahead of them. It also sets the stage for recovery.

There are two routes into recovery for those with serious mental illness. Most enter treatment voluntarily to avoid the different losses caused by mental illness. Before treatment, they see how symptom-induced behavior could cause them to lose what they hold dear -- relationships at home, at work, at school, employment. They also watch their health begin to deteriorate. They enter recovery to avoid these losses.

It would be wonderful if the 400 people targeted by IOC were less impaired and could perceive the losses caused by their illness. But they cannot. The normal way into recovery is not an option for them. Those who do enter recovery do so by a very different and much more difficult route, based on having their liberty wrested from them, again and again, through numerous hospitalizations and incarcerations over many years. By the time they're ready for treatment, their minds and bodies have been so chronically stressed from all their past crises and institutionalizations that a very steep and difficult road lies ahead of them. But they are the lucky ones. Others never make it.

Because IOC intervenes before high-risk consumers become so ill they are dangerous, they respond more quickly to medication and treatment than when institutionalized and in the depths of their illness. If we replace multiple episodes of institutionalization with multiple episodes

of IOC, high-risk consumers will have a much safer route into recovery than current practice. As they gradually learn about how mental illness affects them and gradually learn to feel more in control of their symptoms, recovery becomes an option.

IOC also has a multiplier effect that supports recovery. Its mere presence vastly improves the ability of case managers to persuade consumers to remain in recovery. This allows IOC to be used only as a last resort that targets very small numbers, but with an impact that extends far beyond those who require it to remain safe.

The question is not whether IOC is a good or bad thing for consumers in general, but is it a better or worse way to help specific consumers with specific needs than what is currently available? When New York state implemented a version of IOC, it reported dramatic reductions in homelessness, incarceration, involuntary hospitalizations, violent and suicidal behavior, among other variables. We owe it to those in danger and to their families to implement IOC now.

Thank you.

SENATOR VITALE: Any questions, comments? (no response)

I'd just like to ask, what kind of a role does alcoholism and drug addiction play in the lives in those you describe as being this one-tenth of 1 percent?

MR. MONAHAN: Significant. I would imagine that most of the people would have problems with substance abuse as well.

SENATOR VITALE: To the outside of their other behavioral health issues?

MR. MONAHAN: That is the behavioral health-- Mostly, and what we work with, are co-occurring disorders in the community mental health system, when you're talking about the high-risk adult population. So pretty much every program in the state -- day treatment programs, case management programs -- are trained to work with people who have addictions problems, as well as serious mental illness. It's part of the deal.

SENATOR VITALE: I guess my question is, what percentage of -- you say that all or most--

MR. MONAHAN: Most, yes.

SENATOR VITALE: --most people with whatever mental illness they may have is also--

MR. MONAHAN: Most of the people that are the higher risk clients that we're targeting here would have an addictions problem as well.

SENATOR VITALE: As well?

MR. MONAHAN: Right.

SENATOR VITALE: How do you account for that?

MR. MONAHAN: The fact that there's an addictions problem?

SENATOR VITALE: Yes.

MR. MONAHAN: It's rampant throughout the urban areas where most of our people with serious mental illness live. As you know, most people who have a serious mental illness become poor very quickly. So even if they start off with families that have some means, the fact that they're continuing to refuse treatment over time can lead to estrangement from their family; because families who have been providing shelter for so many years find themselves overwhelmed by the symptoms that their family

member is presenting with. So what often happens is, families say, "I can't do this any more. You have to take care of it yourself." And then that family member winds up in the poor areas of, or urban -- the poor sections of our urban areas and they become subjected to all sorts of potential victimization, abuse, violence, preyed upon by drug dealers. And it's a pretty serious problem that we've got.

So I think if we can do something to intervene before someone falls so deeply into their illness that there's no reasoning with them any more -- if we can intervene and provide treatment, as New York state has done. I think you'll be hearing testimony later on from Mary Zdanowicz that talks about the positive experience that New York state had with legislation comparable to what we're talking about -- not identical, but comparable -- where people have entered recovery as a result of involuntary outpatient commitment and have had improvements on a whole number of indices and outcomes of concern for everyone -- hospitalization -- the things that I mentioned before.

It's a very serious problem that we're confronted with. And our failure to intervene right now-- Right now, the vast majority of people who find themselves incarcerated because of a serious mental illness or hospitalized because of a serious mental illness are minority. And the fact that we've allowed them to kind of slip through our fingers and wind up in these, at times, very brutal institutions, when what they need is treatment -- that's something that I think we have to address. I think it's a very serious problem.

SENATOR VITALE: What about capacity issues?

I'm sorry, Senator. Did you want to make a comment?

SENATOR RICE: No, go ahead.

SENATOR VITALE: I just want to talk about capacity issues in the provider community and where they're located. And this legislation recommends that before we move forward with this legislation, that we also establish a network of providers, obviously what's workable and makes a difference in their lives. Can you describe what currently exists in terms of the provider community, whether it's clinic setting and hospital setting, or other settings, and what you would recommend going forward to provide a greater safety net and opportunities?

MR. MONAHAN: Yes. We've got the beginnings of a good system, but we don't have enough of those good services. What this population is going to need is case management services, treatment, medication, and housing support. We currently have PACT teams that provide that. We currently have integrated case management programs that provide the case management and the outreach, and link the person to medication and treatment. The infrastructure -- and we have residential programs. The infrastructure is in place for much of what we're talking about. Many of the clients that we are talking about find themselves in the State hospital system, leaving the State hospitals for the community. They are case managed. They are provided with linkages to community treatment, and they refuse community treatment for the reasons that I've described. By requiring that, the people who are currently offered services would actually receive those services.

Now, what our concern is, right now, we don't have enough resources to go around. So there is a kind of a musical chairs effect. What we don't want to see happen are people that wind up with this commitment

to displace other people who are in treatment who are doing well, who voluntarily entered treatment. So what we've talked about in terms of the actual cost of this is something similar to what the Department of Human Services, the Housing, Mortgage and Finance Agency, the State Parole Board, Department of Corrections, all came up with in their Promise Program, which was one of the initiatives that the Governor's Task Force recommended and which the Legislature approved. And what that initiative called for, basically, was roughly \$21,500 per person who would be leaving the prison system. The same numbers would be, I think, a reasonable estimate of what it would cost for someone who was on IOC, to provide that kind of support.

Bob, go ahead.

MR. DAVISON: In terms of this year's budget, Senator, what the Legislature did to deal with this issue in anticipating the possible adoption of this is, you adopted several of the Task Force recommendations, one of which was an additional \$10 million in screening money, which will add approximately 166 trained license professionals to do these types of assessments. So that's critical.

The Legislature also adopted a budget with an additional, I believe, \$3 million to pay for 25,000 additional psychiatric hours -- meaning an additional 25,000 hours where somebody can see their doctor. Also, the Legislature adopted, in the Fiscal Year '06, a specialized case management item, which is \$1.5 million. What we estimated, using actuarial tables and other states' experiences, that in the first year that IOC would be available, approximately 100 individuals would be committed to that status. So that \$1.5 million is to provide specialized case management

to those individuals, so the services would be available and they would not have to jump the queue.

SENATOR VITALE: I don't know if it's reasonable or not, and maybe you can offer your opinion. We did appropriate additional dollars this year for just what you have described. But I don't know that in the legislation we have a process to measure what are the desired outcomes of not just the funding piece, but also the ability to hire more case managers and social workers who will manage them. Would you recommend that we have a way in which we can measure the success?

MR. DAVISON: Absolutely. And the Task Force report speaks to that. I absolutely recommend it.

SENATOR VITALE: Okay. Thank you.

MR. DAVISON: Thank you.

SENATOR RICE: Mr. Chairman?

SENATOR VITALE: Senator Rice.

SENATOR RICE: I need to respond to a couple of things. First, I need to ask a question. Are there any consumers here to testify this morning? The reason I raised that is because it appears to me that there are some issues that need to be addressed and both sides of the story needs to be told. And as I look through "New Jersey's Long and Winding Road to Treatment, Wellness and Recovery," and the Governor's Task Force report, even the Task Force agreed that some very serious issues came to light that you couldn't even address, and some were too complex. And note the issues are the issues I've been talking about that have an impact on everybody, but particularly the communities who have the least and where the minorities

are. It appears to me that we've laying a foundation here without everybody being involved with laying the foundation. That's number one.

But getting back, you had mentioned incarceration. And let me remind you that the majority of the people who are incarcerated in New Jersey happen to be minorities. And that's for a lot of reasons. Some who commit crimes and should be there. Some who could be adjudicated a little differently in the court system, but the court system in our community don't give the same equitable treatment, if you will, as they give in other communities. That's subjective by the judge, given the laws we write and their discretions. But a lot of those folks who you indicated that were there, being treated unjustly, if you will, or unfairly, are there based on not clinical judgment -- is based on some judge. And I sat in courts many, many years as an officer, and I still go to courts. But now your judges says, "Something wrong with you young man, and we're putting you in jail and you're getting some help." Well, that was no clinical judgment there. Okay? But they wind up -- and then what happens is that I get very offended as a person when someone is trying to make me think that there is something wrong or something I should be doing; and I'm arguing with you, and the more I argue with you, I don't have any authority. You have all the authority. And all that does is compound my problem, because those who are listening to me, or viewing my actions, think there is something wrong, when even, in fact, it's not.

I think in the Legislature, many times my colleagues think there's something wrong with me when I get to cussing and banging the tables. But I'm passionate about what I feel and what I know. And so, I don't want, on the record, people to think that I'm (indiscernible) being

unjustly treated because these services aren't there, etc. They're being unjustly treated because the system, number one -- how they get into that system -- without the proper history, without limitations on it, without the clinical judgment experience that need to be there, because we don't fund it. When it comes to what we need, we don't want to fund. That's number one.

Number two is, I have some concerns, because when we talk about addiction -- there are various types of addiction to drugs. There are those who take a lot of pills for medication because they're prescribed. And there are those who started in a system of addiction directly through the streets, the substance abuse people. But yet, we refuse in this state to make and spend the kinds of dollars necessary to make beds and the proper facilities available for those folks. They will go for treatment. They will stop using heroin and different types of drugs and shooting if we make them available. I know for a fact, when they walk into these facilities for help, someone is saying, "We want to help, but we have no space, no beds." They stay on the drugs.

And so, yes, they have a problem you can classify as mental. I classify as something different. It's an addiction that you have to work through with the proper people, if you will, in the areas of psychology, and things like that, and counseling. But there's other things that need to be done. But they're mixing this perception that you are talking about to increase those numbers. And so that's got to be addressed. And how you address it, I believe, is that we look at how we isolate some of this and then put the dollars where they should be. I argue that, yes, I support \$200 million for mental health. It's the right thing to do. But I also argue, and

you can call it racist, call it what you want, I said that I don't believe that the number of people who benefit, with chronic mental health areas, are minorities, particularly in the African-American community.

You give us a job, which we can't get, for 5.50 an hour, we don't have no more problems. Other people lose a job making a couple a hundred thousand a year and they jump off buildings. It doesn't mean we have a mental health problem or a stress problem, but I can assure you that the majority are not African-Americans in that area, etc.

We do 150 million for trying for stem cell, but yet we can't move into the area of isolating individuals who need drug treatment and facilities, but also counseling; because whatever mental conditions, that's in the negative, exist, it's existing because of the use of drugs, not because the person has some other type of problem that may be related to other mental health conditions. And these are real things that, perhaps, you're not aware of. I don't blame you for that, because you don't live and have not been raised in the communities and work with people on a seven-day basis, not a five-day basis, seven-day basis. I work with the entire group. I see the problem. But because I don't carry the Ph.D., I don't document stuff in the vein that researchers get paid to do and come up with these hypothesis. No one is listening. And so someone eventually has to start to listen. And that's the danger. Because I can see this legislation with good will and good intent just compounding the problem, particularly when there's capacity and no real resources to deal with the problem -- not this way but as a whole, but also isolating and putting these things in the proper tiers.

And that's my perspective. And believe it or not, you may not know it, I know I'm more right than wrong. People just don't accept it.

The people that come from my community understand I'm more right than wrong.

MR. DAVISON: If I could just respond -- first, I agree with your first statement that consumers absolutely have to be heard from at some point. I think that's essential to the adoption of this legislation. And I know Marie Verna is here, from the Mental Health Association of New Jersey, and she will speak eloquently on the topic when given the opportunity. And families as well must be heard from, and Sylvia Axelrod is here from the National Alliance of the Mentally Ill. And she, as well, will speak very well.

Senator, I work for the Mental Health Association of Essex County. Fifty-four percent of the consumers that we serve happen to be African-American, 10 percent are Hispanic, 30 percent are white folks, and the other 5 percent are Asian and what have you, and we provide a lot of services in your district. And I don't disagree with a lot of what you just said. But the other thing I have noted, through my 20 years of experience in mental health, is there's a lot of folks -- black folks, Hispanic folks, and white folks -- who end up homeless and end up in jail, because they're so impaired by mental illness that they don't have good judgment. And they end up doing things that are dangerous to themselves, others, and property. And I think many of those same individuals, if they were committed to outpatient treatment, would not have to go to jail or become homeless. That's been what my experience has been.

SENATOR RICE: I'm going to end on this. I don't disagree, but it's how you define a good judgment. My judgment is bad too, but I'm not mentally ill when you treat me the wrong way. When you treat me the

wrong way, I make some bad decisions. That does not define me as being mentally ill. It defines me as a person with capacity that made a decision and it was the wrong decision. A lot of people incarcerated are not people of -- who lack capacity. They're not people-- And druggies are the same way. They lack capacity. They made bad decisions. They got influenced by peers or someone disagreed with them, and they disagreed, etc. It's like making any other kind of decision.

I am a Vietnam veteran. We had to make decisions. The boss said, "Go left." You're supposed to go left. Sometimes we decided we're not going to listen to the boss. We go right, we get in trouble. We go right, we may not get in trouble. And so I'm not going to allow you to do that. And I wasn't just talking just Essex.

When I talk about the majorities -- when we say the majority of the people who have HIV are minority and women, we're talking about New Jersey. Grant you, they may be in more of the urban areas. When I talk about the majority of the people I believe with chronic mental illness, not because they're druggies or made some irrational decisions based on other factors or variables, I'm talking about New Jersey. So I'm not going to even allow you to do that without responding back, etc., and it's not a debate.

MR. DAVISON: Yes, I'm talking about New Jersey. I was just referring to our common experience.

SENATOR RICE: Yes. I'm just saying it's not a debate, and I'm happy to know you're doing all you can in Essex. But we're not going to do things -- so it's your profession, or the things you are trying to do, continue to do harm to people. We're going to figure out how do we take

the intent of legislation like this, take all the issues that we cannot address, by your own admission and our admissions -- how do we try to get those corrected first? The worst thing we could do, from my experience in life, is to move forward in areas like this with partial plans or partial solutions, because you're going to find yourself back there, compounding your problem.

We know that there are some things that should be done this does not address. We know that there are people out there using drugs that are not getting addressed. And giving free needles is not going to address that problem, we know that, too. But we'll address it. Happen to be ways and means that's going to require a lot more resources than we're willing to put up. And then that's the problem I'm having. We'll put it up for certain things and certain classes, if you will, but won't put it up for other things when we know they should be there. That's the problem that we have as leaders in the community throughout New Jersey, how we balance stuff.

I know that Senator Cardinale, coming from the community he comes from, will probably see things differently. That doesn't mean he's a bad person. It's just where he lives and what he knows. And so I'm sharing my experiences with you on not what I think in most cases, but what I know. And none of my gray hairs are premature. I've been around a long time, and I've been working with people a long time. I didn't sit up in some bureaucratic office. I've been on the streets a long time as a cop, as a community person, as a council person, as a State Senator. This is all I do, etc.

So if you want me to write a book, then hold the legislation-- I have to start getting some people to write a book so that we can debate that. I don't want to do that. I'm giving you my experience, which differs than my colleagues experience here in many cases. It's the same in other cases. So it's not being antagonistic. It's just trying to share with you that it's wonderful we want to move things, but we can't move so fast sometimes, just to find out 10 years, 12 years after we retire and we're gone that we've done more harm than good to people.

MR. DAVISON: Well, sir, I appreciate what you're doing, and I'm not experiencing you as being antagonistic. I think the one area where we have common ground is, this is not something we should take lightly, and that's why we're all here this morning.

SENATOR VITALE: Thank you. Thanks very much.

Any other questions? (no response) No?

Thank you.

Do you mind hitting your buttons off so that the mikes work?
(referring to PA microphone)

Thank you.

Our next is Nancy Wolf, Director for the Center for Mental Health Services and Criminal Justice Research, at Rutgers University.

NANCY WOLFF, Ph.D.: Good morning.

SENATOR VITALE: Good morning.

Red light? (referring to PA microphone)

DR. WOLFF: I have to push it?

SENATOR VITALE: Red button. Red is go. There you go.

DR. WOLFF: Okay, great.

Good morning, Mr. Chairman and members of the Committee. My name is Nancy Wolff. I am a Professor of Public Policy at the Edward J. Bloustein School of Public Policy at Rutgers, the State University of New Jersey, and I am also the Director of the Center for Mental Health Services and Criminal Justice at the same university.

I've been invited here to talk with you about the research and the motivation underpinning that legislation. And I've been asked to give more of a slideshow presentation, so that way it will keep us all focused. So, unfortunately, the people behind us will not be able to see the presentation, and I will occasionally, since it's not on my screen, will need to be able to turn around every once in a while.

SENATOR VITALE: We can turn it sideways a little bit.

DR. WOLFF: That's all right. I think I can see it okay.

I'm going to focus on getting to reason, because I believe that's what this bill is about -- is helping individuals use their rational capacity. But I also think that public policy should be held to that same standard of rationality. And so I'm going to walk through some rational arguments why I'm uncomfortable with the legislation.

Oops, no. I think -- go ahead and put it back where it was. (referring to presentation) It's just making things worse.

SENATOR VITALE: We just want to give people the opportunity. Can we move the projector slightly?

DR. WOLFF: Yes, that's okay.

Okay, the first thing that I want to do in my testimony is to affirm the importance of treatment as part of the recovery process. But I mean that illness should be treated. And by treatment, I'm focusing on

both the process and the outcome. We have a lot of technology, both psychosocial technology, medication technology, that allows us to improve the well-being of people with mental illness. The issue is whether it's being applied appropriately and whether the process is actually facilitating the potential of that technology.

But I don't want to just focus on clinical treatment, which I think is part of the focus of the bill, but I also want us to focus on procedural justice. That is, that when we're giving people treatment we are engaging not just the illness but also the person. And we should never lose sight of the person in the process. How people are treated matters. Procedural justice relates to how people are treated, whether they think others are acting in their best interest, whether they think that individuals are acting out of genuine concern. They're also concerned about whether they're listened to. And not only listened to, but their views are being taken into account when decisions are made about how they're treated.

I think that we should never lose sight, also, in the discussion that we have today, that parity is elemental to legitimacy for persons with mental illness, both for the person as well as for the illness. So I will be focusing on those dimensions in my talk, both in terms of clinical treatment, but also in terms of procedural justice.

We're talking about coerced community treatment. It's a legal strategy where the State uses its power to substitute the judgment of an individual for a professional, in saying that this individual's judgment cannot be counted on as good, or that it's consistent with social values or clinical values, and therefore it should be substituted with a professional's,

even if that individual's competency is not in question, or at least not in the moment that their competency is in question.

As was mentioned earlier, there are 42 states who have some sort of coerced community treatment standard. Half of those states infrequently use those pieces of legislation, in part because providers are reluctant to impose their power; also, because there are oftentimes not available resources to actually invoke the law. And also, and perhaps most importantly, which I'll get to later, is the lack of an infrastructure to really implement the law consistently, as well, as intended in the legislation.

We should also be well aware that most of the coerced community treatment legislation comes out of a tragedy. That is oftentimes the motivation -- that a person with mental illness has committed a violent act. Although, if you look in those individual cases, what you will see is that those individuals who committed those violent acts were turned away from mental health providers. It was not that they were saying, "I do not want treatment," that "I am resistant to treatment," but they were turned away at the door. We should never lose sight of that.

What is the motivation underpinning coercive community treatment? I think the goals of this policy are laudable. We are trying to enhance the individual's well-being. We are also trying to protect the public. This is, definitely on both those grounds, beneficence in action, both at the individual and at the social level. And we should always look at community safety as also being a part of that.

But I think, as some of the discussion has already alluded to, that we should not lose sight again of the complexity of this issue and not be lulled into the belief that mental health treatment is a panacea -- that it

will solve all of the social dynamics that are related to this particular issue that brings us here today. Yes, there are preferred behaviors that we want our mental health treatment to produce, such as improved symptoms and functioning; and we definitely have undesirable behaviors -- antisocial behaviors -- that we would like to minimize.

There is a belief that these preferred behaviors increase individual well-being as well as community safety, and that the mental health treatment system has a critical role in producing preferred behaviors. But it's also the case that when we have preferred behaviors, such as better functioning, that individuals may be better organized and also better aware of their material deprivation that would motivate them to engage in antisocial behaviors, such as robbery and theft. There are illustrations where people who have minimal symptoms but have serious mental illness, while they are asymptomatic are criminals. It's just part of what they do to support themselves in absence of having a job that supports a living wage. We should recognize that undesirable behaviors can have a negative impact on individual well-being, as well as the safety of the community.

But what are the causes for people not to be in active treatment? This is certainly something that the literature has addressed since the 1970s, and most of the discussion to this point is really focused on individual reasons. And as we've heard repeatedly today, perceived need is frequently cited. Fuller Tory is, perhaps, the best voice in this area in looking at serious mental illness as a disease of the brain that affects rational choice. And therefore, we can't count on people with mental illness, because of their illness, to use good judgment, because the illness

impairs their judgment; and that they may not be able to act on their own behalf, which sets up the framework for substituted judgment.

It also, however, is in the literature that shows that people with a serious mental illness may understand and perceive a need for treatment. But there may be an absence of willingness on their part that is very much based in rationale choice. That is, they don't like how they are treated when they go for treatment. They don't like the orientation of the treatment. They don't like the side effects of the medications, and the system doesn't work enough with them to get a treatment regimen that works for that individual. We all avoid going places where we don't feel like we're treated in a way that's consistent with our sense of self. Also there are reasons why people don't go. They may perceive a need, they may be willing, but unable. They may be unable for financial reasons. They may be unable because of transportation reasons. They may be unable because of the disorganization in their lives. And we can't lose sight of that as being a reason why people don't choose treatment, independent of having an illness.

And also, we shouldn't lose sight of the fact that the process really matters as well -- that we have made a very complicated mental health and health-care system that is very difficult to negotiate the access barriers. And it is people with both mental illness and without mental illness, find it very difficult at times to find their way into the right system at the right time.

Also, since the '70s, there has also been a clear recognition of system failure -- that the noncompliance of individual's principle source is the noncompliance on behalf of the service system. They hear it's the

service system that doesn't perceive the need, that they think instead of focusing on the mental illness, they say, "It's an addiction problem, and that's not my issue," or they'll see it as an antisocial personality problem and it doesn't fall within the eligibility criteria. There's also plenty of evidence to show that some providers aren't willing to treat individuals who are different in their presentations.

Also the ability -- it is not uncommon for providers to say, "Your insurance coverage -- I don't provide services to people with your insurance coverage," or "You don't have insurance coverage, and therefore I can't provide services to you." So the ability-- And also, many times providers will look at individuals, especially those coming out of the criminal justice system, especially those who have violence in their background, to say that they are unable to respond to the needs of those individuals because they have inadequate training to deal with the violence dimension. And there are certainly process aspects of the system that get in the way of the system doing what it should be.

So I think it's very important, when we go to attribute blame to failure to activate treatment, that we balance that assessment in looking at both the individual's portion of responsibility and the system's portion of responsibility, and not use the law to over attribute cause to the individual and sacrifice their civil rights as a result of it.

SENATOR VITALE: Nancy?

DR. WOLFF: Yes.

SENATOR VITALE: Can I just jump in for a minute with some questions to ask?

DR. WOLFF: Yes.

SENATOR VITALE: I just wanted to not wait until the end to ask them.

DR. WOLFF: Oh, sure.

SENATOR VITALE: You talk about certain providers that you believe who are unwilling to treat individuals in an outpatient atmosphere. Can you tell me what kind of provider they are? Is it a hospital setting? Is it a clinical setting?

DR. WOLFF: It oftentimes can be just -- and again, here the evidence and the literature relies a bit more on anecdote, but it certainly has been written in the articles. And it's hard to generalize to every situation. We can certainly look at -- and this is that serious mental illness -- but I just finished a report on sex offenders, for example, who are being released on community supervision for life, which, again, is a piece of legislation passed by this body. Those individuals are required to get treatment, but oftentimes there are no treatment providers in the community willing to treat sex offenders.

So as a consequence of that, we did a study of providing free treatment for sex offenders at the parole office. And as a result of that study and its effectiveness, we now provide free treatment, as well as on a sliding fee basis, for sex offenders at parole offices.

Also the issue of having adequate services. Because we have a bifurcated system in terms of substance abuse and mental illness. There has been a chronic, historical pattern of each system shifting responsibility to the other. "No, the person's principle problem is a mental illness. No, the principle problem is really a addiction disorder." Well, actually, they both co-occur. And certainly, there has been limited services available in most

states, including this one, that integrate substance abuse treatment as well as mental health treatment. And I think it's mostly at the community level that, if we had easy access for individuals to get into services and that those services were oriented to the consumer and used a procedural justice basis, that those individuals would be willing to treat. But there has been a chronic problem with individuals being able to get the appropriate treatment delivered from the service system that has historically used eligibility criteria to avoid certain patients or clients that they would rather not treat.

SENATOR VITALE: That wouldn't surprise me. I just would like to know if we have any data that can support that. If you could find that it would be helpful.

DR. WOLFF: Yes. I can certainly give you copies of articles that have addressed this issue, and it's certainly why there's so much discussion about why the system needs to be improved, and that there's an inadequate supply of services. Because it's not the case that individuals aren't trying to get services, but there's simply not enough services available, and there are barriers that can be put up to make it difficult for individuals to get access to the available services. And one way that you can certainly look at that is just looking at the waiting list for appropriate programs.

SENATOR VITALE: You said that some of the patients sort of resist the treatment regimen that's forced upon them by their provider.

DR. WOLFF: Right.

SENATOR VITALE: Given their condition, whether it's -- there's co-occurring issues with alcoholism or drug abuse or their mental

illness separately, wouldn't that sort of be normal behavior for someone who may or may not be as rational as you'd hope they would be?

DR. WOLFF: Well, Senator, I would ask you to think about people who are being treated for hypertension or other kinds of health problems. They may not like what their doctor chooses to prescribe, and they don't do it. Is their rationality any different from a person with mental illness, who says, "I don't really like how you're treating me. I don't really like what the side effects are," and that they may rationally choose not to engage in that kind of treatment?

SENATOR VITALE: I don't disagree that there are -- again, I don't have the data, and I don't think anyone does, if it's all anecdotal -- but I wouldn't disagree that there are some patients who have mental illness that understand their illness and who are rational and thoughtful and care enough about themselves and their families to want to have treatment. But there are, I'm sure, those who, because of their mental illness, are not thinking as clearly as someone without a mental illness.

DR. WOLFF: I will certainly concede, and I am not-- I am someone who always says there's a distribution. And I believe that the distribution is a pretty normal distribution that has tails on it. And we're oftentimes making policy about very small numbers in the tails of the distribution, and we're generalizing from the tails to that entire distribution. I think that sets up a problem of generalizability. And also, I think also, as Senator Rice has pointed out, it's not clear whether it's the mental illness that's getting in the way of appropriate choices or whether it's the substance abuse that's getting in the way of the rational choice.

SENATOR VITALE: Well, you make a good point that the system does not -- there isn't, at times, clear, in terms of which is it first -- the cart before the horse, or is it the chicken or the egg? Is it the alcohol or drug abuse issue, or their mental illness, which is the root cause of some other issues? And I would recommend to the members and the Task Force and to the sponsors that we look at that particular issue -- how it is that people are treated with co-occurring disorders, so that you don't have this bifurcated system of, "Well, it's not my problem. It's your problem. It's another agency," or -- we see that all over the bureaucracy.

DR. WOLFF: I think we also see it very much, and since we already have talked about the criminal justice system, you see it the same way. Because the criminal justice system is oftentimes the system that can't say no. Is it addiction problem, mental illness, or is it just antisocial personality disorder? Well, all of those three things can happen all together in one person. And we oftentimes, within our mental health system, really don't have appropriate treatments for people, with access to disorders, that really get at the antisocial personality problems. But they occur in the nonseriously mentally ill population with a certain level of prevalence, and there's no reason not to expect that same level of prevalence within people who have mental illness. They don't have some sort of gene that protects them from antisocial personality disorder.

And so I think that it's important that we recognize that all three of those things can co-occur. And it's not the case that one system can treat all of those, although we are expecting the mental health system to approach treating all of those problems.

SENATOR VITALE: Thank you.

SENATOR RICE: Mr. Chairman?

SENATOR VITALE: Mr. Rice.

SENATOR RICE: On the question -- your discipline is criminal justice or mental health, or just both?

DR. WOLFF: Neither.

SENATOR RICE: Neither, okay.

DR. WOLFF: I'm an economist who has specialized in mental health services research for 20 years, and I have followed the people in my study into the criminal justice area, and now focus almost primarily on the criminal justice activities of people with mental illness, as well as people without mental illness who are in the criminal justice system.

SENATOR RICE: And that's fine. I don't have the Ph.D., but I do have the Master's of criminal justice administration and planning. I don't have a law degree, but I did go to law school, so I do have some foundation to speak with some reasonable degree of authority with the experience. And would you agree there's a sociological fact in the reality that, when we talk about groups -- let's take youth, let's take gangs -- that we're talking about subculture groups who establish their own values, subcultural values or morals, that oftentimes conflict with the other, greater world, society; and some of those subcultural norms and values, as a society as a whole, we can accept and live with. But there are many we cannot. And it's not necessarily because someone has a mental health problem, it's because they have established their own values. It could be from a lack of respect for their value -- don't like the flag, don't like the way the country is going; or it could be for the fact that within their values they feel more love, and in their caring or family. Do you agree with that?

DR. WOLFF: I believe that if people are socially isolated that they will be motivated to find their own organizations that will affirm their being as people, and that that can give rise to the development of subcultures which serve the purpose of making that individual feel affirmed and providing a sense of belongingness.

SENATOR RICE: Do you believe that most people need people? Do you believe that to be deprived of a social-psychological need can be just as detrimental as being deprived of a biological need, such as water, thirst, etc.?

DR. WOLFF: You're getting out of my area of expertise. But if you're asking me as a person, as opposed to an expert, I certainly would concur with you based on my personal, but I would be stretching it to say that I have any qualifications to answer that question definitively.

SENATOR RICE: Okay. Well, accept it from me as a sociological fact. And the point is that because of those "needs" that oftentimes can lead to one's detriment, it's still not a mental situation. It's a needs situation. It has to be fulfilled. That, in itself, may cause people to do things that they don't want to do -- make bad judgments and decisions. Some people feel they just have to have a Mercedes, but they can't afford it. They go out and steal one. Well, bad decision, but they're not mentally ill or reached a point where they have to be categorized.

And the only reason I'm raising this, Mr. Chairman, is that we have to take another look at this and figure out how to put those dots in there and take those little pieces out so we can have the real population that legislation like this should be addressing. That we can't afford to say, "Well, we'll get to one of 10, and the other nine will just be the wrong

folks.” We can’t afford to say, “We’ll get nine out of 10 and that one would be the wrong individual.” So I’m just trying to keep the record clear as to some of the things that we should be looking at as we move forward with legislation like that.

I know we’re not voting anything. I know people are going to be testifying. I know we’re going to be revisiting. But I wanted to clear the record of some of the things that need to be looked at that, perhaps, the Committee or the Task Force did not look at or did not go into depth on. So I just want to keep the record there.

Thank you.

SENATOR VITALE: Thank you, Senator.

DR. WOLFF: Can I proceed?

SENATOR VITALE: Sure.

DR. WOLFF: Okay. So back to this diagram, in terms of a break in the process is, that oftentimes outpatient civil commitment has tended to try to focus on the one in the four in this diagram, of trying to make sure that the mental health connection is maintained so that we produce preferred behaviors. And, that if there are undesirable behaviors, that we also make that stronger connection to eliminate those behaviors as well.

But I want to make sure, just as Senator Rice has pointed out, that we have an accurate portrait of the situation. I think we should remember that some people with severe mental illness are not actively engaged in treatment. Let me give you the numbers on that. Forty-seven percent of people with serious mental illness between 18 and 54 are connected with treatment. So that means 50 percent of them are not.

Sixty percent of the people who have schizophrenia are connected with treatment. Those individuals who are less likely to be connected to treatment are African-American, males, and have an education level of less than 12th grade.

But we should also remember that those individuals -- that some of these individuals who are not actively engaged in treatment are unemployed, poor, and homeless; that they're scary looking; anti-psychotic -- or they're actively psychotic; they're using illegal substances; they're dangerous to self and others; and they're revolving through both jails, prisons, and hospitals. And the purpose of this legislation is really to have a treatment prophylactic effect to prevent something in the future, which is violence, by looking at these individuals, even if we try to narrow that down to a small group of those individuals.

But in saying that, we should also be very clear that some people with serious mental illness are actively engaged in treatment, and that these individuals also engage in violent behavior. Okay? Mental health treatment is not going to eliminate violence. There is no evidence that suggests that. People with mental illness are similar in characteristics to people without mental illness who engage in crime. They are poor. They are often young. They are males, and they are living in very disorganized communities. Even the evidence that shows -- evaluating our best treatment programs, like assertive community treatment, you will see that those individuals in those programs getting an abundance of services still have interactions with the criminal justice system and still engage in violence. So we have to keep in mind that there is no guarantee that just providing mental health treatment is going to eliminate violence.

So having a commitment to treatment, I think we have to first recognize that clinical treatment -- we have a lot of technology, psycho-social meds, psycho-social interventions, as well as medications that have demonstrated effectiveness and cost effectiveness. There has been less focus on issues of how the treatment is done and focusing on procedural justice. But there is evidence that shows that the amount of coercion experienced by a person is strongly related to the patient's perception of how he or she was treated. So again, it is so important to make sure that we just don't look at providing intensive case management or providing medications. That's not all of it. It really is how are you engaging the person, how are you treating the person, how engaged does that person feel, how much does that person believe that you care about them that's going to be a critical part in the effectiveness of the treatments that we have available.

So the promise of public policy in this area is, again, individual well-being, but community well-being, but to invoke the State's interest to use or coerce people into treatment has to focus on community safety. That is, it has to focus on the violence aspect, because that's what's compelling the State to act -- is to protect people from harm. But in saying that this is what the benefits are likely to be -- or where the benefits that the State should be focusing on -- to decide whether it should use its powers to compel an individual, against their will, to do something that a professional thinks that they should, we have to weigh against that the likely costs.

And economists usually talk about pecuniary costs -- that is, they have dollars associated with it -- and non-pecuniary costs that do not have dollars, but are still costs just the same. We know that there are likely

to be treatment costs and intervention costs, and civil and criminal justice and social costs, which I will talk about in a minute. But oftentimes, what we overlook are the non-pecuniary costs, and those are the reputation losses, not only to the individual, but to the illness in terms of what is the reputation that -- or what's the reputation effect on the illness when you're associating it with a law that is based on the presumption of violence.

Also, we need to make sure that we recognize that it affects the reputation of providers, if providers are going to be called in to give testimony against their patients in a court of law to say that you're not doing what you're supposed to be doing. So that there can be reputation losses that are non-trivial. We should also recognize that stigma is likely to increase, and this is certainly something that's been talked about in the literature, and also in justice costs and pain and suffering costs. And these have to be taken into the mix, when you're making a public policy that should weigh the costs against the benefits.

And so much of my argument that I am going to formulate now is really trying to better identify what the costs are and what the literature tells us are the likely benefits. The underlying point that I will be making is that if you're trying to get the individual to reason, you should make sure that you're using a reasoned public policy. And I have four key concerns with the reasoning that underpins coerced community treatment.

The first has to do with the lack of a credible empirical base. The second is the increased administrative costs associated with expanding the reach of the court, providers, and clinical treatment advocates. Third, it weakens the notion of parity. And third (*sic*), it reinforces and invites stigma.

I'm going to take each point in turn and try to provide as much evidence and argument within my allotted time. First is, does coerced community treatment work? And this is an issue that I think that this Committee should look at very carefully. We have worked on the medical side to try to develop standards under which public sector dollars are used to support treatment. And there's a rule called *evidence-based practice* -- that we should make sure that public expenditures follow and encourage best practices that have an evidence base, to support that the costs are worth the benefits and that this is the best way in which we can achieve those benefits.

Unfortunately, with coerced community treatment, that evidence is, at best, thin, and certainly is mixed. The claim is, is that coerced community treatment will reduce hospitalization and rehospitalization, and increase treatment compliance, and decrease arrest and violence. This is much more of a belief than it is evidenced based. And part of that reason is, is that coerced community treatment, even though it's in 42 states, has been formulated and mandated in very different ways. It's been implemented inconsistently. And so it's very difficult to assess something that is not a standardized product. Also, it is critical in research to make sure that you have a comparison -- that you're comparing one intervention to another intervention, and you're randomizing people to interventions to make sure that those groups are the same and you don't have what we call *selection bias*.

Now, the best studies that I'm going to cite do use a randomized control design. But I do want to point out that you have heard today, and you will hear the rest of the day, about the New York state

report. Again, I need to point out that this is not a published peer review document, but it is just a report based on the state agency. It is being used to say that, "See, under Kendra's Law, we've got these better outcomes, preferred behavior." But I would like this Committee to challenge that finding and ask, is it really Kendra's Law or outpatient civil commitment that gave rise to that finding, or was it the \$200 million that was introduced at the same time to support Kendra's Law? More specifically, if given a choice what would you rather have: \$200 million dedicated for mental health services or Kendra's Law? I think it's very clear, hands down, what you would prefer.

But let me get back to, also, this in terms of assessing the research. What outcomes do you want to look at? Are you looking at the treatment outcomes or are you looking at the violence outcomes? It would seem to me that given that you're trying to impose the State's power to compel individual citizens to do something, that the evidence of most relevance would be the violence evidence -- that is the public safety evidence -- that would be of most significance. Also, in terms of assessing this literature, we should also know at what cost. At what cost are we getting these benefits? And here's where the evidence is pretty silent, although I will try to lay out to you some of those costs.

So as I said, the evidence is very thin. There are eight studies, two of which are randomized control studies. Both of these studies are suggesting that the benefits associated without patient community treatment or coerced community treatment is very minimal. One study found no difference in the clinical outcomes or in terms of the violence outcomes, or in terms of the criminal justice outcomes, in that still 20

percent of the individuals randomized in the New York study did have some contact with the criminal justice system, but their crimes were property related, as well as drug related.

In the other Duke study, they found no significant differences if they looked at outpatient civil commitment being applied over a six-month period, but if they sustained it for a group for a longer period of time, then they did see some improvements in the violence outcomes. And in particular, with just a six-month's dose, they found that about 42 percent of those individuals committed a violent act. Whereas, if you sustained it for longer than six months, it went to 27 percent. But even that set of evidence -- the researchers on this project say it's still not clear that you need outpatient civil commitment to get those outcomes. You could perhaps get those outcomes with intensive mental health services combined with assertive outreach, without using the State's power to coerce.

But what I think is so important -- and you're going to hear it much today, in terms of the match of the evidence that is available on outpatient civil commitment -- is, like a Rorschach test, you see what you want to see. And there's one issue that was done in psych services in 2001, in which there were a series of articles looking at the same data. And I've just taken a few quotes from these articles. The proponents that looked at the same data, these eight studies, and said, "Outpatient commitment has been shown to be highly effective in improving compliance with medical regimen" -- opponents looked at the same data and said, "Outpatient commitment confers no apparent benefit beyond that available through access to effective treatment."

When California was considering outpatient civil commitment, they hired the RAND Group to do a systematic and thorough review of the literature to decide whether this was something that California should do. So our best critical review, objective critical review of the literature, comes from the RAND Group. And their finding was, “There’s no evidence that a court order is necessary to achieve compliance and good outcomes, or that a court order, in and of itself, has any independent effect on outcomes.”

If we go to the Surgeon General, the Surgeon General in the 1999 report said, “The need for coercion should be reduced significantly when adequate services are readily available.” So the evidence here is certainly not compelling enough to use the State’s power to compel individuals against their will to do something.

But I want to come back again to the connection that we have that’s the strongest, both in the research evidence as well as in the practice area, which is that there’s a very strong connection between severe mental illness, crime, and substance abuse. Co-occurring substance abuse is common. Depending on how you measure substance abuse, 40 to 60 percent of people with serious mental illness have a problem with alcohol or drugs. There is a very strong correlation between substance abuse and criminal behavior, particularly violent. These individuals are also more likely to experience social isolation. And the best evidence we have is that the best way to approach this population is to use an integrated treatment -- has been shown to be best practice.

So let me go and focus on the cost associated with the use of court-ordered treatment. I think that the evidence shows that it has very limited promise and benefits. The eight states that the RAND Group

looked at, in terms of their application of coerced community treatment, have shown that its effectiveness really depends on having a very good infrastructure, adequate resources, and consistent implementation across the counties. And so for that reason, I'm going to talk about the intervention, in terms of the legal infrastructure that is required. I am also going to talk about the injustice, in terms of discrimination and abuse of power and stigma, in terms of what's being said about the incapacity of informed decision making.

In terms of the public policy of coerced community treatment, there are a variety of decisions that have to be made: Who's eligible? Who initiates the process? What's the legal process? What does the court order? What is required for informed participation? What do we tell the individual that he or she is now subject to? Who monitors and for how long? Are we making our clinicians sheriffs or parole officers by making them monitor individuals' compliance? What are the requirements for compliance, in terms of how do you measure compliance? Is it 100 percent compliance with those treatment orders? But if those treatment orders vary across individuals, is that really fair if individuals with similar circumstances have different treatment plans, as well as how are their interpretation of what compliance? I know in the legislation it says *material compliance*, but I'm not exactly sure what that means.

Also, what are the consequences? That is, we certainly heard Mr. Monahan talk about that we should spare people from inpatient hospitalization, in terms of the trauma of inpatient hospitalization. But the consequences of a violation of outpatient civil commitment is, is that the police come and pick you up, they can detain you, they can take you

someplace into the treatment situation. You can be asked to go before a court hearing where you're hearing people talk about you and hearing that you need to do something that you may be fundamentally in disagreement of. So I really think we're exchanging one traumatic experience for another. But which is better -- being with clinicians in a hospital setting or having the police come and pick you up, perhaps put you in handcuffs, and take you someplace that you don't really know where you're going and what's going to happen to you? And also, what's the appeal process?

So I think that we also have to make it very clear that unless I misunderstand the law, that the individual still retain their right to refuse medication. Although in other studies, it has been very clear that the individuals are not informed enough about what outpatient civil commitment means to understand that that can not force individuals to take medications they don't want to, on an outpatient basis.

This perhaps is also -- the second concern is the increased administrative costs associated with expanding the reach of the court, providers, and clinical treatment advocates. As that process just showed, and the legislation describes, there are a lot of administrative layers to outpatient civil commitment as it's developed in S-2760. And in particular, there's clinical certification that's going to require the time of screeners, as well as psychiatrists. There's also going to be a hearing judge, a public defender, multiple formal hearings, an appeal process, monitoring and supervision, and the use of law enforcement.

This is likely to be very, very expensive. And I can only draw on one important analogy here. In the 1980s, we thought physicians were being incentivised within their insurance policies to over-prescribed care.

So managed care introduced what we call *utilization review* and hired a whole group of nurses to question the decisions of doctors, and also then to challenge their access to outpatient services, to laboratory tests, as well as inpatient services. That meant that that policy introduced this huge administrative level of negotiations appeal processes.

In the 1990s, managed care organizations decided to dismantle utilization review because they found it wasn't cost-effective. It rarely ever changed a decision that a doctor had made, although it had huge administrative costs associated with it.

The only evidence that I was able to find is that Erie County in New York, in looking at what the implications were for Kendra's Law, estimated that it was going to have to spend \$1.6 million in processing the petitions. In one period, they had 60 petitions, but only one resulted in a court order. This has raised significant concerns about whether we're going to be using scarce resources to really introduce a huge administrative process; and whether these costs, which are going to be shifted to the county, are going to displace other county services and mental health services. Because I don't see any funding that's earmarked within this legislation for these administrative costs. And even if we're talking about only 400 individuals, how many petitions will you have to process to get to the right 400? And I don't think that's clear at all.

Concern number three, which weakens the notion of parity. This body, in 1999, passed the New Jersey Mental Health Parity Law that says health insurance benefits for people with mental illness should be equivalent to people with other types of medical problems. It affirmed the

principle of equal treatment, and it's consistent with the ADA that says that you should have equal opportunities independent of your disabilities.

But the New Jersey Assisted Outpatient Treatment bill actually mandates that people with mental illness will be treated differently because of their mental illness, even though there are other disorders that have equal chronicity, effective treatment, and public safety risks. And one has to question, how can we justify unequal treatment, or application of the State's power, even though disorders can have equal problems and even greater risks?

So I looked in the literature and found a quote about the lack of insight and poor decision-making as a justification for coercing clinical treatment. And here it says, "The most common reason that people with severe mental illness are not being treated is that they do not believe that they need treatment for a mental illness. A severe lack of insight into illness, whether caused by schizophrenia or other impairment, can seriously interfere with a patient's ability to weigh meaningfully the consequences of various treatment options."

I invite you just to look at a slight modification of that. If we simply replace the mental illness cites with substance abuse, we can see that the same thing could be said for substance abuse. So my question is, why aren't we using the State's power to coerce people with substance abuse to engage in effective treatment?

UNIDENTIFIED PERSON FROM AUDIENCE:
(indiscernible)

DR. WOLFF: I'm sorry.

UNIDENTIFIED PERSON FROM AUDIENCE:

(indiscernible)

DR. WOLFF: Yes. I'm just going to get to that.

So here's the issue, why different treatment for treatment? With serious mental illness, it's justified on chronic behavioral problem, effective treatment is available, and there's a danger to self and family more than to the community. That most oftentimes when there is a violence it's directed at the self or at the family. So we might have a law that would be associated with the serious mental illness that's going to focus on this intervention.

We have a similar intervention that's civil in nature with sex offending, called Megan's Law, that says that there's chronic behavioral problem, there's effective treatment, and that those individuals that have gone untreated are likely to cause danger to family and community. But then if we look at alcohol addiction, drug addiction, and domestic violence, all of those situations are chronic behavioral problems. There are effective treatments available for those individuals, and their impacts, given their rate of prevalence, is much higher on the individual, on the family, as well as on the community.

So the question is, why do we need outpatient civil commitment dedicated to people with serious mental illness when there are other opportunities and there are other disorders that would benefit equally, as well as the communities being protected? So I think that we really have to think about how do we square the whole notion of parity on one side, in terms of insurance benefits. But then we generate laws that say we're going to treat people unequally in terms of their civil rights, even

though we oftentimes engage people in treatment for substance abuse in terms of a criminal process, and tie required treatment through part of the criminal courts, not in terms of the civil courts. And this raises the question, why not civil courts for these disorders as well, especially since individuals are equally at risk?

Fourth is the concern that it reinforces and invites stigma. And here the bill is reinforcing the notion that people with mental illness are different because of their illness, that people with mental illness have unequal protections, that their rights are conditioned by their choices about treatment, although we don't condition other groups' rights based on their choices. And people with mental illness must live under the constant threat of court-mandated treatment because they cannot be trusted to act in their own interest because of their illness. And here -- and also that people with mental illness engage in social and criminal deviance because of their illness.

Here's where I think we have to be very careful. And even though you're saying this only applies to 400 people, the 400 people have only one characteristic that's of interest, which is their mental illness. And that mental illness is the issue that is being the lightning rod for this coercive treatment. And so it does have a mass implication on other people who share that one characteristic.

But let's look at the evidence here. The evidence about people with mental illness, in general, is that they're no more likely to be violent. That they're more likely to be violent if under the influence of drugs or alcohol, and that their perceived and actual deviance is much more likely to be associated with the use of illegal drugs and alcohol, poverty, unemployment, homelessness, and living in disorganized communities.

So here's where I think that it brings up the issue that Senator Rice brought up, which is, how good is the profession on predicting violence? And if we're using a predicted judgment standard, there's fairly strong literature that shows that the diagnosis of mental illness -- and also in terms of the prediction of violence -- is very, very subjective. There is a lot of professional uncertainty, and that they have no special skills to predict future events or future dangerousness. Also, a person may not be violent at any one point, but if they then are under the influence at the next minute, they may be more likely, given the evidence to be prone towards violence.

Also, what we're trying to do is predict very rare events. We are not particularly good at predicting rare events that have happened in only 3 or 5 percent of the cases. We are much more likely to be wrong than right. And here the evidence shows that clinicians have drawn predictions for two out of three patients. Also, when you're talking about using information to help inform those decisions, we have to recognize that that information is likely to be very biased towards individuals who are more socially engaged. Individuals who don't have caring families, who are not very socially engaged, who move around a lot, who are not likely to have equal historical information on those individuals by which we could then use that information to predict future events-- Also, I don't think that the bill addresses -- what's the liability for the screeners, for the mental health professionals, and the court if their predictions are wrong?

So when we look to the recovery -- I think that when we look to recovery for persons with disorders, that safety, security, opportunities, and legitimacy have to be the cornerstone; that family and community play an

important role, as does mental health system and addiction treatment system. I think that the challenge to policy makers here is how best to balance the State's commitment to public safety and fair treatment. And here are my recommendations:

I think that any bill that is considered here, given the severity of the issues in terms of civil rights here, should require due diligence on behalf of providers. I think there should be a sunshine provision that makes sure that the system has tried to do everything that it possibly could and is consistent with best practices, both in terms of procedural, as well as services themselves, before we look to the patient's liberty to be compromised or sacrificed. I think we have to monitor potential abuses. Other areas have shown significant inter-county variation. And if some counties are likely to pursue this policy with a greater vengeance, you might see some people fleeing those counties and going to other counties that don't fall under it, because they don't have as many available resources, or go to counties that are enforcing the legislation less rigorously. So I think we have to be very, very careful here in terms of unintended consequences. We also have to recognize that aggressive outreach has been used in other states and has been found to be very effective.

Again, we have to go back to the history that says that oftentimes the system is not in compliance and that we should compel the system to be responsible and make sure that it can't ignore individuals, first; and that the burden of proof should be on them through a sunshine provision, and that the sunshine provision should be extended while the individual is under any type of court order.

I think that, also, that the challenge to policy makers is that we should make sure that there is a required advance notification and directives. I think the existing bill is particularly silent in terms of the consumer education and making sure that consumers are aware of what is likely to happen to them. I think there should be more respect for their thinking capability, and assist them in meaningful ways. In particular, I think that providers should have to give advance notification to all individuals who are at risk of coerced community treatment. They should require, at the time of advanced notification, that legal counsel be assigned along with a peer professional. They should require that legal counsel review the provisions of the coerced community treatment statute with the individual within a week of its potential activation, and require legal counsel provide the individual with an opportunity to develop an advanced directive to make sure that that individual's voice is taken into account when these decisions are being made.

And lastly, I think that we -- I'm sorry, second to the last -- we should make sure that we provide competent legal counsel. The prosecutors will certainly be aware of the legislation. I still think there is significant concern about whether judges are going to have enough training. I didn't see anything in the bill that would allow for education to make sure that judges will be able to weigh in all of the uncertainty associated with behaviors, as well as to weigh all the legal issues. But I think it's also more important that we make sure that public defenders are adequately prepared to work on behalf and with individuals who are likely to be at risk of coerced community treatment. And what I mean by that is, not just as Professor Jacobi said, that they know the bill or the legislation, but they

have a working experience and knowledge of mental health law. Because it's more than just this piece of legislation, and we need to make sure that individuals have appropriate and adequate counsel.

Lastly, I think that we need to recognize that any bill that's considered and put into law should affirm the legitimacy of people with mental illness. There's a saying in the research profession that has actually been introduced by the consumer movement that says, "Nothing about us without us." People with serious mental illness, because their mental illness, will have nonpecuniary costs imposed upon them because of their illness is being associated with a bill or a law that says something about their rational capacity because of that law.

And here's where I think there should be compensating benefits for those individuals. And in particular, I think that the bill should make provisions to involve people with mental illness in the implementation and application of the legal and treatment processes associated with coerced community treatment. And more importantly, I think that the bill should require that these individuals be paid peer professionals -- should be on-- Let me say this again. I think that the bill should require the inclusion of these individuals as paid peer professionals on support teams for any person who is at risk of coerced community treatment. I think the bill should recognize and affirm the experiential expertise of people with mental illness who are in recovery, and also should recognize that estimates are that people with serious mental illness have unemployment rates that are 60 to 80 percent. I think that employing them at a time, in this way, not only affirms what they know, but also helps them get job experience.

In closing, I want us to come back to reason. I think that we should expect our public policies to meet the same standards of rationality that the State expects of its citizens. And as we try to get to reason, I'm closing with the words of Paul Appelbaum, who is not only a researcher, but a scholar in this area, as well as the President of the American Psychiatric Association. And he states, "Fear of violence by persons with mental illness, although probably the strongest motivating force behind the current push for outpatient commitment statutes, is one of the weaker justifications for new laws."

Basically, the argument is, is that we should not use fear of violence to use the State's power to compel. Also, he says, "Only a tiny fraction of the nation's violence can be attributed to mentally ill persons. The best available evidence is about 3 percent. It is unclear whether many of these acts are perpetrated by persons who would be eligible for or deterred by outpatient commitment." Isolated rare events, no matter how tragic, should not be used to abrogate the civil rights of citizens, nor should it be used to impose huge costs on the illness, the individual, or society.

Coerced community treatment imposes huge costs on the illness, the individual, the mental health system, the court, the law enforcement -- and there's very little evidence of promise that it will stop violence. It is my view that we can do better. We should expect more from our public investments and more from our public policies. We need to get back to reason.

Thank you.

SENATOR RICE: Thank you very much.

We're going to, at this point in time, recess for five minutes, because the Legislators are not here, someone is paging me with a 911, and you need a break anyway.

I would like to ask, doctor, if it's possible -- I don't see it here -- could you share your PowerPoint with this Committee?

DR. WOLFF: Yes, I have them here for you. Yes.

SENATOR RICE: And also, when we come back, the next person may want to get your comments together. It would be Mary Zdanowicz, okay, the Executive Director of the Treatment Advocacy Center. Is she here? Okay.

Let's recess for five minutes. I'll be back, if no one else.

RECESS

AFTER RECESS:

SENATOR VITALE: Okay. Our final witness today is Mary Zdanowicz, Executive Director of the Treatment Advocacy Center, who is going to speak in support of the legislation and provide us with a little bit of a presentation.

Thank you, Mary.

MARY T. ZDANOWICZ, J.D.: Thank you, Senator Vitale and members of the Committee. I really want to thank you for having us here today to talk about this, which is a very important issue. I am the Executive Director of the Treatment Advocacy Center in Arlington, Virginia.

I want to give you a little bit of my background for context in what I'm going to talk about. I actually started my career working in laboratories, actually here in New Jersey. So my first half of my career was in science, and I really like data. I like looking at data, so we're going to talk about data today. But then, of course, I like the public policy issues, too, so I went to law school at Seton Hall, so now I'm actually an attorney. But the event in my life that probably influenced me the most to be here before you today is that I have a brother and sister who have schizophrenia. So this is something I'm fairly familiar with. I'm not a clinician, but I know some -- quite a bit about the illness.

The one thing I'm sure you already know is that the discussion of outpatient commitment becomes a very emotional one. And in fact, peoples' views tend to be influenced by their ideological positions. So that people who oppose outpatient commitment typically have very strong views about personal autonomy, concerns about state control. Those people who support outpatient commitment typically are very concerned about a person's right to be free from psychosis, and they're also concerned about the state's obligation to care for those individuals who are unable to care for themselves. These are all subjective issues -- the things that we could argue about endlessly.

So what do we do when we have issues that are emotional and ideological? We try to look to science, and we try to look for objective answers. So today I do want to talk about what the science tells us and what the research has revealed. Just generally -- I'm going to bore you, if you don't mind, with some preliminaries about the importance of research and the kinds of research. And of course, there are two kinds of empirical

evidence. And as you heard earlier, it's very important that we base our decisions about health care, and particularly mental health care -- that it has an evidence base.

So we're going to look to two kinds of empirical evidence. One is the randomized control study that we heard about earlier. And of course, with a randomized control study, you randomly assign subjects to a control group and you randomly assign subjects to an experimental group. And the purpose of randomization is to try to eliminate bias. You want to know that, in fact, what you are studying, the effect that you're looking at is caused by the mechanism that you're studying. And that makes sense. That's a very important scientific principle.

But the other kind of very important scientific study are naturalistic studies. And the purpose of a naturalistic study is not randomized, it's what happens in practice, what happens in the real world. And in fact, these are important because we want to know that what we learn experimentally can be transferred to real practice. That if we see certain outcomes, that when we actually put it into practice in the mental health community that we will have the same kind of outcomes. So we're going to talk about both kinds of studies.

There are two important randomized control studies in this area -- outpatient commitment. The first is North Carolina, Duke. I say that's the first because it's the most comprehensive by far. And the second is the Bellevue study.

I want to talk about Duke first, and I want to get some background. And I acknowledge that this is a little bit tedious, but I think it's important to know something about the study design. It was alluded to

earlier, and I think this is important to know about. The first is that this was the largest study by far, in terms of the numbers of participants. It was done in North Carolina. There were six counties that participated in this. It involved individuals who were being discharged from a hospital. And all of these individuals were deemed to be eligible for outpatient commitment under North Carolina statute. It was mostly people with schizophrenia, or schizoaffective disorder, about 75 percent. The rest were primarily people with bipolar disorder. About 50 percent had co-occurring substance abuse problems -- to answer your question earlier -- from this study.

And the individuals were assigned experimentally either to the control group -- and the control group did not have a court order. Even though they were eligible for the court order, they did not get a court order. They were exempt from court order for 12 months. The experimental group -- I just said the control group, right? That's the control group, no court order. Experimental group got the court order. There was one exception to the randomization, and that was that people who had a recent serious violent history -- the judges, the clinicians all felt that it was not safe to not have court orders for those individuals. So those individuals, though -- that's a very important component of this study -- so they were kept in the study, but as a naturalistic group. That is, that there was no control group for them, but they kept them in the study.

Now, one of the important questions of the study from the outset was whether the effectiveness of outpatient commitment would require a sustained exposure to court-ordered treatment. That is, how important is the length of the court-ordered treatment? Now, this is an issue that's not susceptible to randomization. The duration of the court

order is determined clinically and, more important, legally. In North Carolina, it's a little bit unusual in that they have a 90-day period for their initial court order. So what that meant for the experimental group, when they came to the end of that 90 days, there was a legal determination informed by clinical input as to whether they continue to meet that legal criteria. If they didn't meet the criteria, they were released from the court order. They now were short-term court-order people. You couldn't randomize that. It's a legal question.

So that's one thing that I wanted to explain, and that will become important as we continue. But they used that then, the researchers, to establish two groups -- people that they called long-term or sustained court-ordered group. And those were people who had six months or more of court-order treatment. And the short-term court-order people, those were people with, obviously, less than six months.

Now, the final thing that I want to detail, that I want to get into, is another experimental question that I think is important to our discussion today, for you as legislators. And that is the question about what impact frequency of services has, or intensity of services has. And I think earlier you heard some assertions that, in fact, we really just need more intense services, that you won't need a court order. And that's the question that the researchers wanted to address, and that's what we're going to get to.

And in fact, what they found was that was really clinically determined. Again, it wasn't randomized, it was presumably what the person needed in terms of clinical services. But it was more naturalistic. It was what they got. And what the researchers found was that for all of the

people in this study, the median level of service was three service visits a month. Those service visits included medication monitoring, case management, psychotherapy, whatever. But the median was three per month.

So they made one more definition -- and this will be my last one -- and that was that people who had intensive or frequent services were people who had more than three service visits a month. And people who had less frequent services were people who had three or less.

Of the frequent service people, just so you know, that was seven visits a month -- was the median for that group. Now, just to put that into context -- for example, in New Jersey, if someone had a PACT team, it would not be unusual to have seven visits a month. And it would not be unusual to have more than seven visits a month. It might be that level of service.

All right. So now let's get to the good stuff, the important -- that is the data and what the researchers found. I want to first look at the issue of medication adherence, because this is a very important issue in terms of outcomes and hospitalization rates. And in fact, the Duke researchers looked at the impact of court orders and frequency of services on medication adherence.

And what they did was, first they looked at the group of people who had either no court orders -- or controls -- or short-term court orders. Then they took that group and divided it into two, and looked at the people who had infrequent services and the people that had frequent services -- that is, more intensive services. Now, what we heard earlier would lead us to believe that those people that got the more intensive services would, in

fact, have improved medication adherence, or improved outcomes. But what they found was that there is statistically very little difference between the two groups.

So then they looked at the people who had short-term court orders and infrequent services, and what they found was there was a difference. It was improved, but it wasn't a statistically significant difference in medication adherence. When they looked at the group that had frequent services and a long-term court order, it was statistically significant. In fact, those individuals had three times better chance of having medication compliance than did the other groups that had no outpatient commitment at all.

So in that context, it made a difference in medication adherence. But I'm sure your thinking, "Well, okay. Medication adherence, what does that mean?" We can talk about that. But let's talk about some other outcomes, some that are important to you, certainly, as legislators, and to individuals with severe mental illnesses in their families.

What's the first one that comes to mind? We've talked about hospitalization. What impact does all of this have on hospitalization rates? It turns out this data is really very interesting. When we talk about it, you'll see why opponents sometimes say that outpatient commitment does not make a difference. But also, why, when they say that, you're not getting the whole story. When people with just a court order, regardless of length of time -- it was just, again, the experimental group -- was compared to people who had no court order, in that analysis there was no statistically significant difference in terms of hospital admissions. So that is true.

Now, I think people who oppose outpatient commitment tend to stop there. But I'm going to suggest that you can't stop there. We need to look further to get some more answers. So, in fact, the researchers looked further. That was one of their research questions, was to understand the effect of duration of court order.

And what they found was that people who had long-term court orders -- again, had a court order for at least six months -- had 57 percent fewer hospital admissions and spent 20 days less in the hospital per year. The most significant difference came for people with psychotic disorders -- schizophrenia or schizoaffective disorder. In that case, they had 72 percent reduction in hospital admissions, and spent 28 days less in the hospital. Clearly, when you sustain the court order for at least six months it made a big difference.

And actually, I can show you this visually. I think sometimes it's a lot easier if you can actually see these things. So I'll try to raise my voice and see-- No? Okay, I'll point (indicates chart). I can just bring it over here.

At any rate, this was reproduced from the *American Journal of Psychiatry* -- reproduced with permission. And here we're looking at data for people with psychotic disorders -- again, schizophrenia, schizoaffective disorder. And in this case we're looking at the people who had more frequent services. So these are the people who have more than the median amount of services. And what we find is that when we compare, over a year's time, the number of hospitalizations -- cumulative hospitalizations-- In red we have people who had no court order but had intensive services.

And as you can see, over time, there was not a significant reduction in the hospitalizations.

The blue line is people who had the short-term court orders, less than 180 days, and intensive services. As you can see it tracks -- it's almost very similar to people who had no court order at all. These are actually the two typical situations right now in New Jersey for people getting out of the hospital. They're either not getting any kind of court order or-- Down in Ancora, in South Jersey, they are using outpatient commitment, but it's very limited. It's for 90 days, like North Carolina. There's a number of limitations to it. And that's, so again, more similar to the blue line.

However, when we look at people who had, again, intensive services with a long-term court order, at least six months, the reduction in hospitalization -- this is the green line -- is significant.

So I think you can see visually that it does-- The court order makes -- a long-term court order makes a big difference in hospitalizations. The scale here is, by the way, 1.4 hospitalizations over a year, mean, for the group.

Now, one of the things that I think is important to talk about is this, you know, bias question for this group here that we were talking about that had the long-term court orders. Remember we said that that was not randomized -- could not be randomized because of the nature of court orders. It's a legal determination.

So the question here becomes, did we introduce some bias that would make these results look better for the individuals who had these long-term court orders? And in fact, you can analyze that. And the researchers

did a multi-variant analysis to try to determine if there was bias; and, in fact, they did find bias. But the bias that they found was, the group that got the long-term orders were, in fact, the sickest group.

I say sickest in terms of the most difficult to treat. Because at the beginning of the study they had a lower insight into their illness -- that is, a lower awareness of the illness and the impact of the illness; they also had much lower levels of adherence with medication. They were the more difficult population to treat. So as a result, you would expect that population to have more hospitalizations. But, as you can see, they had less. So if anything, the bias that was introduced actually worked to make these results look not as good as they would be had the populations been the same. But I wanted to show you that because, I think it effectively does illustrate that there is a difference, there is an improvement when you have a long-term sustained court order.

Let's talk about some of the other outcomes. The researchers, in fact, looked at the effect on arrests, and they found that people who had long-term court orders had 70 percent reduction in arrests. Victimization: And we know that this a big problem for people with severe mental illness -- that they are victimized at a rate-- One study said three times greater than the general population. And that victimization rate was reduced by 50 percent.

Violent behavior: They looked at the violent group -- that is, the group that had a recent history of violence. And they were able to look at long- and short-term orders because, in fact, half of the people in that group had short-term orders -- their orders were discontinued -- and half went on to long-term. So they were able to look at the two groups and

compare them. And what they found was, those who had the long-term court orders had substantially reduced violent behavior. And in fact, I think you heard earlier some of the statistics. When they broke that group out and looked at the people, like this one, who had sustained treatment and a long-term court order, they had 13 percent reduction in violence. I'm sorry, they had 13 percent incidence of violence -- much lower than the other groups.

Now, we started out talking about, you know, kind of ideological views and concern about autonomy and how this affects a person's ability to make their own decisions. And that can be reflected in, you know, whether they feel that they've been coerced or not. And coercion, of course, is reflected in whether a person feels that they've been forced or manipulated into treatment, whether they're able to voice their own preferences in their treatment. It takes into account whether their opinions are taken into account in their treatment, and whether they have experienced procedural justice. That is, you know, have their civil rights been protected by, for example, having due process, a court hearing. You know, have they gotten the process that they deserve to make this decision about their treatment.

And in fact, what the researchers found when they looked at this, and then looked at impact on overall quality of life, they found again that the individuals who had the sustained outpatient commitment had significantly improved measures of quality of life -- things like their residential situations, their relationships with family. I mean, all of those daily living, important things of quality were substantially improved for those individuals who had the long-term court orders -- despite the fact that

they reported, in some cases, that they did feel that they had been coerced to some extent. But that was not overridden by the improvements that they themselves could see in their lives.

Another claim that you'll hear often is that opponents will say that the fear of coercion will drive people away from seeking voluntary treatment. And in fact, there has been quite a bit of research done on this, and what is found is that, in fact, the majority of people with severe mental illnesses actually find and support outpatient commitment. And this had been done in a number of context, in terms of evaluating. And that notion that the majority of people will be driven away from services because of this fear has been shown not to be true.

One other thing that came out of the Duke study that I do want to mention -- and this is an important issue that was talked about earlier, but it really even goes to something that Governor Codey spoke about in his State of the State Address. And that is, he recognized, so importantly, that 50 percent of people with severe mental illnesses are living at home with their families. And in many cases, their families are aging parents. And so whatever we can do to help those parents, I think is very important -- and caregivers in general.

And what the Duke researchers found was that, again, sustained, court-ordered treatment, for this population that we're talking about, significantly reduced caregiver strain. And that's an important factor as well.

The other randomized study that is important to talk about is the Bellevue study. And in fact, this study is talked about more often by the opponents, despite the fact that, unlike the Duke study, the report that

is relied on was not peer reviewed. All of the Duke study reports appeared in peer review journals. The original Bellevue pilot report was not a peer review journal. In fact, when it was finally published in a peer review journal, the authors cautioned against using that data because of the number of limitations in the study itself. One was -- and an important one -- was the size of the participants, the size of the study -- the number of people in the study. Now, what the authors pointed out was that despite all of that the control group -- that is, again, the people who had no court order -- in the Bellevue study spent almost two months more, on average, in the hospital than did the people who had court orders. But it was not a statistically significant difference. It was certainly a trend, but it wasn't a statistically significant difference. So what the authors pointed out was that if they had had twice the number of people in the study -- by the way, similar to the number of people in the Duke study -- it would have been statistically significant. So there are a number of limitations to the Bellevue study, and I'm going to suggest that probably one of the most beneficial things of the Bellevue study is to instruct us as to what it is about the two programs -- the way the two programs were run that made North Carolina successful and Bellevue show not the same results.

And one of the first things, of course, is that Bellevue, the pilot program, there was no enforcement. In other words, if somebody did not follow their treatment plan, they did not take their medication, nothing was done. Everybody was pretty much treated the same, control group or court order. They got the initial court order, but if they didn't follow it, there was nothing that happened. As a result, everybody in the program begins to know that, and where's the incentive to follow the treatment program that

you've been ordered to follow? It isn't there to the same extent as it was in North Carolina. Where North Carolina -- they followed a very stringent procedure. If individuals did not follow their treatment plan, there were steps that were taken by the mental health providers, and they followed it very consistently. The ultimate step being that they could seek hospitalization for the person.

Now, of course if somebody in that program knows that, "If I don't take my medication or I don't follow this program, I'm going end up in the hospital," that's very good incentive. It's the leverage that's needed to keep people in treatment.

And, in fact, we know that people who are in the hospitals, who are in State hospitals here in New Jersey, take their medication, because they know if they do they will get out of the hospital. But the piece we don't have is ensuring that, you know, if people want to stay out of the hospital that they continue taking their medication.

So those are the two randomized control studies. But I did mention also the naturalistic studies. It's the other aspect of this that we have to look at. We want to know that, in fact, when we take everything we've learned in the studies that we can apply it in real life. And in fact, there've been a number of naturalistic studies from a number of states, smaller studies. By far the most comprehensive now is the New York study that came out of Kendra's Law.

And the result from that were very consistent with the Duke study -- reductions in hospitalizations, reductions in harmful behavior, reductions in homelessness, incarceration, arrests. I'm not going to get into the details of that. Actually, in your binder there is a copy of the report,

and we also gave you a summary of those results. And they're really very encouraging, and it's worth looking at. But I won't take the time now to talk about it. But it does tell us one thing, and that is that what we were able to do experimentally can be reproduced, and that people with these illnesses can benefit from this kind of treatment.

I'd like to step back and talk about why this is so important.

SENATOR RICE: Could I?

MS. ZDANOWICZ: Oh, sure.

SENATOR RICE: Mr. Chairman?

SENATOR VITALE: Sure.

SENATOR RICE: Before you leave the studies, let's talk about the studies.

MS. ZDANOWICZ: Okay.

SENATOR RICE: First of all, was this a longitudinal study?

MS. ZDANOWICZ: Yes. Well, the Duke study?

SENATOR RICE: Beg your pardon?

MS. ZDANOWICZ: The Duke study?

SENATOR RICE: Duke, Bellevue, either of them. They both are longitudinal?

MS. ZDANOWICZ: Yes. Well, what do you mean by longitudinal? I'm not sure.

SENATOR RICE: Well, you know, you do a study now, and you measure out over a period of time, long term.

MS. ZDANOWICZ: Yes.

SENATOR RICE: Okay? Not a short term. Not a year, two years, three years. That's not longitudinal. A true longitudinal is 20 years plus, a lifetime (indiscernible). But was it longitudinal in nature?

MS. ZDANOWICZ: Yes.

SENATOR RICE: Okay.

MS. ZDANOWICZ: For at least a year, for example, for the Duke study.

SENATOR RICE: That's not longitudinal. Okay.

All right. Then the question is, this was a research project with control and non-control groups?

MS. ZDANOWICZ: Yes.

SENATOR RICE: Okay. Do you happen to know how the population in the control group was selected, what criteria were used, who used them, who chose them? In other words, who chose -- were these clinical people, people with experience in mental issues and rights? Do you happen to know that? Do you have information you can send us to identify that?

MS. ZDANOWICZ: Yes. I can address the-- Let's start with the Duke study, which is a control study. And the individuals who were assigned to the control group and the experimental group came from the same pool of individuals. Those individuals then were randomly assigned to the control or the experimental group, so there was no decision, again, to remove any bias in that. In terms of the criteria for those individuals in the study, the first part was determined legally. They had to meet the legal criteria under North Carolina's law for outpatient commitment.

And that -- the way that's done is there's first a clinical evaluation of the clinical issues. And so, for example, a physician would make a recommendation about that. That would then proceed -- for the legal due process, there would be a court hearing. And just as in any trial, that clinical person would appear as the expert to inform the judge and the attorneys about the clinical issues. The patient had the right to have their own clinician testify as well. The attorneys would make the legal arguments, and then the judge would make the final determination as to whether the individuals met the legal criteria.

If they did, then they were eligible for the study. But there were other criteria that had to be met for people in order to be in the study. One was that they had to be individuals who had received intensive treatment within the last two years. And I think part of the reason for that is to show that-- In fact, these were people who had services, but still had to be hospitalized. It wasn't a case where it was somebody who had never been, you know -- gotten any service, so we didn't know. In addition, they were coming from one of the state hospitals in one the six counties in North Carolina.

Let's see. What were some of the other criteria? I can tell you some of the demographic information about the...

SENATOR RICE: Were any of them inmates?

MS. ZDANOWICZ: No, this was all civil commitment.

SENATOR RICE: Okay. Do you know whether or not -- were the methodologies in the two studies different? Do you know what methodology was used? Were they different methodologies?

MS. ZDANOWICZ: For different aspects of the study, different methodologies were used. And the studies -- the two studies, Bellevue and Duke, North Carolina -- had some significant differences in the way that they were done.

SENATOR RICE: Would that reflect the fact that there were different variables and elements in these studies?

MS. ZDANOWICZ: Yes. I think there definitely were different elements in the two studies, Duke compared to Bellevue, which I think accounts for the different results.

SENATOR RICE: Well, it did then. And if you used the same elements and variables in the Bellevue study with (indiscernible) you still can get a different result. It's possible. Were the hypotheses the same?

MS. ZDANOWICZ: That's a good question, actually.

SENATOR RICE: Yes, it is, because our hypothesis would determine -- with the variables and elements, and the history and methodology -- what you're trying to prove or disprove--

MS. ZDANOWICZ: Yes, in fact the Bellevue study did not look at what I think--

SENATOR RICE: --which would be apples and oranges in terms of conclusions, if someone was to assume from the Bellevue study that they should be reaching the same conclusions, okay, as the Duke study. And that's why the methodology, the hypothesis becomes very important, as well as the variable and the elements and the questions asked.

MS. ZDANOWICZ: And I think that there were different hypotheses in the two.

SENATOR RICE: Then that may account for the differences, so I wouldn't, as a legislator, be so stuck. I would want to go back and revisit Bellville -- Bellevue, whatever it is -- and see what they were trying to accomplish with that study, based on the hypothesis. Or maybe change and redo their hypothesis with some the methodology, if you will, to see if I get the same conclusion of Duke.

I just want to be on record with the academic side, because what I found out is that grassroots people and organization people who have an interest and concern of things, who will listen to those of us who are legislators or those who specialize in these fields, they have to rely on us. And sometimes people think that those of us who sit here don't understand what those of you out there are actually saying, or we don't know what tools should be used in some of these things to get the results that we're looking for. So I want to keep the record straight that there is a question on the methodology, there is a question on the hypothesis, and there's a question, possibly, without seeing the studies, as to what they were trying to conclude -- the real, intended purpose of their study. That's all I wanted to say.

MS. ZDANOWICZ: And I did, by the way, include in this briefing book most of the studies that I referred to today. And if there are any other's that I've referred to that aren't in here, I'd be glad to provide them. One of the reasons I did this was so you have it at your disposal. You can make sure that what I'm saying is correct. And I want you to know that what I'm saying is based on what the data says.

SENATOR RICE: Well, through the Vice Chair, the Chair -- through the Chair, I would like to have staff work with the administration

to really analyze those studies, but get me some folks who understand how methodology is supposed to work. In other words, how research design problems are supposed to actually work. And I need some folks who understand statistics and probabilities so they'll know exactly what they're looking for. You know, if you don't look and understand what a variable is or what it means, or an element, if you don't understand the conclusion, that conclusion of those things -- if you understand methodology, understand hypothesis, you understand if you change hypothesis of this little piece, what would you get? We're not going to get the right information. So there must be someone in between, be in our government, that have that ability, hopefully without having to go out and contract someone, because I don't trust contractors or consultants.

So maybe OLS can take a look at that and do some things for us. Because I think the Governor needs to know this stuff. You know, this is not his background. He has to rely on people he appoints. If he had appointed me, I would have raised these questions right there. But sometimes they think those of us in the Legislature shouldn't be on anything because we don't know much, always be a bias. So would you do that? Can that be done, through the Chair?

SENATOR KARCHER: Yes, thank you.

SENATOR RICE: Thank you very much.

MS. ZDANOWICZ: If we have a couple more minutes, I'd like to talk about why this is so important, why we need to address this issue.

SENATOR KARCHER: Certainly.

MS. ZDANOWICZ: You know, it's well established now, in the scientific literature, that despite decades of working to improve

treatment for people with severe mental illnesses in the community, there are still some people -- the proportion of people who relapse in their treatment, require hospitalization, many times because of medication compliance issues. And in fact, treatment non-adherence or compliance has been studied extensively. But recently there has been some new data that just demonstrates why this is so important and why we need to pay attention to this issue, and why it's relevant, actually, to what we're talking about today.

Medication non-compliance is a significant factor in hospital admissions. A recent study found that individuals who are medication non-adherent were two-and-a-half times more likely to be hospitalized than those who are adherent with medication. The study also found that those who were non-adherent with medication incurred 43 percent more in-service costs than individuals who were compliant, who were taking their medication.

We typically talk about medication compliance in terms -- in kind of absolute terms, like a person has stopped taking their medication, and for a long period of time. But in fact, some of the recent data suggests that partial compliance, partial compliance as short as periods of one to 10 days, can have a significant impact on relapse and hospitalization. In fact, (indiscernible) recently reported that a gap of one to 10 days in medication over the course of the year can increase the risk of hospitalization two times. As you go up in length of gap in medication, of course, the risk of hospitalization increases more, so that when you get to over 30 days, the risk is up to four times more likely that somebody who stops taking their medication -- for 30 days or more -- will be hospitalized.

The association between medication compliance and other outcomes, such as arrests and substance abuse and violence, actually has been well established. It is true that people with severe mental illnesses or mental illnesses as a group are no more violent than the general public. But when you factor in medication non-compliance, that risk increases substantially. Then when you also factor in substance abuse, it's a very big problem.

Still, non-adherence is a complex issue. There are many reasons for non-adherence. Those reasons can be put into three categories. One is efficacy; the other is system barriers; and then, finally, would be refusal. Now, the first two: In New Jersey, we actually have good systems, services available to address those issues. And just briefly, an efficacy issue would be somebody who takes medication but it does not treat their cognitive deficits. So they have severe cognitive deficits, meaning they forget to take their medication or they forget to fill their prescription. A service like PACT can be absolutely essential to that group because PACT can provide the kind of compliance monitoring, the kind of medication support that an individual needs. The PACT team could bring medication every day to the client. We know that that happens. So that is something that can be resolved with the existing services.

The systems barriers are very common. System barriers -- that somebody loses their Medicaid eligibility. And of course, if you know what it takes to remain eligible, in terms of paperwork and so forth, that's daunting for anyone, never mind someone with a severe mental illness who might still have cognitive deficits. But a service like Intensive Case Management, ICM -- or Integrated Case Management, can be very effective

because that case manager can help the person maintain their Medicaid eligibility so they don't lose it, so they can still afford their medications.

But the final issue -- refusal. Actually, in New Jersey we don't have a good way of dealing with the most common cause of refusal, which is that people don't think that they're ill. And in fact, we know that -- I just want to step back for one minute. We know that, in New Jersey for example, that those first two cases with the PACT teams and Integrated Case Management, we've actually done quite a bit to reduce hospital admissions in New Jersey, since Marlboro Psychiatric Hospital closed. And in fact, there are 31 PACT teams for 21 counties in New Jersey, serving almost 2,000 individuals. That's more per capital than New York has, and New York is considered the gold standard in terms of funding for mental health services. ICM has the capacity to serve more than 14,000 individuals.

So in fact, people coming out of State hospitals in New Jersey are given priority for those services. And, as I've said, to a large extent, they've been successful in reducing the hospital readmissions. But not enough, because the hospitals are still overcrowded. And in fact, as the Office of Legislative Service pointed out in reviewing the FY 2004 budget, we have consistently overestimated the census in all of the State hospitals by as much as 14 percent over the last four years. The census is still higher than it really should be. And I would submit that part of the reason is because we don't have a way to ensure that when people are released from the hospital that they continue to get the treatment they need.

And why do I see that? Because PACT teams and ICM are prioritized for people coming out of the State hospital, presumably those

who are the most ill. However, individuals in New Jersey have a right to refuse the PACT services, refuse ICMS, or if they, in fact, accept PACT services they can still refuse medication.

So in fact, one study showed -- a study of voluntary PACT services -- showed as many as one-third of PACT clients, voluntary PACT clients, are medication non-adherent at one time or another. So in New Jersey that translates to about 600 individuals in PACT services being non-compliant with medication. Which is also, by the way, the same number of people who are readmitted in a year to a hospital within six months of being discharged. That's almost -- that's about 20 percent of people being discharged from State psychiatric hospitals in New Jersey are being readmitted within six months.

Over 200 people are being readmitted within 30 days of discharge, and I submit that it's probably because we don't have a good way to deal with people who are refusing medication or are refusing treatment.

So why do people refuse treatment? I think that's the other thing that's really important to talk about. And in fact, we know that one of the most common reasons, as I said, that people refuse treatment is because they don't think that they need it, they don't think that there's anything wrong with them. They lack awareness of their symptoms, such as hearing voices. We now know that that's actually part of the illness. It's a neurological deficit called anosognosia. It's found in other illnesses like Alzheimer's. Sometimes people with Alzheimer's are not aware of what's happening to them with their brain disorder. And in fact, there was a really good article in the Science Times, in the *New York Times*, last week, talking about this phenomenon in another brain disorder, and that is people who

experience stroke. And I think we may have included a copy with your materials. But it's really interesting and I think it's helpful to us in understanding what is going on, because this is the same thing, but it's observed in a different brain disorder, somebody who has had brain damage from a stroke. And what the researchers studied -- people who, as a result of stroke, were paralyzed. Now, some people who are paralyzed after a stroke are not aware that they're paralyzed. In fact, this is something that any neurologist will be able to tell you about. They are paralyzed but they say no, that they are not. And what the researchers did was, they studied, they wanted to find out what part of the brain was actually impacted that caused this.

And what they found was that it was the frontal lobe, which is also the same part of the brain that's affected with people, for example, with schizophrenia, who lack that awareness of their illness. They aren't able to access what's going on with them. This is helpful because I think it's a more visual explanation of what happens, but in the article they are talking about someone who, in fact, is paralyzed because of stroke but doesn't realize that they are paralyzed. And they explained that the regions of the brain that maintain awareness of movements and carry them out are not working. The conflict between these regions of the brain become overwhelming. The sense of having moved the arm is powerful, but awareness of actually moving it is absent. The solution for the paralyzed patient is to confabulate. If prodded for hours, the patient will actually make up a story to explain their lack of action -- why they didn't move their arm.

And in fact, they give one example. One man said his motionless arm did not belong to him. He told the doctor, "That's not my arm." When it was placed in his right visual field so he could see it, he insisted it was not his arm. The doctor asked, "Well, whose arm is it?" and the patient said, "It's yours." And the doctor said, "Are you sure? Look, I only have two hands." And the patient responded, "Well what can I say, you have three wrists, you must have three hands."

But that was similar to what happens with a person with schizophrenia who is experiencing it. For instance, they might hear voices. And whereas you and I would look around and look for someone talking to us, and when we didn't see that we'd look for a radio or something -- some cause of the voices. And when we couldn't find that we might say, "I better get to see a neurologist or a psychiatrist. There's something wrong that I'm hearing these voices that I can't explain."

A person with schizophrenia who is experiencing anosognosia won't necessarily do that, and in fact what they will do is confabulate -- the same thing observed here. And so very often we hear people say that, "Oh, the CIA planted something in my brain that's causing these voices." And that's not unusual at all. We hear that a lot. That's the way that they are explaining, and then it becomes a deep-seeded delusion, and talking that individual out of that delusion, talking them out of the fact that the CIA is after them is as possible as it is to tell this person who doesn't realize he's paralyzed that he can't move his arm. I mean, it's the same problem with the brain.

And so what the impact of that is, if the person doesn't think that they're ill and they don't think that the voices are caused by their brain

disorder, they're not going to take medication. And in fact, if you tell them that they should take that medication, they may think you're part of that CIA conspiracy and that you're trying to poison them.

So what do we do for these individuals? We can try to help them understand what is going on with their illness. But how long do you wait, and what other options do you have? Well, one of the best ways to help them gain some insight is to, in fact, get them on medication so they can get rid of those symptoms, so they can begin to analyze and see what the difference is when they're on medication and not. They can begin to realize that this is caused by their brain and that they need medication to stop it.

Now, some people never develop insight, and some people have it and then lose it. But the only -- really the most effective way, in the end, is to ensure that they get the medication that they need. The only way to do that, though, is with court-ordered treatment. Now, of course there are concerns about personal autonomy and that person's ability or right to make their own decision. But are they making a rational, reasoned, informed medical decision if they don't even think that they're ill? And this kind of goes to the issue that you were talking about before, in terms of capacity and the current New Jersey standard.

The current New Jersey standard does not take into consideration capacity. But many state standards do. And in fact, consider whether -- if it is a person who is in this condition who can't make an informed decision, then it's more like guardianship, or limited medical guardianships that are done in New Jersey for people who, you know, aren't able to make an informed decision about any kind of medical treatment.

It's more like that. From a legal standpoint you don't need the kind of immediate or substantial bodily harm that's required under the law, current law. I mean, you can look at -- other states have at least -- looked at broader kinds of harm that the person can come to if they're not able to make an informed decision about their treatment.

And so this does become a very important piece of this, to explain why it's needed; and maybe different ways of resolving those problems.

I think I'd just like to close by making a couple of comments about the Task Force recommendations. And first of all I want to commend them. Because as you have seen today, this is a tedious -- a very difficult, complex issue. It's one that people have very different views about. It's not easily resolved. I mean, the fact that the Task Force members themselves could not reach a unanimous decision is an indication of that. But I have to commend them, that despite that they did reach a majority decision and made some recommendations about this.

And I just wanted to comment on a couple of them. And the first is this notion of having a safe and appropriate network of services. That sounded to me like we need to have the perfect service system before we implement this. And that's a very subjective thing. My idea of a perfect system might not be the same as yours, or your-- That's going to be a hard goal to attain.

But I think that there are certain things that the Task Force was trying to address that can be resolved without that larger goal. One is that they were trying to ensure that there was not a-- Court orders were impossible for the patient to maintain, in other words, that -- to ensure that

the person got the services that they needed. And there are two ways that you can do that. One is New York's approach, which was in the statute. They actually specified that there has to be a certain minimum level of service. For example, case management or a PACT team for anybody receiving a court order. So that's one way to ensure that those individuals getting the court orders have the services that they need.

Another approach would be Florida's approach, which was to say that there had to be testimony that whatever services were clinically needed by the individual were available and appropriate for that person, before the court orders treatment. So that's another way to ensure that a person does not get a court order unless they have the services that they need to be successful in that court order and have the kind of outcomes that the Duke study had.

The second issue went to the concern about jumping the queue. That somehow that this would put these individuals in a higher place, in terms of getting services. But that's actually done right now. That's done for people, for example, coming out of the State hospital. The most ill do have priority for some of the more intensive services. And there's a reason for that. There's a good public policy reason for that. And that is that those are typically the individuals who are costing the most amount of money, having the most hardship. And so by providing them with the services that they need, you can reduce cost overall and make more services available for everybody else. There is some good public policy behind providing services to those who are most in need.

The second recommendation about the standard -- and I thought that it was very thoughtful, in terms of the dangerousness standard

and trying to address concerns with how the standard in New Jersey is implemented right now. But I think I do have some concerns with the approach, in that it maintains that high level of danger that is in the current standard, which talks about serious bodily harm.

New Jersey's standards really is one of the most stringent standards in the country. And I just suggest that maybe some consideration be given to taking an approach like some other states have. New York, which has a very objective criteria -- has about eight or nine criteria that someone has to meet. That's one possibility.

Or Wisconsin, which has a unitary standard, but in fact they have about five standards, actually. And a couple of them incorporate this concern about capacity, so that you're talking about people who really don't have the capacity to make an informed decision about treatment.

Finally, I think the idea about having a study and tracking outcomes, I think, is very important. In fact, New York did that and learned some things from it.

I want to take a chance and try to address the issue that you raised earlier about the concerns about racial bias, if you'd like?

SENATOR RICE: Go ahead.

Then I'm going to do Schools Construction, where I have the same problem.

MS. ZDANOWICZ: I'm sorry?

SENATOR RICE: Go ahead, go on.

MS. ZDANOWICZ: Okay. This is a legitimate concern that I think that you raised about racial distribution in these programs. And I say that because, in fact, in the New York study what they found was that in

Kendra's Law, 44 percent of people who received court orders were African-American. And so, in fact, that did raise enough of a question for them that they went back and started to look at some issues with that. And one of the things that they looked at was, what was the composition of people who were receiving similar services -- those similar intensive services -- PACT and Intensive Case Management. And what they found was that, in fact, it was very similar proportion of people who were African-American were receiving those services without a court order. So presumably then, it wasn't an issue with the court order, it was the fact that there was a higher proportion of people, African-American, receiving those services.

So I think one way that you could monitor for that as part of this report, or monitoring the implementation of this, would be to look at what is the proportion of people now in New Jersey who are receiving those kinds of services, and then see if that carries through to the proportions of people who are getting court orders.

Similar in North Carolina, 66 percent of the people in the North Carolina study were African-American. And again, they looked at that, and what they found was that -- remember all of these people were coming from state hospitals in North Carolina -- and that that was a very similar percentage to the population of the state hospitals that people were coming from. So it wasn't, again, an issue of the outpatient commitment orders were impacting a higher proportion of people who were African-American, as much as-- That was the people who were in the state psychiatric hospital.

And in fact, you could look at that here, in New Jersey. We do have data. I've looked at it while we were talking. Twenty-eight percent of

people who were discharged from State psychiatric hospitals in New Jersey are African-American. So I think you would want to know that you don't have a higher proportion who are getting court orders, who are being discharged. So I just wanted to offer that as maybe at least a partial--

SENATOR RICE: Madam Chair?

SENATOR KARCHER: Yes.

SENATOR RICE: I don't disagree. And maybe we should make a note that we should look to see if those proportions are the same. But I can tell you this, if they are the same, then we have another problem. Okay? The problem is the State is still going to want to spend the dollars to put the other pieces that go with that. Because I can assure you, without even a guess, from my experience, that they're the same. You're going to find out that they also come from different economic classes. Which means, then we have to go back and address sociological issues in urban communities, (indiscernible) better parts of the life stuff, and we come back and say we don't have.

But the issue that's bigger than that is not the issue-- The issue of proportion, yes, but it's also an issue of classification, identifying when it comes to "minorities." This State has gotten so crazy that if you-- Remember the little kids and the gun situation -- the teacher goes out of the class and I go, "Bang, Kathy." And someone tells, "Ron said 'bang' to Kathy," all of a sudden I'm special ed. And I've always said "bang" coming up. I did a lot of things coming up as a kid. In today's society, I would not be sitting here when they finished classifying me. In our situation, when the same thing happens in a criminal justice arena, it's almost a way -- out

of sight, out of mind. Just find a way to get rid of these folks right now, and find another way to hold them.

And so my point would be identification and classification. Because once we address that issue, then it becomes somewhat clearer to me that the population that we're dealing with is more than likely the right population that needs the help. There may be some people caught in the crack, but, in general, it's the right population.

That's why I raised the question about the Duke experiment, if they're using the inmates and (indiscernible). Did they identify how these people got to the system in the "first place," as relates to that "need." And that's the big issue we have to grip with. And I don't think that my colleagues, this woman, to grip with that, because there are people saying, "We want, we want, we want." And a lot of people saying "we want" are people who understand what's happening on the other side. In our community are people who want these things to happen, too. We just want them done right.

We're not in denial of things. We just have a different kind of experience than most people, to be honest about it, coming from our slave history to the Tuskegee experiments, to everything that still happens to us today, including the abandoned buildings that are left in Newark and these other cities where people live and can't move and some did move, etc. So we have to be, in our leadership role, as a people, more cognizant of what peoples' needs are, but also how do we get fairness out of it, not just foul in one community and fair in the other. And that's the only reason I raised them.

And so, yes, I want to see legislation go forward that makes sense. And these hearings to me are very important. I just don't think that this bill should be going anyplace any time soon. I think more research needs to be done. I think more questions need to be answered. If it's not for one population, at least for the other population. I think we should put a lot of time into this whole criminal justice thing. There's some denial in terms of who actually needs -- not counseling, but who actually has some chronic or serious -- you may have capacity -- mental illness problems that need to be addressed, versus those who don't. But if you keep classifying me, eventually they're going to have them. At least, they're going to think they have them. And that's a real concern. We can't deny their concern because we want to fast track things. It means good politics. It sounds wonderful. We're making a lot of people happy, and we're helping a lot of people. But the question is, when you leave people hanging out there, particularly when it goes across the racial lines like that, or the gender lines, in some cases, things we do -- that's not America to me. And it'll never be my America, etc. And that's just from experience.

So I think your presentation was swell, because there were things that you brought up that we may not have thought about until later, and we can work on now. And that's taking a look at those studies to see just what they were intended to do, what's missing in those studies. We may have to come back and do our own study. It's nice to have the University of Duke do something. But I remember the case on Duke Power and Light. Now, you remember that case, right? One of the most discriminatory cases around that set the stage for a lot of things. It's nice to go to Michigan. It's nice to go to California. But they're so liberal. Maybe

once in a while, New Jersey will take the lead and do their own thing, and then maybe we can look at that, too. Well, I have two lawyers here. You remember Duke, right?

MS. ZDANOWICZ: Can I just address that one question, and this is where I will get emotional. I tried to stick with the science. But I do want to say that to study this again -- and we do have good data. To study it more, I think only postpones the inevitable. But more importantly, it really is going to just lead to more human suffering. This is not a silver bullet, as I tried to say before. I mean, I don't want to sell this as something that is going to solve all the problems in the mental health system. It's not. It's really designed to address one specific problem. And that is to try to help those individuals who aren't able to recognize on their own that they need treatment. And I hope that I demonstrated, at least from the study data that we have that, in fact, this can help reduce hospitalizations, which is a great benefit for the state. It reduces costs. For the individual, it maintains or improves personal autonomy -- for the family members, what they go through, before somebody has to be hospitalized.

And even more importantly, I heard earlier someone say that we can't react when there is a death or a horrible incident that occurs and do this kind of legislation. And yes, you can't do it for just one incident. But clearly, when somebody loses someone to this illness -- and we have a couple of family members here who have lost someone -- for the simple reason that they-- It was an individual who would not seek treatment on their own, and the families were told that they weren't dangerous, they weren't homicidal, they weren't suicidal, therefore, nothing could be done.

And in one case, a young 10-year-old boy, who had nothing to do with anything, was killed. Now that has a substantial impact on that family. And that boy's autonomy -- he'll never have his autonomy back. And in the other case, it was a young man who was shot by police, an African-American man. His autonomy is no longer protected. And by the way, the man who killed Gregory Katsnelson, he's in jail for at least 25 years. His autonomy is gone, too. And unlike the previous speaker who said, "People with mental illness is scary," the two people with mental illness that I've just described were handsome young men. They're not all scary. And they are our brothers and our sisters and our husbands and our wives, and we need to do what we can to protect them.

SENATOR RICE: Madam Chair, let me conclude next on this. I don't disagree. I think every life that is taken is a tragedy, regardless of how it's taken. But I'm not naïve. And understand that people who are alive, incarcerated, classified, put back in society, classified, denied -- they're basically just moving. They're dead too. They can't function. They're not an asset anymore because they can't get that rope off. The only difference is we just didn't pull it. That's the only difference. And so that has to be addressed. And I'm not talking about studying to the extent that we're going to do "longitudinal" studies. I think someone should pay particular attention to the issues raised, and constantly raised with a lot of the things we do, that people ignore because they've fast tracked -- like the hell with you -- on the disproportionateness of the minority population; and also have minorities unclassified, particularly when it comes to that inmate population.

And also make sure that resources are available to not only isolate -- get those away from that "identification" and identify those who truly need help and put the dollars there. But understand, when you put the dollars there, don't cry the blues when in one community setting it causes economic community to family economics, that we can provide -- and they can help provide too -- some of the other things that's needed, like a decent home or something like that, and it's denied over here. You would do this, but you're not going to do this, because you're defeating the purpose. And so, I'm never going to let people tell me that if we wait we're doing more harm. If we move too fast, we do more harm. If we continue to put the wrong people, in the process -- and that's black, white, Latino, young, old -- doesn't make a difference, male or female. And we got to be very cautious. And I'm telling you, no one is going to basically argue this case from this perspective but individuals like me, okay, and one and two others. You're never going to get 120 legislators to argue the side of the case I usually argue down here. I respect that for a lot of different reasons. So it's got to be said and heard. But that's not (indiscernible) anyone here, and it's not to be a barrier. It's to say I understand the situation over here. I understand this situation, now how do we make this work for the benefit of everybody, especially, if we can, the majority. There's always someone caught in a crime. And that's all I'm saying.

Thank you.

I have to leave.

SENATOR KARCHER: Thank you.

I think that concludes our testimony today.

We will be revisiting this issue at a point in the Fall again.

I want to thank everyone who has participated today and given testimony.

Thank you very much.

We're adjourned.

(HEARING CONCLUDED)