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# *Committee Meeting*

of

## SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

SENATE BILL No. 2760

*(Establishes involuntary outpatient commitment to  
treatment for persons in need of involuntary commitment)*

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

**DATE:** September 26, 2005  
2:00 p.m.

### **MEMBERS OF COMMITTEE PRESENT:**

Senator Joseph F. Vitale, Chair  
Senator Ellen Karcher, Vice Chair  
Senator Barbara Buono  
Senator Fred H. Madden Jr.  
Senator Ronald L. Rice  
Senator Diane B. Allen  
Senator Thomas H. Kean Jr.  
Senator Robert W. Singer



### **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*

***Meeting Recorded and Transcribed by  
The Office of Legislative Services, Public Information Office,  
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey***

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(On September 26, 2005, the Senate Health, Human Services and Senior Citizens Committee held a meeting; following is a portion of that meeting.)

SENATOR ALLEN: Mr. Chairman, I'd like to have a moment?

SENATOR JOSEPH F. VITALE (Chair): Yes.

SENATOR ALLEN: For the record, when you last held this meeting in August, you mentioned that you felt that all three Republicans were at a Wayne Newton concert, and I want to be clear that we have never all gone together. (laughter)

SENATOR VITALE: I feel much better now. (laughter)  
Thank you, Senator.

This is the second hearing we're having on Senate Bill No. 2760, sponsored by Senators Codey and Cardinale, establishing involuntary outpatient commitment to treatment for persons in need of involuntary commitment.

Senator Cardinale stayed with us during the first part of this hearing, and I'd like to ask if you would like to come forward and offer comments on the legislation.

Thank you, Senator.

**SENATOR GERALD CARDINALE:** Thank you, Senator Vitale, distinguished members of the Committee. I will attempt to be brief, but this is an issue that I think is extraordinarily important to many folks in our society.

It's an unfortunate, but unmistakable fact that there are mentally ill folks among us who do not seek care, even though their illness may seriously interfere with their ability to lead normal, satisfying, productive lives. It's also an unmistakable and unfortunate fact that a

number of these mentally ill individuals will cause damage to themselves or others, some of them will kill, some have become homeless, and some will cause every variety of problems imaginable to themselves and to those closest and dearest to them; not the least of which damage is further deterioration of their condition due to lack of intervention.

It's an unfortunate and unmistakable fact that schizophrenia and other mental disorders affect those afflicted in such a way that a third to half of them cannot recognize their illness and so do not seek treatment or refuse treatment when it is offered. Let me be clear. If one knows he has cancer, he or she may refuse treatment, under our laws, and that's acceptable to all of us. But mental illness is different, because it deprives people of understanding what is happening around them. They're detached from the reality, and therefore informed consent is for many of these individuals an impossible state.

We are fortunate that mental science has advanced to a point where many, if not most, of these patients can be treated in nonrestrictive environments. Outpatient treatment consisting of medication and counseling can, in most cases, enable these patients to lead relatively normal, productive lives and pose no danger to themselves or others. But today's legal status creates roadblocks that, as a practical matter, result in too many of them going untreated. Many other states have amended their laws so as to facilitate involuntary outpatient commitment in minimally restrictive or nonrestrictive settings. It works.

This bill attempts to bring New Jersey in the direction of providing mentally ill persons with realistic opportunities for treatment, and it should be passed.

I came upon this issue back in 1983. I was a brand-new Senator. I attended a meeting of the Judiciary Committee. And at that meeting, I heard a mother present the case of her son who had been released from a mental institution, despite psychiatric advice. He wandered out into the middle of the street -- he didn't hurt anyone else -- but he wandered out into the middle of the street, got hit by a car and was killed. She blamed the court system. She blamed the judge. But, in fact, it was the laws under which the judge had to rule that are in need of attention.

Since that time, many families have come into my office, and I think, too, many of your offices. Because as I've talked to many of you, I have heard that you've had similar experiences to mine. A family is coming in and saying, "Something needs to be done. Something needs to be done to change the law."

Oh, I guess it was a year, maybe a year and a half ago, I became aware of a group based in Virginia, a nonprofit group. I believe they testified at your last hearing -- Mental Advocacy Group. And their focus is to go state by state and have laws changed. They have a model bill. Many of you were cosponsors of the model bill which I introduced. As a result of the hearings which Senator Codey had on mental illness, which Senator Codey caused to be heard on mental illness, we have a new bill -- probably a better bill than the original one -- and that's what's before us here today.

Why is it a positive bill as it is? It could be better if we dealt with one additional issue, and perhaps that can't be dealt with in this bill, perhaps it will have to be a separate bill, but I want to mention it now. So many people who have come to me have been family members who have been shut out of the nature of the illness, the nature of the treatment. You

see, we can send someone to get care, but are they taking the meds? Are they making the appointments? Are they keeping the appointments? Are they doing the things that are recommended? If a family member could somehow -- if we could somehow modify confidentiality so that the treating folks would be in a position to confer with members of the family about what is the status and what to expect and how to intervene, I think we would have a much better bill.

You're going to hear from a number of people today. You're going to hear from groups who support this program; you're going to hear from groups who oppose it. There are always those who will oppose change. There are always those who prefer the status quo. I'm sometimes one of those preferring the status quo to change. In this instance, the present status of the law is not working. Too many folks are rotating through the system.

Many of us have read the case of Kendra, who was pushed under a subway train by one of these very folks that we're talking about -- rotated in and out of the system, the courts always releasing the individual until that individual ultimately pushed someone under a subway. New York state passed Kendra's Law to address that problem. I've spoken with some of the authorities who are administering that law in New York state. They tell me it's working very well. And what they tell me -- and this is not exactly what is going to happen, but very, very similar. A person ultimately goes before a judge, as they would under the terms of this bill, and the judge will say to that individual, "Look, I realize you don't want to have treatment, but I'm ordering that you have treatment. And if you don't comply with the treatment, you come back before me, I'm going to put you

in an institution where you will have no choice but to follow the prescription, follow the treatment plan.” They get a great deal of compliance. Because if nothing else but to satisfy that judge’s order, people are taking their meds. And I’m told that they are having good results. They are able to lead normal, productive lives. Many of them.

If we go too long, every day that we wait there are other individuals who, with treatment delay, the disease becomes worse and the end result is not as good as it could have been had we intervened sooner.

I would encourage you, as you hear all of this testimony, to weigh not what is said about the bill, so much as what the bill says. Look at the process that the bill envisions, and say to yourselves, “How can this be bad? How can this be bad?” This is a very good approach, and I would hope that we get an opportunity for the full Senate to act on it before the end of the year, and maybe we can get this into law and help the people of New Jersey.

If any of you have any questions, I would welcome them, but I know you have a long hearing. So I will not be offended if you don’t ask any questions.

SENATOR VITALE: Senator Buono has a question, though.

SENATOR BUONO: Thank you.

I did have one question. You probably don’t know that I used to be an attorney, and my former boss is in the audience with the Division of Mental Health Advocacy, the Office of the Public Advocate, which is now back in existence, I’m happy to say. And at my recollection, because I represented people at their recommitment hearings, and my recollection is that the number one reason for readmission to inpatient psychiatric

treatment was noncompliance with taking medication or medical treatment. And so I'm trying to-- Initially, when I heard of this concept, involuntary commitment to outpatient treatment, I had a problem with it initially until I read the bill very thoroughly. And I just had a question or two, just to make sure I understand it completely.

It seems to me that the major difference from the current definition which would justify involuntary commitment inpatient is that the definition of dangerous -- you have to be dangerous to yourself or to others or to property in the reasonably foreseeable future, as opposed to the standard for inpatient commitment, which is imminent, I believe. Does my memory serve me correctly?

SENATOR CARDINALE: Yes. It's a nuance. It troubles me that the language--

SENATOR BUONO: Because how do you determine reasonably?

SENATOR CARDINALE: --that the language-- What happens under the language in the present law is, as a practical matter, if you were representing the people who didn't want to go back--

SENATOR BUONO: Well, nobody does really, just so you know. (laughter)

SENATOR CARDINALE: --you had great success rates. Because those who try to keep people out of the institutions under the current law succeed most of the time. So these folks rotate through the system. I've heard from these crisis intervention teams, for instance, that they bring people in. They can keep them for three days. And then there's going to be a court hearing within the next couple of days, and invariably

they come out. Now, in that three days, there can be some basic workup, but not a thorough diagnosis. And it's only when these folks-- And we've had incidents in South Jersey -- we had one, I think it was Burlington -- where one of these folks killed somebody.

We have-- I'm told that our prisons are populated by quite a number of people who have mental illness. And because we have nowhere else to put them, we have no way of getting at this problem under the rest of the law, they're populating our jails. And I don't know what percentage that is, but I'm told there's a significant percentage. So there is a nuance, and I don't understand, myself, how the legal interpretation of that nuance of language from the old law to the new law will work, except I'm told that it will effectively provide, as it does in New York, as it does in California, as it does in Florida. Those are three big states which have enacted laws very similar to this for the same reason. They have the same problem we do.

SENATOR BUONO: So then -- and I'm really just trying to understand the bill, that's it.

SENATOR CARDINALE: I understand.

SENATOR BUONO: There's not a need under the current bill, under your bill, to show current or imminent danger in order to establish the need for outpatient civil commitment. But I guess my question is this, how -- what goes into the assessment of whether or not an individual is considered to be dangerous to themselves? Is it just the fact that they're noncompliant?

SENATOR CARDINALE: It's a-- Well, the noncompliance is an issue the second time around. The first time around you have the screening committee -- the screening outfit that gets set up under the terms

of this bill. This is a difference from the model bill that I had introduced previously. And I think it's a very good idea, because these are professional people who are going to now make a judgment based on professional standards rather than words written in a statute.

SENATOR BUONO: And who's on the screening committee?  
I'm not familiar--

SENATOR CARDINALE: They are -- that was the question that I asked. The bill does tell you who's on the screening committee. They are certified by someone, by the Department.

I have been instructed that on Page 3 there is, halfway down a bunch of underlined stuff in Paragraph *H* -- and that is the changed definition. But my question would be the same as yours. How does that, in fact, translate into a legal interpretation that accomplishes the goals of the bill? I'm not an attorney. Perhaps, as an attorney, you could explain that to me, but I would not presume to explain that to you.

SENATOR VITALE: Do you have any attorney friends, Senator?

SENATOR CARDINALE: I'm sorry.

SENATOR VITALE: Do you have any attorney friends?

SENATOR BUONO: Never. He'd never admit to it.  
(laughter)

SENATOR CARDINALE: Yes.

SENATOR VITALE: We could find them.

SENATOR CARDINALE: Yes. But in the bill there is a definition of the screening committee. I will find it for you. The mental health screeners -- "a psychiatrist, psychologist, social worker, registered

professional nurse, or other individual trained to do outreach only for the purposes of psychological assessment who is employed by a screening service and possesses the license, academic training or experience, as required by the commissioner pursuant to regulation.” So the screeners are set up by this bill, and they’re going to be professional people licensed and with regulation by the Commission.

SENATOR BUONO: Okay. I’m just-- I’m not entirely clear, but I’m just going to read a little further and maybe, in the interest of time, I’ll come back and ask questions a little later as well.

Thank you, Senator.

SENATOR VITALE: Thank you, Senator.

SENATOR CARDINALE: Thank you very much.

SENATOR VITALE: Thank you, Senator.

SENATOR CARDINALE: Are there any other questions? I’m sorry.

SENATOR VITALE: Senator Rice.

SENATOR RICE: Yes. I have a question, through the Chair.

SENATOR VITALE: Yes, sir.

SENATOR RICE: Before the Senator leaves, do you have a Jean Ross on your list to testify?

SENATOR VITALE: Yes.

SENATOR RICE: Okay. She wanted to be sure.

Senator, are you leaving now?

SENATOR CARDINALE: I’m going to stay for a little bit, but I can’t stay-- I see how long your list is, and I didn’t anticipate that.

SENATOR RICE: Could you make sure that Ms. Ross's comments are, hopefully--

SENATOR VITALE: Up front.

SENATOR RICE: --are articulated while the Senator is here, so maybe we could ask some of those questions, since she comes from an organization that is based in my community and my district, and this is the first time I'm hearing from the organization, even though I know the organization well.

SENATOR VITALE: I'm going to ask one group to speak first, then I'll call on Ms. Ross.

SENATOR RICE: Thank you.

SENATOR VITALE: Thank you.

Phil Lubitz and Sylvia Axelrod, you're here in favor of the bill.

**PHILIP LUBITZ:** Yes.

SENATOR VITALE: Phil, if I may. Just in the interest of time, as happened last time, we just want to be able to concisely present the testimony. Thank you.

MR. LUBITZ: Thank you, Senator Vitale, and members of the Committee.

Are we on?

SENATOR VITALE: Yes.

MR. LUBITZ: One, I'd like to thank you for the opportunity to speak in favor of S-2760. Again, we know it would establish involuntary outpatient commitment to treatment. This bill clarifies the guidelines for treatment and offers a less-restrictive alternative to inpatient commitment that we currently have. We believe this bill strikes a proper balance

between individual rights and responsibility of State government to protect those who are unable to protect themselves.

It's important to keep this bill in the context of the full recommendations of the Governor's Task Force and what you, as a Legislature, did when it came to budget time. We've added \$40 million in new mental health programs in order to realize the recommendations of the Task Force. But in addition, we've added \$200 million in a housing trust fund. We've also added a \$30 million cost-of-care initiative, which I believe \$12 million went to mental health. We also added a \$20 million wraparound, so people would have access to needed psychiatric medications. We've also added \$55 million this current year for the child welfare system. We've also increased funding for self-help centers and supported employment programs. And consumers now can direct their care when they become incapacitated, because you as a Legislature passed the Advanced Directives for Mental Health Care bill.

During the Task Force hearings, we heard passionate testimony regarding recovery-oriented services. And we applaud that because we fully support people in directing their own recovery from mental illness. But we also know that there are a group of people who, because of their illness, either will not, or cannot, access services. These people must currently descend repeatedly into the nightmare of mental illness where they become homeless, get placed in jail, or victimized.

Is there anyone here who would say that we shouldn't have inpatient commitment for these individuals who become dangerous to themselves or others? And if we believe that, that's really a responsibility of the State. Can we truly say that we shouldn't have a less-restrictive

alternative for those people -- outpatient commitment -- where we can treat them sooner?

We've heard a lot of testimony, and I'm guessing we're going to hear a lot of testimony today about the research. And I'm, quite frankly, not going to get into that. But what I can say is that really, within the last -- it's actually less than two years, four states -- California, Florida, West Virginia, and Michigan -- have added brand-new outpatient commitment bills for this very reason. In addition, New York state, just this past July, reauthorized Kendra's law after going through the debate that we're going to have here today. So what did their evaluation of Kendra's Law show? Well, it showed there was an 87 percent in reduction of incarceration, a 77 percent reduction in psychiatric hospitalizations, and a 74 percent reduction in homelessness.

We'll talk about the categorization of these people, but after reading the report-- We worry about this bill, and I think people are going to testify that they worry about this being a wide sort of net. And quite frankly, I understand that fear. And many of the people who are going to testify today, there's no intention of this bill reaching them. I can understand why they're afraid of this, but this bill isn't intended for these people who are directing their own recovery.

But in New York, it was very targeted, Kendra's Law. The people who received outpatient treatment -- 71 percent of those people have schizophrenia, 13 percent of those people have bi-polar disorder. So clearly, 84 percent of the people that get outpatient commitment are people with the two very most serious mental illnesses.

So again, in the interest of brevity, I'm going to ask that you support this legislation that's going to offer a less restrictive alternative to our current only option of inpatient commitment. This bill does not change New Jersey's standard. I may be incorrect, but I believe that *foreseeable future* is currently in New Jersey standard, and the real problem has occurred because it's been misinterpreted. Okay? So this bill seeks to clarify that, and I believe John Jacobi testified to that in August.

It also gives guidance to what we mean by dangerousness. So I think we've added clarity to the standards, so it can be more equally applied. Again, family members ask you, in considering this bill then, to think about what is in the bill and not what we are afraid might happen in some other world. This is something that family members have wanted for so many years. And actually, today, we're going to hear a number of consumers who are going to tell you their story about how this bill, if it had been in place when they became ill, it would have saved them from hospitalization, homelessness, and victimization.

So again, I thank you for your time.

SENATOR VITALE: Senator Buono.

SENATOR BUONO: I just wanted to thank you for your testimony. I just wanted to say that as responsible policy makers I think it's incumbent upon us to thoroughly examine and debate and discuss the potential unintended consequences in any piece of legislation, particularly where there's a threat to personal individual freedom. But I must say that your testimony is very encouraging. Looking to the example in New York, they've obviously reexamined Kendra's law, and it looks as though it's working the way we want it to.

MR. LUBITZ: Yes. Thank you, Senator.

Actually, we at NAMI debated this for four years to come up with this position. So I can appreciate your concern.

SENATOR BUONO: That's the way the process is supposed to work when it's good.

MR. LUBITZ: Thank you.

SENATOR VITALE: Thank you.

Senator Rice.

SENATOR RICE: Yes. I can tell you, I'm just as impressed. Sometimes I'm not impressed easy. When people start to identify the analysis and how they did it and where it comes from, sometimes that's valid and sometimes it's not.

I want to ask a question, first, okay? Did I hear you mention something about this is a great bill or a good bill because it balances, I believe, the protections and the rights of patients, etc., etc.? Well, I've got something here -- from people who I believe work with enough networks of legal minds -- to the contrary, so hopefully you can (indiscernible) to hear Ms. Ross speak as well. And let me say this for the record, my biggest problem here is that New Jersey needs to start leading. I've always said this. I think we all should do research and see what other people are doing, but don't necessarily do what they do. That's the problem I'm having. So the mere fact that, although I dispute the Senator in terms of me being impressed, is when you start off by telling me what Michigan did, California, and other states -- we didn't do a Michigan (indiscernible), but they were wrong. And I'm the one that dove in the water and said nothing is going to help us, but at least give me an option, so we have an option.

That's an insurance. We look at every other state, and we said we should do self-service gasoline, because only two states don't have it, but we're the only ones right. It's cheaper. And everybody is telling me about needle exchange, how all these states have it, and I disagree with other states.

And so when you mention other states to me, I'm just going to look at what they do, but be very cautious about what you interpret. In this case you may be right, but that doesn't impress me. When people say that, I always start backing up and say, okay, now we're looking for an easy way out, rather than taking what we have and make it work for us.

But I really want you to be around so when this next speaker talks about the balancing, and why they feel it's not balanced, you need to tell us why it is balanced, okay? Because legal minds can agree and disagree and researchers can do that too, but I want to hear more about that aspect of it myself. I just don't like comparing, going back to the other side, variables.

New Jersey is not New York. That's like saying the Newark Police Department, now we're doing an analysis with Asbury Park. No, you have to do an analysis for the Newark Police Department to Oakland, California -- that's probably your closest department.

So I'm going to listen, but please try to hang around, if you can.

MR. LUBITZ: I appreciate your comments, Senator. Quite frankly, I think that healthy skepticism is really the right approach. I was a skeptic who actually got won over to this. So I appreciate where you're coming from.

SENATOR RICE: Well, you may be right in this case. But normally, in New Jersey, I find over 50 percent of the time we are wrong on

the analysis, because California is also the one that locks up people for drunk status. An attorney would tell you that that was a status -- but you can't do that. They'll try anything in California, including Proposition 13, that they can't get rid of.

SENATOR VITALE: Thank you.

Senator, just so-- For your information, there are going to be proposed amendments to the bill that will include an amendment that will provide for a period of time that this will be studied. Or rather, putting it differently, that after a period of time the Legislature, the administration will analyze the effectiveness of the legislation. It's not a sunset clause, but it's a look back.

**S Y L V I A A X E L R O D:** My name is Sylvia Axelrod. I'm the Executive Director of NAMI New Jersey, a statewide education support and advocacy program dedicated to improving the quality of life of individuals with a serious mental illness and their families.

I'm here today to speak on behalf of the many family members who are constantly wary of losing their loved ones to untimely death, incarceration, and estrangement as a result of untreated mental illness. We see involuntary commitment to outpatient treatment as a much-needed option, and therefore support S-2760.

My testimony today specifically addresses the need to include in this bill a provision that addresses the involvement of those family members who provide care and support for a loved one who is being assessed by a screening center when involuntary commitment to treatment seems necessary.

Over 60 percent of persons diagnosed with a serious mental illness, including those discharged from psychiatric hospitals, receive residential care not from a paid provider but from their families. A paid residential provider is presumed to be part of the treatment planning process in order to ensure the delivery of quality service and good coordination of care. When a family member provides residential care, they are not included in treatment planning. They are often not even informed about aspects of the treatment plan that are crucial for a family caregiver to know if they are to understand and support their loved ones' treatment plans and goals.

Family members may not even be given the opportunity to provide relevant information to treatment providers concerning the behaviors and reactions they observe that are clear warning signs of an increased likelihood of their loved one becoming a danger to themselves or others.

This legislation should ensure that it is an obligation of the screening center to obtain relevant information from family members of persons being assessed for commitment to involuntary treatment. This is consistent with best treatment practices that consider family involvement and support essential to promoting recovery.

This legislation should make it mandatory to involve family members in the development of the treatment plan if the family will be providing the residential care or other significant support for a person involuntarily committed to an outpatient setting. Any decision to involuntarily commit a person to an outpatient setting that includes living with his or her family should not be approved by the court unless it is clear

that the family providing residential care was involved in the development of the treatment plan along with the outpatient providers.

SENATOR VITALE: Thank you.

Questions, anyone? (no response)

Thank you.

Jean Ross, from People's Organization for Progress.

**J E A N R O S S, ESQ.:** Do you want to wait until Senator Rice returns?

SENATOR VITALE: We're going to grab him now.

MS. ROSS: I'm sorry?

SENATOR VITALE: We're going to get him now.

MS. ROSS: Good afternoon, Senator Vitale--

SENATOR VITALE: Good afternoon.

MS. ROSS: --and Senator Karcher, and the rest of the members of this Committee, which in my mind is the most important Committee in the Senate. But that's just my personal bias. I'm here as a representative of the People's Organization for Progress. And I just want to say two sentences about POP, because some of you may not be aware of its work. It's a grassroots community organization, primarily based in Newark, which is deeply concerned and involved with the welfare of the people in the community of Newark and the state, and also in human rights and civil rights.

Our membership includes people who are both providers of mental health treatment and also people who have experienced both hospitalization and treatment in the community. As an organization largely based in communities of color, which have been historically underserved

and poorly served by the mental health system, we have a direct and immediate interest in this bill.

I'm going to take a second so that you can hear me. (coughing)

SENATOR VITALE: Please.

MS. ROSS: Thank you.

This is our position on S-2760: We agree with the previous speakers and with Senator Cardinale.

I have to drink the water in order for it to have any effect.

(laughter)

We agree that there have been changes in the ground in the mental health system since the screening was enacted some 18 years ago, I think. And therefore, we think that there need to be changes in the law to respond to what's happened on the ground. And what we see on the ground, which you've heard about -- so I'm just going to run through it quickly -- is the revolving doors between hospitals, jails, and prisons and the street, which Senator Cardinale mentioned; overcrowded hospitals, under-resourced community agencies, and this trans-institutionalization -- that Mary Zdanowicz, I think, may have coined that term -- of people with serious mental illness from hospitals to jails and prisons. So if we want to look at the mental health system, if we want to look at where institutionalized people are receiving treatment, we know that those are -- two or three times as many of those people are in jails and prisons than are in psychiatric hospitals.

So we really believe that there's a very great need for a law, either a comprehensive law or a law that could provide a first building block for a comprehensive approach. I look at S-2760 as in the second category.

Unfortunately, although POP would support a credible, effective outpatient commitment bill which would address the presenting problems that we're seeing in the system, we don't think that S-2760 provides that legal basis, and therefore we strongly oppose the bill.

We also believe that with more open discussion and debate, which would include people whose voices were not heard at the table, including the people in our communities-- Most of the people in POP don't look like me -- they're African Americans and Latino people and some white people. We think that more vigorous and open debate would produce a much better bill.

In the materials I have given you, this-- A little bit of a biography, which I'm not going to go into. But suffice to say that I've worked in different arenas in the mental health system. You may also know that I have worked with NAMI New Jersey for over three years, I think, to draft another bill. But don't think for one minute that I'm going to ask you today to put this bill aside and substitute it for the NAMI bill. My concern has been to see whether this bill could be made to be a good foundation for an outpatient commitment bill. And I regretfully -- regretfully -- concluded that it could not.

I'm going to focus on an analysis of the text from the perspective of people on the ground. My objective this afternoon, very quickly, is to raise in your mind reasonable doubts so that you do not rush to judgment, and that you honor Senator Codey's commitment to changes in the system by insisting that we have a good bill, which this is not.

I'm glad that I was able to hear the last speakers, because I think some of the discussion reflects our concerns about this bill. We are in

very much agreement with both what Senator Cardinale said and what Phil Lubitz said about the objectives of an outpatient commitment bill. We want to get -- family members and other people want to get timely treatment in a credible public health perspective. We want to get timely treatment so that they don't have to be hospitalized, so that they don't get imprisoned, and so they don't cause harm to themselves or others. So far, there's been agreement about that.

Unfortunately, this bill doesn't provide it. Because as you noticed-- Senator Buono, I'm glad that you asked the question that you did about the dangerousness standard. I think it's probably clear to many of us who've looked at the bill that the dangerousness standard in S-2760 is exactly the same, and was intent to be exactly the same, as in our current standard. Now what does that mean? That means that you can't get evaluated or brought to a screening service unless you meet the current -- unless there is a reasonable cause for someone to believe that you meet the same strict dangerousness standard that we have in our current law. And there's not really any nuances about that.

Our New Jersey Supreme Court and our statutes say that you have to be dangerous within the reasonably foreseeable future. That's what our current law says, that's what S-2760 says. So that means that for those people who are hoping that this bill will allow their loved ones to be treated before they get so sick that they reach the depths of their illness, etc., they're not going to get it in this bill.

Secondly, there's some real question about what this bill intends in terms of providing the most effective treatment that very ill people will need in the community, which is medication. I myself read the

bill to say that the bill authorizes involuntary medication in the community, but others read it differently. That ambiguity is a serious problem.

And let's take a step back and look at New York for a second, because some people have mentioned Kendra's Law. Kendra's Law is different in two very important ways from S-2760. First of all, it's a law that has a dual standard for commitment -- a lower standard for inpatient-- No, a lower standard for outpatient commitment and a higher standard for hospitalization. That makes it very different. It does not present some of the problems that a unitary standard provides. And secondly, it does not authorize the involuntary administration of medication in the community. The New York Court of Appeals case, which resisted a challenge to the constitutionality of Kendra's Law, specifically said that they were approving, essentially -- approving the law because the law did not permit the state to involuntarily medicate people without a finding of incompetency.

This bill appears to authorize the involuntary administration of medication in the community without a finding that the patient in question has a lack of capacity to consent to treatment. I'll get back to that in one minute.

I love Sylvia Axelrod's testimony about the importance of family members. I have nothing to say in response to her testimony.

So far, what I hope I have established is that the hopes that family members and senators and other people have, which is that this bill will stop the revolving doors, because it will permit early, timely intervention including the most effective intervention, which is medication

-- that those hopes and expectations, at the present time under the current language in the bill, are predictably going to be dashed.

We had a situation where a lot of very intelligent, experienced, powerful, entitled people of very good will have been talking about the mental health system and had some conversations about involuntary outpatient treatment. And yet POP and I are here before you today to question their judgments. How could we be doing that? First, we note that the bill does not, in fact, honor the recommendations of the Task Force in two important respects. We don't believe that we will have appropriate community treatment in place in time to satisfy the first recommendation of the Task Force.

Secondly, although lip service is paid by the Task Force to their commitment to having treatment in the least restrictive alternative, they have left intact in our current statute a provision for voluntary admission that does the following: It says, if I have -- me, living in Princeton -- I have insurance and I have money, if I get sick and I want voluntary treatment in a hospital, I go to Carrier Clinic, or some other place, and I can get in if I'm mentally ill. But if I don't have insurance and I don't have money and I'm getting sick again, and I think I need to go into a hospital, I can't go into a hospital voluntarily in the public sector unless I become dangerous to myself or if I'm, basically, at the verge of crashing. We have a class difference here which I think is -- we should not permit in our mental health system.

The bill -- well, sorry. I'm going try to finish this while I'm still middle-aged. I'm not going to spend time defending or promoting outpatient commitment, although I think that we would accept, as I said, a

Careful outpatient bill, because other people are going to talk about the virtues of proper outpatient commitment.

So let me just give you a few examples of how I think that this bill will not work the way people hope. And in doing this, I'm going to be highlighting three things: patients' rights issues; constitutional and other legal problems with the bill, including unprotected loss of liberty through involuntary hospitalization and involuntary medication in the community; and problems with the right to treatment and the right to refuse medication. So those are legal issues and patients' rights issues. There are a number of systems and policy issues which we think will make the bill ineffective, and I'll give you some examples of those.

To start off, let's look at Section 13, which is kind of hidden in back of the bill. Basically, what this bill says is that, as in our current law, people can get committed. There's a decision made that people can get committed if they're mentally ill and dangerous. And then there is another decision, a separate decision, which is made just to whether they should go into the hospital or the community. That decision is reviewed by a court and then there are periodic review hearings which will check to make sure that people who are involuntarily committed to inpatient or outpatient treatment meet the commitment standards.

But what happens in between those court hearings is in Section 13. Either chief executive officers or outpatient treatment providers can unilaterally move patients from the community to a hospital where they are locked up, or from the hospital to the community where they do not have full autonomy -- without any judicial review, without a right to a hearing, only the opportunity to request a hearing. Our Supreme Court, as long ago

as 1975, in the *State vs. KROL* and then, three years later, in the *State vs. Fields*, said that these decisions about whether people should go into a hospital or not are not decisions for clinicians to make. Clinicians must present their testimony to courts, but the decision about whether to hospitalize someone is a legal decision to be made by a judge, not by a chief executive officer of a hospital, not by an outpatient treatment provider.

I wanted to -- although that puts us kind of in the middle of the bill -- I wanted to mentioned that problem first, because it indicates that there's some real problems with the credibility of the approach of this bill.

With respect to involuntary medication in the community, there are two possible interpretations of the bill -- either involuntary medication is authorized or it isn't authorized. If involuntary medication is authorized without a finding that the patient lacks the capacity to make treatment decisions, then you're going to have problems with the lawyers.

In Wisconsin, for example, a state whose laws many people have looked to, decisions about medication can be affected by court orders, but only after the court has decided that the person doesn't have the capacity that takes them to treatment.

If the bill does not authorize involuntary medication, then the problem is, what are we doing here? We've been talking about a bill which is supposed to deal with people who don't have insight into their illness, who don't want treatment, who don't want medication, who stop their medication. And if we can't insist that they have medication in the community, what's the point of the bill?

UNIDENTIFIED PERSON FROM AUDIENCE:  
(indiscernible)

SENATOR VITALE: Hold on, please.

SENATOR RICE: Mr. Chairman?

SENATOR VITALE: Senator.

UNIDENTIFIED PERSON FROM AUDIENCE:  
(indiscernible)

SENATOR VITALE: Well, now, this is-- You're out of order, sir, please. We're going to get to everyone.

SENATOR RICE: Yes. Because I was getting ready to debate him, and we can go outside and talk about this. I like to get people to talk. I was getting ready to say, could maybe some of the testimony be submitted to writing, because I think that the bullets are important. I think what we've heard so far disputes a lot of what was said by some of the previous speakers and the questions I have.

SENATOR VITALE: Sure.

SENATOR RICE: Even to the point when I said we have to be very careful when we do analysis in other states how we interpret what other states did. And that's a good example of -- where she cited New York. Because when she talked about New York -- and I do keep my peripheral vision -- and I noticed that-- I've seen Senator Buono start to look, and say, "Oh." Because that means it's a legal thing, and she's concerned about what New York did that is correct, maybe, that we are not doing.

SENATOR BUONO: I really ask that you not interpret my thoughts, thank you.

SENATOR RICE: I understand that. But I really believe that you made some notes to look into those things.

SENATOR VITALE: Can we have, then, the balance of your testimony submitted in writing so that we can move on?

SENATOR RICE: Yes.

SENATOR VITALE: Would that be all right?

SENATOR RICE: (indiscernible) the Committee suggests, because I think there's a lot of substance to what she's saying. We need to have the substance, okay? But I just want the gentleman to know that I respect what he's saying. She just happened to be from my district, I didn't know it until today, okay, and I do defend people in my district.

SENATOR VITALE: Absolutely.

SENATOR RICE: Okay. I just wanted him to know that.

SENATOR VITALE: Okay.

MS. ROSS: Can I make one point about the dilemmas faced by doctors under the way that this bill is written?

SENATOR VITALE: I'm sorry?

MS. ROSS: I would like to make one point about the dilemmas faced by doctors with this bill.

SENATOR VITALE: We're going to be hearing from the Psychiatric Association. If you wouldn't mind, we have-- You're the second speaker out of 10, and it's already almost 4:30, and so we need to move on. Have you submitted your testimony in writing?

MS. ROSS: Yes.

SENATOR VITALE: Then we're all going to read that testimony and then correspond with you in the individual, and you can correspond with us directly. But I really need to move on, because none of

our speakers have taken this long. This information you're providing is important, it's terrific, and you spent a lot of time doing it.

MS. ROSS: Okay.

SENATOR VITALE: I just need to move along.

Senator Buono.

SENATOR BUONO: I just have to -- since you're here -- I just have to clarify something. You're talking about how -- why the bill doesn't work. You didn't explain to me, really, how you think it can work. And I know we're short on time, but just make sure I understand your testimony. You support outpatient commitment, but you believe that there should be two tiers of commitment?

MS. ROSS: Yes. Yes, as in New York.

SENATOR BUONO: Rather than amending-- What this bill does, and as I understand it, is amend the definition of dangerous -- let me finish -- to make it more expansive. It does. And then, if you read it in conjunction with the least restrictive environment, and that's how you arrive at the goal of the legislation. And that's-- I mean, are there two approaches to the same problem? I don't know that one is superior over the others, honestly, but I'm not--

MS. ROSS: Okay. One, there is a problem with having a unitary standard for commitment to the community, as well as to the hospital.

SENATOR BUONO: Okay.

MS. ROSS: Because you're asking doctors to decide that people are dangerous, and then send them off into the community where they may not get the medication that they need. That's number one.

The second thing is that before--

SENATOR BUONO: But that's included in the definition of dangerous. It talks about treatment and response to treatment, so it's really -- you can--

MS. ROSS: That's very different from a court deciding that a person does not have the capacity to give informed consent to a very intrusive treatment, which is the administration of psychotropic medication.

The second thing is, which is what Wisconsin and Massachusetts do, is that that court hearing could do what you just suggested, which is they could make a competency determination. And if they did that, then there would be no problem in authorizing and having court orders that authorize involuntary medication in the community. Those are two things that would make a big difference.

SENATOR BUONO: Competency while you're on medication or while you're not compliant?

MS. ROSS: The court decides should you be committed, and at the same time they decide whether you have the legal capacity to consent to treatment. They can do that at the same time.

SENATOR BUONO: Okay. Well, I don't want to take up any more time, but this is an interesting discussion. Very fruitful.

Thank you.

SENATOR VITALE: Thank you, Senator. Thank you very much.

SENATOR RICE: Mr. Chairman, while she's asking -- through you. Have your organization get in touch with me, submit to us more

detail. I'm going to come talk to them. Because just being here, I can see where it's going. And I heard your organization thinks it's a good bill with intent. It needs some tweaking. I'm not so sure if I'm hearing-- At least, I can't gather here that there's (indiscernible) that has to do some tweaking. So I want to at least know what's in my guns when I come back and we do decide to vote on this and deal with it. So I want to come talk to your organization. I'll be loud and clear.

MS. ROSS: Thank you very much. Thank you.

SENATOR VITALE: Deborah Nolan.

**DEBORAH NOLAN:** I submitted a longer written version of the testimony, so I'll just go over the main points. I'm here today because a year and a half ago my parents tied themselves together and walked into the ocean, in Seaside Park, New Jersey.

SENATOR VITALE: Excuse me? Members, we need to hear that opening statement over again, please.

MS. NOLAN: Okay. I'm here to speak to you today on behalf of my family, on behalf of my children whose lives were completely redefined by an event last year, on behalf of my mother who died, and on behalf of my father, who after spending a year and a half at the State hospital system, has been recently released into the community. At this point, I'm not sure whether this specific legislation will help him. But I would like to ask the Committee to support some kind of assisted outpatient treatment that can help some of those people who are in between the different definitions.

At the time of his release from the hospital, the medical director of the hospital told my father that if he does not stay on medication, or

compliant with treatment, he will decompensate, he will attempt suicide again. In 2003, my mother and my father separately attempted suicide. They were in contact with psychiatrists and some medical doctors, and presented a facade that everything was under control and stable, did not share with the necessary people, including a VA psychiatrist, that they had had extremely complicated, life-long histories of mental illness beginning with childhood abuse and trauma. Back in the 1930s there was no rescue from such things. There was not appropriate intervention at any time. And eventually, in the early 1980s, when my father had to go out on permanent disability for emotional illness reasons, he was not only the victim of stigma, but completely humiliated when a disability insurance carrier came and investigated whether he was actually disabled or whether he was committing fraud.

They moved down to a beach community in southern New Jersey, started a new life keeping secret everything in the past, and attempted to go on coping with very little help from the outside. Two weeks before they attempted suicide together, they saw a doctor, who had treated my mother back in September of 2003, in her individual attempt, and said that everything was fine. For the entire year, they had been -- suggested to pursue therapy and treatment for my mother. My father decided he could handle it.

My father has been diagnosed with a number of different illnesses, and he is very intelligent. My parents were creative. They thought that they could work through it. They were unaware of how their illness was controlling their lives. In the final two years of their life, they amassed \$240,000 in debt, which required a Chapter 7 bankruptcy filing.

It necessitated the liquidation of their only tangible asset, their home. They could not understand that friends and family and social service agencies were at all available to them; had decided that everyone -- including family members and friends -- were threats, and lived a completely reclusive life for almost a year.

Two weeks before they attempted suicide together, they told the doctor that everything was fine. Two weeks later, they were found at 6:30 in the morning on a beach by a local fisherman, tied together with electrical cable. My mother died at the scene. My father, remarkably, was resuscitated. He spent time in a short-term facility, went into the State hospital system for about a year, and he is now in a group home for the mentally ill.

I was appointed by the court, first as my mother's administrator in order to get a body out of the morgue. And then I was appointed to the guardianship for my father, because his illness revealed itself to have a lot of complicated layers he had never shared with anyone. If he does not comply with treatment, if he does not deal with his issues, if he does not stay on medication, this will most likely happen again.

I don't know if this legislation can help him at this point. But the medical director of the hospital told me that such legislation should be relevant to his case. So I'm asking that if there are questions, which I was not aware of, about who can be helped by such legislation, they be addressed. I know that in my experience with the (indiscernible) family support services at the county level, with ICMS -- because I think I bothered everyone in the state to try to get through just the hospitalization period with my father, including Mr. Lubitz.

I found that there are a number of problems, and staff at the state hospital said there are a number of problems throughout the system, from the hospital level down through the community. Even the perceptions of what appropriate and relevant therapy and medication are differs from person to person, and agency to agency. So, at this point, I'm asking for your help. My children need your help. I don't know if our case is relevant to you. But if it is, I would appreciate any support that you could have. And if there's anything in our story that can help you or give you background to some of the people who are not necessarily in the criminal system, then please contact me.

SENATOR VITALE: Are there any questions or comments?

Senator.

SENATOR RICE: I just wanted to say that everybody I heard so far, whether we agree or disagree, agreed with you and the need and the intent. The question is, how do we get there where we could balance some basic rights? There are some people who may, in my mind, think they're balancing basic rights when, in fact, they could be doing more harm.

MS. NOLAN: Right.

SENATOR RICE: And so that's where the real debate's going to be, from my perspective, as to how do we make sure that the very people we're trying to help are also protected. Because there are some fundamental rights in this country that some people, to be quite frankly, in the minority have been denied for years, and we continue to do it indirectly through the way we write legislation. I get concerned when everybody wants to help me and they don't listen to me sometimes, but they share information. When

they share it, it's like, "Thank you," and we move to what they want to do. That's where we're coming from. At least where I'm coming from.

MS. NOLAN: That's why we had to pursue the avenues through the court system of administratorship and guardianship, and I understand that there are certain states who, in lieu of this type of legislation, do use those mechanisms. And I know a lot of the other families that I've met don't even have that. But guardianship is not even permanent when it's said to be permanent, according to the court system. So as long as I am policeman and compliance officer for my father, as long as I have that position, then I can try to make him at least adhere to medication.

I know that one thing that I've seen that might help is, if you had opportunity to kind of investigate the anatomy of certain illnesses and how they develop through a lifetime. Because there are times when a parent may have a child who gets into substance abuse or gets into some need of emotional help. And in fact, because of this situation, we had to face that. My son was almost 18 years old at that point, and it was negligent, at that point, for us to stand back and wait to see the degree to which he would decompensate before getting him help. I understand. And because I was raised, I think, in an atmosphere of secrecy -- because the utmost goal was to keep my parents seeming normal -- as far as I knew, they were absolutely fine. Nothing was fine as I grew up.

I do think it's possible for legal frameworks to provide some ability, in the same way that a parent might have to intercede with an older child, for a government to help a person take care of themselves. I understand that that's tenuous. I understand competency issues and incompetence. At this point, it is my father -- because I am guardian -- is

listed as legally incapacitated. But I don't think that it's possible if you see an illness evolving so that-- I don't think that mental illness should be fatal. I don't think that my mother should have died, and I don't think my father needed to get to the point that he felt that the only thing that was possible was to kill both of them in order to escape from the financial difficulties, and from the illness, and from the stigma that they were facing.

So I don't know what specific, exact wording should be. But I do know that something like this legislation does need to exist.

Thank you.

SENATOR VITALE: Thank you. And thank you for your personal testimony, and we're all sorry for your loss.

Thank you for being here.

MS. NOLAN: Thank you.

SENATOR CARDINALE: Senator, before I go, I just want to bring two things to the attention of the Committee. One, take a look at the old bill. It created a category of gravely disabled, which I think is what some of the witnesses are talking about -- you need another category. That did not repeat in this bill. And I think it would be useful to maybe pull some of that concept into it.

Secondly, in the definition there is a subnumeral 3 -- which I just went over with Senator Buono -- and I think that does, in fact, accomplish the thing that POP said needed to be accomplished, if it is interpreted, by the judge who looks at it, to mean what I think the people who drafted it intended for it to mean. And perhaps that can be made more explicit, but I think the basis of it is here. And I agree that it needs to be something that cannot be easily misinterpreted when it gets to a court.

I'm sorry that I have to go.

SENATOR VITALE: That's okay. Thank you very much for being here, Senator.

Carolyn Beauchamp and Marie Verna, Mental Health Association of New Jersey.

CAROLYN BEAUCHAMP: I'm going to hand it over to Marie first, if that's okay with you.

MARIE VERNA: Good afternoon, Senator Vitale and members of the Committee.

My name is Marie Verna, and I work as the Director of the Consumer Advocacy Partnership for the Mental Health Association in New Jersey. I was diagnosed, in 1983, with bi-polar disorder and have been hospitalized four times -- twice in Pennsylvania, once in New Hampshire, and once in New Jersey. My hospitalization in New Jersey was the most painful and the most traumatic. It was the only hospitalization where I'd been forced. To this day, I attribute my recovery from mental illness to the compassionate care of a highly qualified psychiatrist, loving support from my family of origin, and my own personal will to survive. To this day, I believe that the force that was used on me in 1993 was counterproductive, unnecessary, and cruel.

The Consumer Advocacy Partnership is the only coalition in New Jersey that represents people with mental illness. We're made up of four, long-standing organizations in the state -- the Mental Health Association in New Jersey, Collaborative Support Programs in New Jersey, COMHCO, and the Consumer Provider Association in New Jersey. Together we represent thousands of consumers in New Jersey who, while

passionate about the lack of quality services in the community, want you to know that involuntary outpatient commitment is not the answer.

I've asked several of the partnership leaders to work with me on consumer policy to come and amplify the position we state in our policy statement against IOC, published earlier in 2005, which you have a copy of. I want you to hear their opinions about the problems that IOC claims to solve, as I've heard them over the many months that we worked on our position and struggled with our recommendations to legislators like you, the Governor's Mental Health Task Force, which many of us served on, and to the Governor himself. Some of them have already expressed to me that the efforts to pass IOC make them feel the same way they feel when treatment's been forced on them. No one is listening, but everyone is forcing.

Also listen carefully to those consumers who are here to explain to you that they support IOC. Their observations about what it's like to confront the illness, accept treatment, and recover will sound similar. Their descriptions of the dearth of services in New Jersey will duplicate what you hear from consumers who oppose IOC. They come to the conclusions that had the right services been available they would have accessed them. In these hypothetical situations, this would amount to voluntary services if those services had been there.

There is no way to delude yourselves into thinking that IOC alone will help the citizens in New Jersey who can't, who won't, or don't want to use mental health services without the services being there. I congratulate you and all the advocates here for the tremendous work we did in the past year gaining \$40 million in mental health services. But all

experts and all consumers know that this is nowhere near enough and is long overdue.

As you listen to the consumers here, also consider that not one of us lives with the confidence that we will never be incapacitated again, despite our obvious success. I for one am told on a regular basis that I don't look like someone with mental illness and that IOC would never be used on me. Most of the consumers here are told that they don't fall into the population for which New Jersey needs IOC, the implication being that they shouldn't worry about their civil rights being abused, or they shouldn't worry about being forced.

As members of the Senate Health Committee, I beg you to listen to the reality of what mental illness is. Not one of us is so self-confident and so recovered that we don't see ourselves in the handcuffs, in the police cars, in the chaos on the street or in our homes. People with mental illness live with the terror of their illnesses, but they also live with the terror of discrimination, ridicule, and the idea that they could once again lose their mind, their dignity, and control over their own lives.

Thank you.

SENATOR KARCHER: Thank you.

MS. BEAUCHAMP: We're shifting to the other side, you can tell that. I'm Carolyn Beauchamp. Thank you for listening to me. I'm President of the Mental Health Association in New Jersey.

It feels to me as though the train -- and I'm going to speak in clichés, which I don't like to do -- but the train has left the station and IOC has been put on that train. And perhaps just listening to all of the confusion and the questions and the difficulty in figuring out this bill,

perhaps this is not good timing. We have had an incredible year-and-a-half with leadership from Governor Codey reducing stigma, adding \$40 million plus a huge housing trust fund to our mental health coffers, which -- this has never happened to us before. And the feeling that I get is that, please, let's get as much as we possibly can for mental health now, because we may never get this chance again.

I don't disagree with that feeling. It's simply when we try to tackle something where we are forcing people to treatment when they have not done something illegal, and that is not done in any other medical practice, it is a very serious issue. We have not had the whole mental health community involved in that discussion. The Task Force had difficulty agreeing on that discussion. It's a very, very serious thing.

And I think-- I'm sorry, I forgot to tell you, in case you don't know, we are opposed to the bill, because we find it unclear, confusing. It leaves many questions that are absolutely critical, and because we are absolutely opposed to involuntary outpatient commitment.

It seems to me that we agree, and I think people who have spoken, we all agree that timely treatment in the public mental health system is what we all want. What we're not recognizing and we're not, I think, clear enough about is that we need much more in the way of a mental health system before we're able to impose any kind of treatment on people. What are we going to do if we commit someone to treatment and there's nothing there for them that's appropriate? What are we going to do when places are backed up and all we have -- our only choice is forcing injectable medications on folks? There's a question, again, about whether

this bill allows forced medication. We don't know that, but that's an enormous issue.

We know that the 40 million and the trust fund will not be up and running for a period of time. And yet we're trying to impose a bill on top of that. It seems more reasonable to take a close look at how the 40 million and the trust fund and all the other money deals with the folks that we're most concerned about. We need an evaluation, we need an evaluation component, and we need to be able to be responsible in terms of how we proceed.

And what we know, as we look at research-- Because we say, why is this being brought up state after state after state? Because there is desperation and there is enormous need from families and from consumers, because the mental health systems are probably, across the nation, underfunded. And people feel that if there's one thing they can do, if they can get medication into people, it will help. And I understand that need. But if we don't develop our resources, we are not right now in any position to treat people who have both mental illness and substance abuse. Co-occurring disorders, which is what that is called, is the most prevalent issue and the most prevalent problem that cycles people through hospitals. And yet we have almost no treatment across the state that treats both conditions. And it is not included in the 40 million in the Governor's Task Force report for this year, for the budget. We hope it will be involved in next year's budget. But that's an enormous treatment block that isn't being addressed. We also know that housing takes a while to get up and running, and here in New Jersey, housing is an enormous problem. We have people

in hospitals who are ready to come out, and they can't because we have no housing capacity for them.

Research is absolutely inconclusive, it's conflicting. I don't know if anyone is going to go into any great detail about research, but the one thing that research does agree on is that intensive treatment is what seems to make the difference in whether people accept treatment and get better -- intensive treatment. We have some of that here, in terms of PAC teams, but it doesn't reach enough people. Again, we need to broaden our services.

We know that 34 states have IOC laws on the books. About 42 percent of them use that authority. Some of the reasons are similar to our concerns. You can pass a law, but can you spend the money to create a system of intensive mental health services that will really make it work? There has to be that backup. There's a concern that a therapeutic relationship will be broken as people see people who are involuntarily forcing them to do something. They see them more as parole officers than as therapists.

There's a lack of clarity about consequences. If a consumer does not follow what they're told to do, what are we going to do with them? Are we going to put them in jail? Are we going to commit them against their will to an institution when that's perhaps not what they need? How do you follow up on something like this?

There's a reluctance of judges and police to enforce IOC when no crime has been committed by people that don't pose any threat at that moment to themselves or to others. We also know, through looking at the results of the survey of Kendra's Law, that there's a tendency to target

minorities. We know that two out of every three court orders in New York were levied at people of color. And yet, we are the least prepared to provide mental health services in minority communities. We have not even learned how to access folks from other colors -- from both Hispanics and African-Americans. We are very, very slow to move in that direction.

I will simply finish up by saying that the Governor's Task Force had difficulty, also, dealing with this issue. And they finally agreed that they could recommend a current need to adopt IOC, only if there were four principles that were put in place: One of them was, the first one, was that the community treatment would reach a safe and adequate level. That does not exist. That simply is not there, and we don't have it. The 40 million won't make it happen either. So we've already broken that promise to the Task Force.

The dangerousness standard should be clarified. It's very confusing. I'm confused by it, and I helped write the first screening commitment bill. I'm confused.

The commitment standard applied to inpatient and outpatient should be accompanied by a least-restrictive principle. Jean Ross spoke to you about how do you put someone in an outpatient setting if you found them dangerous? How do you medicate them? How do you carefully help someone get on medication who is confused, upset, and needs a doctor and nurses? What do you do with that?

And the last one is that they wanted a promise that there would be an evaluation within two years, and then again within five years, of a variety of things, including who was actually being helped by this kind of law. And that is not part of the bill as well.

So my sense is that if there's a way to slow this process down, it would be helpful. It's so serious and it could have such effects on so many people. And it feels like we're rushing to get this train through before Governor Codey leaves, because he's been our champion. And I want us to be careful how we proceed.

Any questions?

SENATOR KARCHER: Yes.

Senator Buono--

Actually, myself, I wanted to say the good news is we have completed four speakers and we have seven left to go. So with that in mind, yes, you may ask questions.

SENATOR BUONO: I just wanted to say that-- I wanted to just really comment on your testimony. I think that what your testimony, along with all of the others, really convinces me is that it's an astounding lack of consensus on what exactly this bill does or does not require.

MS. VERNA: Yes, it's scary.

SENATOR BUONO: And I think it raises a lot of questions that I think need to be examined and definitively resolved before I'm ready to make a decision one way or another. And like a lot of ideas, they're good -- a good kernel of an idea, but needs to be fleshed out and needs to be examined. And it's true, the more questions you ask, it seems as though the more questions are raised.

MS. VERNA: Senator, when we worked on the first screening commitment bill, it took us three years. The mental health community met from every aspect of it, and it took us all that time to hash it out, because it

was so hard to balance rights and treatment. If we're going to redo it -- and I don't disagree that it needs to be redone -- we're going way too fast here.

SENATOR KARCHER: Thank you.

MS. VERNA: Thank you.

SENATOR KARCHER: Next, we'll hear from Richard Hyland, former Superior Court judge, who is testifying in favor of the bill.

And I would like to reiterate, in the interest of time, I think we would like if you could as quickly and in as abbreviated a fashion as possible.

**RICHARD S. HYLAND, ESQ.:** I timed myself. I think I'm less than five minutes, when I timed myself this morning.

SENATOR KARCHER: Terrific, thank you.

MR. HYLAND: Thank you very much, Lady Chairman and members of the Committee, particularly for staying at this late hour.

I live in Cherry Hill, New Jersey. And as I served as Superior Court Judge in Camden County and for a period of time was assigned to the Civil Commitment hearings held at Lakeland County Psychiatric Hospital and Ancora State Hospital, my experience was unsettling in two respects. First, at times it was clear to me that in certain cases the legal procedures I was applying to the patients at the hearing were far more concerned with their "constitutional liberties" than their safety and well-being.

Secondly, I was struck by how infrequently members of the patient's family attended the hearings. On the rare occasions when they did attend, it was usually to express their fears of what would happen when the patient stopped taking their medication, and they would relate the serious consequences that took place as the patient's condition usually quickly

deteriorated. This was information that the hospital psychiatric staff could not provide and, of course, the patient was reluctant to admit.

As a result of experience I've had in recent years with a family member, I have gained insight as to why otherwise loving family members may no longer involve themselves in a patient's care and treatment. Frankly, the present procedures simply exhaust the patience of the family, when time and time again they have to jump the high legal hurdles placed in their way by the existing system. Unless you have gone through the experience of trying to commit a family member who has stopped taking their medication and is psychiatrically deteriorating, you have no idea of the frustration that one encounters. And as a lawyer and as a former judge, I was no less frustrated than the average person dealing with this problem.

As a former judge and a former member of this Legislature, I urge the passage of this legislation, and also do so based on my personal, painful experiences. I recognize New Jersey's present and future fiscal problems. However, the support that a patient can get from his or her family is a resource that doesn't cost the taxpayers anything and should be utilized to the fullest, not discouraged as in many cases it is under the present system.

And I want to pick up on what Senator Cardinale had said about privacy issues. Families, unless the patient is willing to give his consent, are shut out of the therapeutic process. It's like asking a surgeon to operate blindfolded. And as a practicing attorney, I want to learn all the information I can from my client and those who may have a different story than my client. And I wouldn't go to court unless I talked to other

witnesses, too. It's-- Under the present situation, if the patient refuses to allow that, then the doctor or therapist only gets one side of the story.

In conclusion, this Committee, I believe, is familiar with the tragic circumstances involving the murder of Gregory Katsnelson by a psychotic individual who stopped taking his medication while living in his family home. He started a murderous rampage by a confrontation with his mother, who he stabbed repeatedly after she refused to give him money for cigarettes. He tied up his 5-year-old niece, who witnessed the brutal slaying, and then in his delusional travels came across a beautiful and innocent 11-year-old boy on his bicycle, Gregory, who became his next victim. And I know, Senator Allen, you're familiar with the case, because it took place in neighboring Burlington County.

I followed it closely, including the sentence of the defendant, who received a life sentence. This is a classic case of a tragedy that could have been prevented, and which has been and will be repeated again and again unless our laws are changed.

Just recently, in Camden County this Summer, a young boy, Jevon Lampkin, who refused to continue with his medication, took off from Somerdale, New Jersey, went to Philadelphia. And in the middle of the day, took off his clothes and tried to get into a police car. And the result, he was shot by the Philadelphia Police. His mother doesn't understand why the system didn't respond to him, and that's what goes on.

I heard a lot of testimony today about the individual rights and personal needs. I didn't hear any testimony about protecting the rights of citizens of this state, which is the foremost responsibility of the State and this Legislature. Frankly, the State of New Jersey did a lousy job in

protecting Gregory Katsnelson from the defendant, who stabbed him brutally several times. The upshot of the system's focus on individual rights in this case, is that the defendant is now enjoying very few of his constitutional rights while he's incarcerated for the rest of his life. And of course, Gregory has no rights to be protected any further, and his family must now live with the tragedy of this case.

This bill should not be put off. There are issues which a court of competent jurisdiction will decide -- on the legal issues. You were confronted with the same situation when you passed Megan's Law. At that time, the civil liberty groups said all kinds of things were wrong with it, and it never would stand constitutional muster. They were incorrect; it has stood constitutional muster. Twenty-five years ago, if you had presented Megan's Law to the Judiciary, they probably would have found things wrong with it. But the courts do listen to the public and do listen to the Legislature, and we have a very serious problem here, that's not being attended, in taking care of individuals -- not blameworthy because of their own mental illnesses -- who are a threat to others and to themselves. And the primary cause is the failure to take their medication. So a very simple situation.

I've heard talk here today -- it seems to me the bill provides, as I read it -- and I'm not an expert on the bill -- that one of the reasons that a person can be readmitted for evaluation and stabilization is their failure to take medication. And that should be something that is so obvious, because they were only released because the medication was working in the first place. So I think this bill is a good first step. It may have its imperfections. The legal challenges will happen whether you change it or not. So I say cut

it loose, let's see what happens, and you may well end up saving the lives of a lot of people in New Jersey by the prompt passage of this bill.

SENATOR KARCHER: Thank you, Judge Hyland.

SENATOR RICE: Madam Chair?

SENATOR KARCHER: Are there any questions for the judge?

SENATOR RICE: I don't have any questions, but I don't want you to leave without knowing my feelings for the record. I don't disagree with you, but I'm very much concerned about everybody's rights, not just individual people's rights, in general. And we have to do a balancing act. But let me just say, for the record -- this is me, no one else. I don't want to offend anyone. The courts have shown "my community" how they treat rights when they're supposed to balance them. I'm just being honest about that. What I mean by that is that if everything is equal, we're still not treated equal, for whatever reason, in "most" of the court's decisions when it comes to these kinds of things. And I'm not saying that we don't have some needs and we don't have bad people. I think that's the concern you hear when you hear organizations like POPs and other folks of legal minds, as well, because keep in mind that within these organizations we do have former judges, and intellectuals, and attorneys too. I don't need a response, but I just wanted to at least be on the record to say I agree with you. We've got to face it, but we've got to make sure we do it-- Nothing is perfect. We're not going to be perfect with the bill. But we must make sure we do everything we can to get the people to come to me who want the ability, as family members, to do something more. At the same time, we have to make sure we do everything we can to protect as much of innocent people's rights, that do not need to be in the system, as we can.

So I don't need a response, but I wanted to be on the record with that. I live this stuff.

MR. HYLAND: Senator, if I may respond just briefly. This case in Somerdale I talked about, the mother, Sharon Lampkin, and her son, Jevon, was a young black man, who unnecessarily died.

SENATOR RICE: I understand that. And you have a lot of them in prison.

MR. HYLAND: This goes across race most of the time.

SENATOR RICE: There are a lot of people in prisons because of the status that was given to them by the courts that need not be there as well. That's my point. We want to balance all that.

SENATOR KARCHER: Thank you.

Next, we'll be hearing from a panel of -- Steve Deschaines, from Ocean County Mental Health Board; and several consumers -- Marcia Coward, Gerald Higgins, and Valerie Fox -- consumers in favor of the bill.

UNIDENTIFIED PERSON FROM AUDIENCE: Should we all go at the same time?

SENATOR KARCHER: Yes, thank you. I think you'll need to pull a chair, to have you all-- The chair that's right behind you, bring it.

I'm going to try to encourage you to stay to the five minutes, since there is a large group of you -- five minutes each. I think it would be well appreciated by all the others that need to follow you.

Thank you.

S T E V E D E S C H A I N E S: Okay. I hope this is working. (referring to PA microphone) Is that one -- it applies to this one also?

SENATOR KARCHER: No, just that one. State your name, and thank you.

MR. DESCHAINES: All right. My name is Steve Deschaines, and I'm a consumer. I have schizophrenia. I contracted it about 25 years ago and have been struggling with it. I was hospitalized five times for it, which is the inpatient that we speak of, at the State Hospital, and released. And each time I was released-- Well, basically, I should explain, first of all, that the illness is an illness. It's clinically quantifiable and diagnosable. When a person comes to you, as a psychiatrist, or when they go to PES -- that's the emergency screening center, which is the first part of the system -- that's where they'll figure out what's happening with you, look at you, speak with you, interview you, and decide what you need.

The next phase for a person like myself with schizophrenia, which is usually contracted when you're young, in the late teens, or early to mid-20s -- which is why it's difficult to deal with, because it strikes you when you're just starting your life and you don't have much to go back to when you get better, because you didn't get college and so on. But you start with the screening. Then the next level would be short-term care, which might be hospitalization. And they figure that out -- the doctors and the clinicians will decide these things. Then the next level, if you really need it, if they decide you need more care, you go to the State Hospital, which is where you're forced to take the medicine if they feel you need it.

When you first contract schizophrenia -- which is what this bill mostly applies to, the majority of the people it applies to would be schizophrenics -- they try a number of different medicines to see which one is right for you. It's based on your, basically, genetics, your metabolism. In

my case, it's Trilafon. That's the one that they found. And some of the problems they have with getting people to take the medicines, to stay on it, is a lot of the side effects of the medicine can be quite disturbing and painful, and that's one of the reasons it's such a tough illness to deal with.

So, in my case, once they figured out what medicine was right for me, then they get you to a point-- It's not a fixed amount, but they decide that by the care team, and then they decide when you will be released. When you're released you're -- that would be the outpatient mode you come from -- you're stabilized, you're well, on the medicine that--

Oh, by the way, schizophrenia means "double mind." In other words, you're you, and then when you get to schizophrenia, you start to become-- It's almost like a split personality, but--

UNIDENTIFIED PERSON FROM AUDIENCE: Not at all.

MR. DESHAINES: Okay. I know there's debate about--

SENATOR KARCHER: Excuse me. Excuse me. We're taking his testimony. Please do not give any comments from the audience, please. Please respect his time.

UNIDENTIFIED PERSON FROM AUDIENCE: It's a myth.

SENATOR KARCHER: Excuse me.

MR. DESHAINES: Well, the main thing that happens is the person begins to believe things that are not true -- called *delusions* -- whether he's hearing audible voices or-- Most of it is audible voices, with schizophrenia. It could be just things that he believes that aren't true. So he becomes what we call *delusional* and this affects his life and, possibly -- not possibly -- other people's lives. If you're married, it could be very difficult to deal with that, if the person you're married to has trouble. In

my case, it was my mom and dad. I was still at home. And that's one of the things that this bill would help with, is the people who have to deal with you when you're ill.

Now, my point about all this is that there's a system in place and there's a definite clinical diagnosis to schizophrenia, my illness, which is predictable. I know it was brought up before about the bill and it's talking about the future -- the person will possibly become a danger to themselves and others. In other words, when you're in any type of medical condition-- If you break your leg, they set it, they put a cast, and the doctor usually can give you a date by which you'll be healed, when the cast can be taken off. If you have a heart condition, they can usually pretty well predict the phases of your illness. If it's cancer, the same thing. And the cure applies the same way. Some illnesses they can cure, and some they never do. Schizophrenia is, as far as I know, you never get over it. You have it the rest of your life, as with diabetes. That's why the medication is so important.

Now most people, when they have diabetes or a broken leg or any type of illness, most people try to cooperate with the care they're given when they're an outpatient from the hospital. If they have a heart condition -- there are some people who just continue smoking when they have emphysema, and so on, and people who continue eating high cholesterol foods when they're warned against it. But in general, people don't want to die and don't want to be sick.

Now, the difference with the schizophrenic is that he is not himself, which is what I was trying to say before I was interrupted. You become a different person. You start to follow and believe -- it's almost like

you're a cult member. Your condition has convinced you of things about yourself and about life that aren't real. So that's the reason they use the terms *in danger to self or others*, because a lot of these people will end up trying to commit suicide and they'll also -- they may hurt other people. Or they may just do things that are -- jumping off a roof. They think they can fly. They jump off the roof. That may be dangerous.

So the goal of care is to keep them well, and the medicine is really the main thing that does it. So that's why it comes down to -- in outpatient, when you're released from the hospital, you're stabilized and made well. And the outpatient portion of the treatment is where you're almost on your own recognizance as to whether to take your medicine or not. And I think that's what the bill is targeted at. At that point, you're out of the hospital where they don't force you any more and you're offered--

People were mentioning before that we need to change the system or add more money to the system. Maybe that's true, but there are, in my case, there are always options offered to you. We have programs for you, and you're sent out there. And before they release you, they make sure where you're going to go and they try to arrange everything. But, in my case, my parents were nice enough to take me back home when I was released. They would have to sit there and watch me go downhill and become my other self, confused self, because I decided on my own to stop. And that's where this bill would come in, is to enable the system itself to say, "You're out of the hospital setting. You have a condition which needs this medicine to keep you you, and you have people who love you and are watching you go into God knows what."

And even when my parents would call the social workers, they'd say, "We can't do anything. We can't make him take the medicine." They tried every branch of the system -- the police department, legal issue-- Everyone said, "Our hands are tied." And the thing is that -- I'm almost finished--

SENATOR KARCHER: Okay.

MR. DESHAINES: --is this is designed for the part of the system that the person is -- he needs someone to, I'd say, force him. In other words, if you-- You run the risk with the person who decides to go off this medicine, that, as they use the term, *will hurt himself or hurt others* -- is predictable and it happens all the time. A lot of the homeless people are people who aren't being allowed not to stay well, a lot of the people who commit suicide. And everyone suffers for this in society, whether it's someone they hurt or someone who watches them hurt themselves. And you may argue about the technical, legal points about the bill -- that I don't know much about. But the thrust of the bill, in my point, is valid. That an outpatient -- at the outpatient part, is designed to make sure that people have a definite medical condition, that they've been diagnosed, they have it, and if they need the medicine to be themselves and stay well, then why shouldn't you.

And I'll just finish with this. If our society decides that when they're inpatients that they can force them to take it, and we also decide that people who don't have mental illness at all can't drink when they drive or they can't take certain drugs because those things are decided to be dangerous to them and others, it's not good for the public, then why can't we decide in this case, with a specific small group of people who have a

condition that's able to be figured out and clinically known -- why can't we force them to stay well and stay themselves so they're not a danger to themselves or others.

SENATOR KARCHER: Thank you, Mr. Deshaines.

I think we'll proceed down the table.

V A L E R I E F O X: Okay. My name-- Well, first of all, to the Committee, I want to say thank you for having the hearing and letting us speak. I am a proponent of involuntary outpatient commitment. My name is Valerie Fox, and I've lived with schizophrenia for 40 years. So I've seen many, many changes in the system, and I've dealt with schizophrenia for 40 years, from a young woman to a woman approaching senior years. So, within five minutes, I hope to give you a fine synopsis of why involuntary outpatient commitment legislation needs to pass now and not in a year from now.

Prior to being diagnosed with schizophrenia, I worked for an airline in Rockefeller Center in New York in a very good job, and I knew the fine things New York offers. I traveled and, in general, was very happy.

With the diagnosis of schizophrenia, my life changed as I think everyone's does with a mental illness diagnosis. I had to learn how to live a good life with schizophrenia, and at times I had setbacks in my journey of recovery. That is what I will speak about today.

The low point of my living with mental illness was being homeless and mentally ill for a two-year period. I was preyed on and abused because I was very vulnerable and a target for predators. Toward the end of this homeless period -- and this is factual. I never write anything that isn't factual from that period. Toward the end of this homeless period,

I found a pair of scissors on the street which I immediately picked up and planned to use the next time anyone tried to hurt me. Wandering in that state of mind, there would have been a next time. The consequences of this act may have caused me to be killed by the predator, or possibly kill the predator. Had I killed someone in this state of mind, I probably would not remember why I acted violently when I, again, would be taking needed medication. I may have been in prison for the rest of my life or I may have been killed. And why? Because I had no insight. I was ill, and therefore I refused to take needed medication.

Today, because I did get needed treatment, I am enjoying the many things life offers. I work. I drive a nice car. I live in a nice apartment, and I have relationships with friends and family. Today, because I received treatment, I am, as I had always been when healthy, a law-abiding, decent person pursuing my dreams and goals.

Please help other people who cannot help themselves because they are too ill to know they are ill. It is logical and it is humane. A person lost in delusions and hallucinations cannot help himself or herself. And I thank you very much for listening.

SENATOR KARCHER: Thank you.

MS. FOX: You're welcome.

**GERALD HIGGINS:** Good afternoon, Committee.

My name is Gerald Higgins. First off, I'm a consumer, and also I was on the Advisory Committee and the Hospital Committee of Governor Codey's Mental Health Task Force. For the most part of my life, I've been a consumer. I spent several years at Greystone, including -- at Trenton, and Klein Forensic. And in my younger years, I was also a patient at the Essex

County Hospital Center, formerly Overbrook. So I'm very knowledgeable concerning mental health issues.

I've already submitted my written testimony to Senator Vitale, so I need to rehash the vital points, which I've made an issue of numerous times at our meetings to my peers on the Advisory Task Force, using my friend as a prime example, whose name I cannot mention. So I will refer to him as Nicholas, using several examples to emphasize why involuntary outpatient commitment should be enacted as law here in New Jersey, as it is successfully in 42 other states already.

First, when my friend Nicholas could have very easily killed some innocent people, or at the very least, maimed them for life-- On one occasion I had to actually take the steering wheel from his hands to prevent him from running over a total stranger, because he believed the person made some derogatory remarks against him. Then again, at the ShopRite on a Friday evening, when the store was very crowded, Nicholas went after someone he didn't even know for the same reasons. Then at a mall on a Saturday, while the mall was extremely crowded, Nicholas went after another stranger again for the same reasons. I would like to point out that all three strangers were an ethnic race, black. I, as well as Nicholas's parents, brought this to the attention of the outpatient services who oversee Nicholas -- the PAC services of Morris County. And their response was always the same, where they stated there is nothing they can do until something happens -- where Nicholas has to actually act out, attack somebody first, before they can do anything.

Again, I must say, are we to just sit around and wait for a tragedy to happen first? It wasn't until after Nicholas attacked me, while I

was sleeping, by spraying me in the eyes with a chemical where I could have gone blind -- a nightmare I will remember for the rest of my life, especially coming from my best friend. It took all that before the PAC services finally acted on it. I confiscated Nicholas's car keys and kept them at my apartment for his own safety, as well as for the safety of others.

While there, Nicholas wrote out several checks made out to the Ku Klux Klan in the amount of \$15. And I will quote exactly what he wrote. Now, this is nothing personal if anyone is here of ethnic race. I don't want you to take this to heart -- but he wrote in the memo section, "For all dead (expletive)." Yet, on another occasion, a while back, Nicholas purchased a hand gun to kill his grandfather, but fortunately someone found the gun and disposed of it. I'm almost finished here.

Just recently, Nicholas's brakes on his car failed and he declined to have them repaired. So, as a result of this, he ran through a brick wall of someone's home -- through the kitchen wall. On a final note, I would like to sadly point out, as a result of that incident, nothing happened, or at least right away. It took 10 days to get him into a hospital. The incident occurred on August 1, but Nicholas was let go by the Psychiatric Emergency Services, known as PES. It wasn't until Nicholas's mother called the PAC services, as she was very upset and shocked by them letting him go. She had put a lot of pressure on them, so Nicholas was finally hospitalized on August 10, just one day before the last hearings held here on August 11, on IOC.

The psychiatric Emergency Services of Morris County, as well as the PAC services of Morris County, are a mockery. I don't need to say what would happen if Nicholas was driving on a major highway. We would

be making funeral arrangements instead, or for some innocent people. When Nicholas is taking his medication, he does quite well. But when he's not, he's a tragedy waiting to happen, as so many other consumers are. Nicholas's parents are elderly people and are not in the best of health -- unfortunately, could not be here today, so they asked me to speak for them as well.

Thank you, Committee. That's all I have to say.

SENATOR KARCHER: Thank you.

**MARCIA W. COWARD:** Good afternoon. I'm Marcia Coward. I live in Moorestown, New Jersey. I am not a consumer. I am the mother of William Mark Coward, who died in 2001 of mental illness. I am here on his behalf and the behalf of everyone who gets in the straits of my son. My son, a brilliant biostatistician, had rapid cycling bi-polar illness. And we've heard very little about bi-polar illness this afternoon. Bi-polar illness is a mood disorder with great highs and lows, or sometimes highs and lows within the low, and highs and lows within the high, but it is hard to control. It is a very difficult disease. It is a disorder of the mind. My son was quite brilliant, and it is very hard to get it regulated.

Now, Mark also was an addict. And many people you've heard today are addicts, in addition to being mentally ill, because they want to self-medicate. In my son's case, I would believe that probably on his low points he felt depressed and wanted to perk himself up, whatever. I don't know. I wasn't in his mind.

However, I want to say one thing about the noncompliance. I was at a conference this last Saturday in which many consumers were discussing how they achieve wellness and recovery. And that is where it's

all about -- helping people to become well and helping them to recover as best they can. It may not be 100 percent, but it is recovery. And one of the people spoke about the three needs of treatment. The first is medication where it's called for. The second is other types of therapy and care that is on a professional level. The third is support, which includes the family, different support groups, the community, and all of that.

He said that just as location, location, location is what is important to real estate, compliance, compliance, compliance is the key to having recovery. And I feel it's true. I also would like to dispel a notion that not taking medication is only something that someone does out of some kind of reaction to others. People may stop taking medication because temporarily they feel just great. The medication worked, and therefore they think they don't need any medication -- "Now I'm fine." So there are many reasons for not taking medication.

One thing I would like to point out is that when the system believes that it should wait and do nothing, it isn't that nothing then happens. Much happens -- there are episodes, there is disintegration, there is a battle in the family. There is lack of job -- people losing their jobs, people not doing their jobs. And billions of dollars in cost to society.

So I'd like the Committee to please look at the overall cost to society of having people untreated who should be treated. There are family implications, community implications, and individual. And we've already heard some people eloquently say that those who are not treated, who are at most risk for being dangerous to themselves within a reasonably short period of time, are themselves being deprived of certain rights. Now, I

think the issue on what is dangerous is, indeed, interesting. But I'd like to tell you a little story about my son.

My son was hospitalized hundreds of times, and was in prison in this state, and was in many homes and many Oxford Houses, and in and out of this and that. At one point, I called an HMO that was responsible for paying for more care in a hospital. It was clear from having spoken to the people there that he needed more care. And I called the HMO, and I said my son needs more care. And the woman said, "Well, Mrs. Coward, he may have said he was going to kill himself, but he didn't have a gun." I said, "Are you telling me that if he said he was going to stand in the front of a truck, you'd have to see the exact truck coming down the road that he would be in front of?" And she said, "I guess so."

So these are all things that we must consider -- what are we doing to society, to families, to individuals. I applaud the efforts that have been made in this state in examining our mental health system. I applaud all moneys that will be devoted to housing and treatment. We know there is much, much, much more to be done. And though I can see some imperfections in this bill, I think that they could be worked out, and I do believe that with more research and a little luck and some guidance from psychiatrists, the idea of the dangerousness issue can be resolved.

I thank you very much for giving me this opportunity to speak.

SENATOR KARCHER: Thank you, Mrs. Coward.

SENATOR RICE: Madam Chair, a quick question to the Chair and the staff. Do we have a copy of any written testimony from the speaker, and also the Nicholas scenario?

MS. SEEL (OLS Committee Aide): The transcript is being prepared. So if we don't have written testimony submitted, there will be a transcript.

SENATOR RICE: All right.

SENATOR KARCHER: Dr. David Reskof, Dr. William Greenberg, and Dr. Anna VanderSchraaf have to get to office hours, so we're going to see how quickly we can hear your testimony.

WILLIAM M. GREENBERG, M.D.: Dr. Reskof had to leave.

SENATOR KARCHER: Oh. And Dr. Reskof already had to leave to get to the office hours.

ANNA VANDERSCHRAAF, M.D.: I have given some copies of things that we would like to hand out, in addition to what we're saying here.

SENATOR KARCHER: Thank you.

DR. VANDERSCHRAAF: Thank you for the opportunity. It's late and everyone has given such good testimony. Dr. Greenberg is the former President of the New Jersey Psychiatric-- And I'm in charge of Legislative Action Committee, and very interested in all what you people are doing, and trying to read in the bill. In preparation of this, I know that time is limited, and I'm used to that.

I reviewed the earlier attempt in New Jersey to address the problem of linking persons with recurring mental illness to available and effective treatment. S-327, Senator Bark, and companion bill S-999, from Assemblyman Chatzidakis -- I hope that's how you say his name -- and S-1640, Senator Cardinale and Codey, and cosponsored by seven senators

who were originally here in this Committee earlier. So I don't think I have to go into the facts which have been really expressed by many people, and the Committee is probably aware of.

S-2760 expands the criteria for involuntary commitment to those who would relapse and deteriorate unless they are treated. It also is a bill that recognizes the seriousness of depriving an individual of their liberty, such as things in this bill of informing the patient of their rights, treatment plans, and changes as they occur; and including the patient in discharge planning -- really all point to maintaining respect for the patient. But if you hear-- For instance, with representation of counsel, are spelled out in a timely fashion.

The treatment plan and the choice of the least restrictive place will be carried out. An important detail here is the inclusion of the accepting provider, who accepts the case in point, so that there is no fallout between the mandate and the execution of it.

I have this question in the wording of Section 2, under 2H, on Page 4, which defines dangerous to self. In a few lines further, it says, "incapable of maintaining or providing the essential medical care." And I don't know whether that should not be expanded to medical and emotional care, or mental care? And then a few sentences further, it says, "that would lead to serious physical debilitation." And maybe there the word of *emotional* or *mental* could be inserted. That is one of the points I looked at.

SENATOR RICE: Through the Chair, what section was that?

DR. VANDERSCHRAAF: That is under Section 2, under 2H, on Page 4.

SENATOR RICE: Okay. Danger to self.

DR. VANDERSCHRAAF: You know, the definition of dangerous to self.

SENATOR RICE: Through the Chair, what was the question again?

DR. VANDERSCHRAAF: It speaks of medical care and medical deterioration, and maybe that should be expanded, too. It is not just medical, but there are also the mental condition of the person.

SENATOR RICE: Through the Chair, are you indicating this needs clarity? You say you have a problem with it, or you need clarity?

DR. VANDERSCHRAAF: No. I thought it might be inserted so that it is not only the medical/physical condition of the person, but that there is also attention paid to the mental condition.

New Jersey can be the 47th state, I think, to have a mandatory outpatient program preventing relapse or deterioration in patients who currently may not be dangerous to self or others, but whose relapse would predictably lead to severe deterioration and dangerousness. There are studies available. There are only two random, precontrolled trial studies. The one in Duke is very notable for that, which says that the length of this commitment, so to say, is important. So of the 180 days, because a short -- the studies that look at short-term results are possibly not that representative of what really can be done. And the other part is that in the Duke study it says that the patients who were under court order and had intensive treatment-- First, there's a controlled study who had only the intensive treatment. And then there was a third group that was not controlled because they were violent offenders, and they had the court order.

So the first two groups, in 90 days, there was not much difference in rehospitalization and all that. But if you look at 180 days, there was definitely a better number under the court-ordered treatments.

I will be short. So the length of treatment -- I told you about, and the studies about. So I have here a document that sort of helped me provide a few sentences I want to speak about. I will, if I have a minute, I will just look at these things. Again, if properly implemented, mandatory outpatient treatment can be a useful tool in an overall program of intensive outpatient services aiming to improve compliance, reduce hospitalization rates, and decrease violent behavior among a subset of the severely and chronically mentally ill. It should not be reserved exclusively for patients who meet the criteria for involuntary hospitalization. It should be available to help prevent relapse or deterioration for patients who currently may not be dangerous to themselves or others, but whose relapse would predictably lead to severe deterioration and/or dangerousness. And that can all be predicted and based on the occurrence of such episodes in the recent past.

That's why a good history -- again, taken with the help of families, for instance, of the patients -- of previous occurrences of illnesses will be helpful. And again, it should not be reserved exclusively for patients who lack the capacity to make treatment decisions and should be available to assist patients who, as a result of their mental illness, are unlikely to seek or comply with needed treatment.

And maybe in all of what I heard today, the diagnosis of severe mental illness is that mental illness is not something that is a continuum in several cases, in several diagnoses. This condition can come and go, and the patients can have a very good period of functioning in between. But when

the next phase comes in, they might not be able to have the insight into what has happened to them before, and therefore resist or not make use of the available treatments.

Anyway, the rest of it, I think, is all in the bill, and that's all very commendable. And here is a last piece. We shouldn't really wait for all the research that might say, "This is good," or "It is not good," or "There is no result." And second, there is no evidence, okay, at this point that the judicial order reduces or offsets the positive effect of enhanced treatment. The only question is whether it has additive effect. And the Duke study suggests that it does.

The matter of interns and available community services -- this bill might really commit the Legislature to provide the funding which is needed to provide enhanced community services for all patients, whether or not they are subject to commitment order. And in a political context, enacting a mandatory outpatient treatment may provide the leverage for increased funding for community mental health services and particularly for the severely mentally ill population.

Thank you for your attention.

SENATOR KARCHER: Thank you.

DR. GREENBERG: I'm Dr. William Greenberg. Thank you for the opportunity of hearing us all here. I know the hour is late, so I'll try and be brief as well. I am the immediate Past President of the New Jersey Psychiatric Association. That's an Association of 900 psychiatrists in New Jersey. That's the district branch of the American Psychiatric Association. And I think you have before you an editorial I wrote -- I think Dr. VanderSchraaf distributed it -- and also a resource document. The NJPA

passed a resolution sometime back on assisted outpatient treatment. I talk from that perspective; also from the perspective of the last quarter century practicing and treating thousands of patients -- inpatients, outpatients, people in emergency rooms in New York and New Jersey -- mostly in public health. That's been most of my career.

I think you've heard compelling testimony. I believe everybody who has talked to you has been very sincere. To cap a few points, first of all, this is not a new idea, obviously. It doesn't mean we should copy what other states are doing. But at this point, we have many different models. There are 43 states that have passed legislation. And I believe different models have different virtues. I don't believe there's one right answer. We can look from the experience of other states and choose something that appears wise to us. So this is certainly not a new idea. It's not an attempt to deprive a large percentage of the population of rights, but I've been involved in similar issues before.

As a matter of fact, the Public Advocate, or mental health legal services, never seemed as interested in forced medication, because they felt that this actually served the -- limited the interest of less restrictive environment. It managed to get people out of the hospital, who otherwise were going to be there for weeks or months, or transfer to the State hospital. So in my frequent dealings with this, this is really not an issue that was often proposed. And I did want to bring that out, because it sounded like some people don't realize there is a forced medication provision in New Jersey. There has been since 1983. That's *Rennie v. Klein*, and that follows not a judicial model. There seems to be some confusion in the testimony. Unlike Massachusetts or New York, that have a judicial

model, we have a clinician- and administrative-driven model for viewing issues about forced medication. But that's all inpatient. And actually, I've published several papers and literature about this issue back in the '90s.

As AOT is implemented in New York, it has been used far less frequently than the most concerned individuals anticipated. It has not been used wholesale and willy-nilly. It actually involves more work for everybody. This is certainly not work saving. However, it is work that people should be doing. People routinely fall between the cracks. You're a little bit better, you're out of the hospitalization, and whatever happens to you, happens to you. You may get to the community mental health center, you may not. Your parents may throw you out, because they can't take it anymore. Or you may drift into drugs. You may get violent and assaulted by somebody. There's a large gap in the system there. There is not enough continuity. PAC teams help, but there needs to be treatment, besides supervision.

I think it's been clearly pointed out that part of the problem is, in this illness, part and parcel of the illness, a failure to appreciate what is really going on. And people fail to take medication, even though they're feeling better before, because they can't remember it. And their thinking is not clear. This happens, unfortunately, far too frequently, resulting in numerous circumstances that just lead to an increased mortality, morbidity, people losing social networks, and often losing their lives. People do die earlier with these severe and persistent mental illnesses.

I think there are some things that can be clarified in the proposed bill. In Section 13E, that's on Page 16, there is a notice of change in placement that's required 10 days prior to the date set for the change in

placement. This is from inpatient to outpatient, or vice versa. That's often not feasible. You can't simply wait 10 days if somebody is rapidly decompensating, and very often hospitalizations don't even last 10 days. There's no point in keeping somebody locked up just for additional notice that I don't feel is really necessary. I think that could be streamlined.

In my mind, this bill ought to be used to prevent hospitalizations. I think it should serve liberty interest. It should catch people before they are getting ill. Lastly, I just want to indicate that I think this is really, very much, a very leaky levy. We have holes in our system. It's not going to result in something catastrophic, like Katrina, that everybody wakes up and notices. But these preventable tragedies are happening all the time. If you want to wait around for another year or two, you're really signing off on more mortality, more tragedies happening that we know how to prevent. And the important thing is to be able to plug some of the gaps. This is one of the gaps in the safety net that does not exist, and it should help for more seamless continuity of care between inpatient and outpatient, and helping people when they don't have the capacity to know how to take care of themselves.

Thank you.

SENATOR KARCHER: Thank you, doctor.

Any questions? (no response)

Thank you.

Next we'll hear from Dennise Babin, from the Mental Health Association of Passaic County; and Kelli Cochran from the Mental Health Association in southwest New Jersey.

MS. VERNA: (speaking from audience) Both of those consumers are opposed and both of them had to leave, and I think you have their written testimony.

SENATOR KARCHER: Thank you.

And we've got next, then, George Brice from the Collaborative Support Programs; Margaret Swarbrick, from Collaborative Support Programs; and Marta Espinvera, from the Mental Health Association -- all opposed.

**MARTAB. ESPINVERA:** Good afternoon.

SENATOR KARCHER: Thank you. Good afternoon.

MS. ESPINVERA: My name is Marta Espinvera, and I'm a mental health consumer and a consumer provider from Union County. I also serve at the Consumer Public Policy Committee, at Trenton, which represents thousands of consumers in the State of New Jersey.

On February, 2003, I had a depression episode. After my therapy session, my therapist thought it would be better for me to be referred to a psychiatrist. After I saw the psychiatrist, she came to the conclusion that I was not in a good state. So she decided to send me to the hospital. I did not want to be sent to the hospital. I did not see the reason to be admitted, so I left the doctor's office. Thirty minutes later, three social workers and the police arrived at my doorstep. After a couple of minutes arguing about my state of mind, they told me that I should go to the hospital to be screened. And after that, I would be able to go back home. After they (indiscernible) me, the doctors decided that it would benefit me to stay at the hospital for a couple of days.

Of course, I opposed the decision. I had all my senses. I knew where I was. I felt depressed, but I was not a threat to myself or others. So they popped the question, “Are you going to sign yourself in?” or “Should we commit you?” I was in shock. All I needed was to stay close to my family and I would feel better. I did not need to be committed, nor needed, I, to sign myself. They did not leave me any other choice. It was either I sign myself in or be committed by them. Of course, being committed was not the best choice. It would take me more time to come out of the hospital, so I signed myself in. I felt the doctors who advised me did not hear what I had to say. Anything I said was not important to them. They had made a decision and that was final.

Being forced to stay at the hospital does not lead anyone to recovery. The answer that leads to recovery was far away from what they believe -- being close to the community, family, and friends. Something as simple as attending church meetings or going to a support group would benefit the patient more than staying for a week at the hospital. There is no evidence that by forcing someone to stay at the hospital the patient would have a better chance to recover. If there is no specific data that states that the person is a threat to self or others, neither to property, no judge should commit anyone without specific evidence just because someone thinks it would be the right thing to do.

Thank you.

**G E O R G E H. B R I C E JR.:** Good afternoon, honorable New Jersey State Legislators.

There’s been a lot of talk about medication, on adherence. And with that, in the context, we also have to think about issues of poverty,

issues of lack of social supports and natural supports, which are causing recidivism back into the State hospitals, costly State hospitals, warehousing, and partial care programs, going on average of three-to-five days a week. There are a number of issues that are causing issues of recidivism in the State hospitals, and it's not just medication. It's about having a life.

For example, August 17, the South Jersey Behavioral Health Resources outpatient service in Camden County, that I've been going to for a number of years, cancelled my psychiatrist's appointment about 1:30 in the afternoon, when I had an appointment at 4:45 p.m. at their Camden City office. And because -- knowing the system and been receiving services for almost 24 years, I demanded to see my psychiatrist who was willing to see me. But it was basically because they wouldn't take my Aetna anymore, my Magellan. But they had been seeing me before. It was a billing issue. And yes, they were willing to give me another psychiatrist, but I knew probably in about three weeks I'd be begging for services, thinking about running out of medication, wondering if I'm going to maybe do the pilot program. And let's say they give me a psychiatrist appointment, and it's going to be beyond three weeks, and I'll take myself to emergency -- and we know how hospitals, generally speaking, don't want to give out medication. So then I cost the State more in a State hospital.

Please don't be fooled by my master's in social work degree. I spent 19 years in college -- took 14 courses over to get my bachelor's in social work, six courses over to get my two associate degrees. But I come before you offering almost 24 years as a recipient of mental health services, being an African-American male. I'm conscious of civil rights and have an awareness of the disproportionate amount of people of color and women

who will be affected by involuntary outpatient commitment -- IOC legislation.

The IOC legislation proposed to be implemented in New Jersey will promote emotional distress and mismanagement of limited community mental health services dollars. It would be necessary to administer IOC like the majority of our states that have been unable to significantly improve their community mental health system. New Jersey's mental health system is in need of transformation to a recovery- and wellness-oriented model of services to address past and current deficits in accessing timely services by individuals diagnosed with mental illness, and mental health consumers. Those diagnosed with mental illness -- family members, friends, providers, politicians, and concerned citizens need to acknowledge that a concentration of resources is required to improve access to mental health services.

IOC legislation will further complicate a complex and inadequate system for current and new recipients of mental health services, who want services and have difficulty maintaining and timely accessing needed health care.

In addition, I'm also somebody who hasn't worked full-time for a long time. I'm 43 years old. My first full-time job, which I held eight months, I was denied life insurance because of my mental illness. So, yes, I'm in a community, but it doesn't take much of a trigger with the issues that we have with our mental health system for me to go back to the State hospital.

Furthermore, our current mental health system is plagued by a lack of accountability on the part of clinical providers and agencies -- it's

not all about mental health consumers -- and timely and adverse medication side-effect reactions, unreasonable standards and controls imposed by health insurance companies, excessive and demanding caseloads of clinicians. There is a growing population of people diagnosed with a mental illness, and efforts need to be placed on early detection and prevention, acceptance, and educational wellness and recovery strategies, so people resume roles as contributing citizens of our society.

My message as an employee of Collaborative Support Programs of New Jersey, CSPNJ -- and the only publicly known mental health consumer who is vice-chairperson of Acting Governor Codey's 11-Committee member Task Force on Mental Health -- is that I ask my peers, colleagues, mental health providers, family members, politicians, and concerned citizens to recognize and acknowledge we will further stigmatize people diagnosed with a mental illness by implementing new IOC legislation without placing attention to the complex problems of the current mental health service delivery system. We need to objectively acknowledge New Jersey's significant systematic inability to currently serve adults and the children who will soon become adults.

And I'd like to just go on record, because I demanded to see my psychiatrist without being covered by insurance, I'm supposed to get a bill for the full price. We need to objectively acknowledge-- As you know, people diagnosed with mental illness are not the root of the injustices and/or social ills in our communities. On a daily basis, the chronically normal people-- I'm sorry, I picked that up in Michigan at a conference -- people without a mental illness. On a daily basis, the chronically normal

people commit the vast majority of social injustices influencing culture and defining economic and social policy of the haves and have-nots.

This proposed IOC legislation is not a result of evidence-based practice research and not an effective means of legislating human behavior. Coercive treatment and court-guided principles has not and will not work in the manner of IOC legislation as intended. Furthermore, it is easy to legislate a seemingly vulnerable population who are perceived as not having true valued social roles in society. However, the Constitution -- and yes, the Constitution is important-- However, the Constitution and birth rights ensures equal access to basic fundamentals of recovery and wellness needs such as affordable, decent, and safe housing; food, clothing, health care, respect, and work -- part-time, full-time, and volunteerism -- for one's daily routine of meaning and purpose, and social, economic, and political integration. Additional reasons of recidivism, not just medication adherence: You can be on medication and go into the community and not have supports, nothing to do with your time, and go back to the hospital.

In conclusion, we live in a violent society led by chronically normal people and not those receiving mental health services. IOC legislation diverts the attention from the need for wellness- and recovery-oriented mental health system, and diverts attention from provider and agency accountability who should be implementing evidence-based and best practice models. For example, historically ignored, increased community respite services rather than hospitalizations; the downsizing of partial-care day programs, which tend to warehouse people and many do not address vocational rights; the generic hospital discharge plans promoting recidivism;

discharging to non-existent resources, or lack of support to access resources; no choice or support for outpatient services; and inefficient housing.

Thank you for providing an objective forum to hear testimony against proposed IOC legislation.

Thank you.

SENATOR KARCHER: Thank you.

SENATOR RICE: Can I ask him a question, very quickly?

SENATOR KARCHER: Yes.

SENATOR RICE: Did you say you were the vice chair of the Commission?

MR. BRICE: Yes. The Governor's Task Force on Mental Health.

SENATOR RICE: Okay. Which-- Work on the recommendations that eventually wind up (indiscernible) being a product of?

MR. BRICE: Yes. I've been part of the core 11-Committee team since the beginning, and I was also on the Subcommittee for rehabilitation and employment.

SENATOR RICE: Okay. Did you raise some of these issues when they were making recommendations -- concerns of the concerned?

MR. BRICE: I raised some of the concerns. But even though, with my formal education and my life experiences as a mental health consumer, it's very difficult, with just natural feelings of feeling a bit intimidated. But I hope this is my coming out party.

SENATOR RICE: Okay, I hear you. That's always the case. There's one or two of us that make up the Committee -- don't want to

listen to our experiences; and thereby want to help. I just wanted to be clear that you were vice chair of that.

MR. BRICE: Thank you.

SENATOR RICE: No problem.

SENATOR KARCHER: Thank you.

**M A R G A R E T A. S W A R B R I C K, Ph.D.:** I apologize for before.

I'm here today to share concerns regarding involuntary outpatient commitment, as introduced in S-2760. These concerns represent an analysis of the complex social, economic, and systemic issues surrounding the proposed legislation. Additionally, these concerns are influenced by my personal experience as a consumer of mental health services since 1977, as a family member, as a mental health service provider since 1986, and a researcher and faculty in the area of psychiatric rehabilitation, self-help services, and occupational therapy practice.

This legislation would be like putting the cart before the horse, or keeping the cart there. It is in the best interest of the New Jersey citizens to first focus on systematic, thorough examination of our current system, in order to transform the current fragmented, deficit-based public mental health system in New Jersey. The current policies, practice, attitudes, and programs need to be transformed. If the existing system is transformed, there may not be any need for court-ordered compulsorily treatment. Thus, if the Governor's Task Force on Mental Health places attention on making the multiple necessary changes to move the system towards wellness and recovery, resulting in a more integrated and accountable service system, there won't be a need for this legislation.

Many of the things -- I'll try to go quickly, because many of the things have been somewhat pointed out. But some of the concerns are to properly execute outpatient commitment -- would require a great deal of public resources. When implemented, it results in comprehensive services to those under the order. The outcomes of such services are comparable to other comprehensive, enriched treatment systems, not better or worse. Court-ordered treatment does not ensure quality. Outpatient commitment does not provide a solution to the many existing problems in our existing system that many people do think can be addressed by outpatient commitment. Outpatient commitment may be used inappropriately when, in fact, a person requires inpatient services. Significant civil liberty issues are at risk of being violated and should be seriously considered. Existing law, if used, could address many concerns.

The issue of -- the significant resources, I would think you have copies of that -- I'd try to be quick. We know in Kendra's law, \$200 million additional mental health service dollars were needed to appropriate, to expand service. For New Jersey, this would be \$80 to \$90 million, about one-third of the entire, current State appropriations for community mental health. In fact, because treatment would be court ordered, it may, in fact, take resources from other mental health recipients who voluntarily are receiving these services.

I did give you a bibliography of research, and I also distributed a summary of the Cochrane review, some of the research. The compulsory treatment results in no significant difference in service use, social functioning, or quality of life compared to standard care. You'll see in the research it's really -- we need more quality, random control studies to

consolidate findings and establish whether it is the intensity of treatment in compulsory community treatment or its compulsory nature that affects the outcomes.

Evaluation of a wide range of outcomes should be included in this, if this type of legislation is introduced. It generally is not going to result in quality treatment. There's many issues already with other states. Looking to them, to the problems that -- there's some things that are problematic. It may be used, like I said, when people need inpatient commitment. Civil liberties -- involuntary outpatient commitment, like any restriction of liberty, is and should be subject to due process. Individuals to whom these orders will apply, typically, do not have the resources for legal representation. Provision for these must be included in the passage of the law. It is nevertheless difficult to conceive of another group in society that would be subject to measures that curtail the freedom of 85 people to avoid one admission, or of 238 people to avoid one arrest, in the Cochrane report.

Some concerns can be addressed under existing law. For example, the existing screening commitment law has a gravely disabled criteria that can be used, but rarely used to commit individuals who are not explicitly a danger to self, others, or property. That law also allowed for a broad range of services, that were never funded, to treat this target group. This law was 1987. Many of the things that were supposed to have happened didn't happen -- a lot of the problems we face today. The screening law and commitment law, if fully implemented, with the variety of crisis intervention and hospital diversion provisions, could address many of these concerns. Innovations in providing assertive treatment to individuals, and early intervention teams to visit individuals before they are

in crisis and ready to be screened should be considered, as should crisis residence and other alternative approaches.

Until there is a thorough examination and an adequate array of assessable and adequate service available in the community for those who voluntarily seek them, New Jersey should not pass S-2760.

I've attached the information if you need any further--

SENATOR KARCHER: Any questions? (no response)

Thank you.

MR. BRICE: Thank you.

SENATOR KARCHER: John Monahan, from the Greater Trenton Behavioral Health, was here earlier in favor.

UNIDENTIFIED PERSON FROM AUDIENCE: He had to leave, but I think he left his testimony.

SENATOR KARCHER: Yes, he did.

Thank you.

And Joe Young, from New Jersey Protection and Advocacy.

**J O S E P H B. Y O U N G:** Good afternoon. This is not the first time that I've been called at 6:00, at the end of a long hearing day. So I'm getting good practice in summarizing.

You have my written testimony, and I won't elaborate. I want to just highlight, very briefly, the points that I attempted to make. One is that the research, as indicated, does not support the conclusion that forced treatment is an effective alternative to the standard care that people receive. The references are in my testimony. Peggy just repeated a lot of the things that I was going to say.

The second thing is that the pro's legislation threatens significant intrusion on the fundamental and civil rights of people with mental illness. There's a lot of discussion already today about the definition of disability, the dangerousness in the current legislation. We share those concerns to the extent that New York has been mentioned as a state to look to. New York -- Kendra's Law -- has several more protections for persons who are subject to outpatient commitment than the proposed New Jersey statute. I've cited three of those in my testimony and have given you the full definition of *dangerousness* that New York uses in Kendra's law, which is different from what's proposed.

The third item is, again, without the resources, without funding the current mental health system, as well as the additional services that will be needed, involuntary outpatient commitment is simply not going to work. The studies all show that what works is the additional treatment, not necessarily the coerciveness that goes along with it.

Finally, the current process-- The mental health community, this Summer, has passed two other -- has worked together to pass two other pieces of significant legislation. One eliminating the lien law, the other is the work on the advanced mental health directive. This process has been different from that. This has not necessarily been a collaborative, open, cooperative process. We would encourage the people to open up this process and to allow everybody to come in and discuss all our varying concerns to produce a better piece of legislation.

Thank you very much.

SENATOR KARCHER: Thank you.

I thank you for being succinct.

And are there any questions, comments? (no response)

I think it was aptly said that there -- this has raised as many questions as it answers.

And I want to thank everyone for being here today.

And that concludes today's testimony.

Thank you.

**(MEETING CONCLUDED)**