

Legislative Acts and Psychiatric Input — A New Jersey Experience

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Organized psychiatry has not been very successful in communicating to government what it believes to be appropriate professional standards of psychiatric treatment or what it believes to be appropriate governmental policy to provide such care.

Governmental mental health care is primarily a matter of state government, not federal government. Therefore, any attempt to influence social policy must most appropriately be made at that level. As we have been taught in our early school days, governmental authority in the United States stems from three sources — judicial, executive, and legislative.

In the last decade, judicial policy-making has been of extreme import. The American Psychiatric Association has responded by forming a commission on judicial action and has intervened in a number of lawsuits, usually with the preparation of an *amicus curiae* brief which sets forth the recommended position of a national body of psychiatrists and the rationale, medical and legal, for that position. The cases before the courts have had great effect because a federal court, in dealing with constitutional rights and state responsibilities, has the authority to force states to adopt certain policies and procedures. Organized psychiatry has taken the initiative in participating in selected lawsuits because early significant suits did not allow psychiatrists to have input into the decision-making process, which resulted in policies thought detrimental to psychiatric treatment. Most of the suits have been individual or class action suits against state government hospitals or programs. Clearly the state governments themselves, often ill-defended, frequently did not have the capacity to formulate intelligently the need for appropriate professional input at the litigation level. Only recently have the states, with their service systems under attack and their authority vanishing, recognized the appropriateness of professional medical input as well as adequate legal assistance. The judicial intervention into patient care has had both good and bad effects on care itself; its insistence on due process has ameliorated many past inequities while occasionally creating new ones.

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The second area of formulation of governmental policy is the executive — either through the efforts of an activist governor or through the activities of the leaders of the appropriate state department, whether it be entitled a department of mental health or something else. In many states, these departments are semi-independent satrapies. The types of persons running such administrative empires vary greatly. Often the highest authority is a political appointee with no knowledge or experience in the mental health field; at times the position encompasses correctional or welfare functions. Sometimes the dominant person is a psychiatrist; the kind of psychiatrist, whether director or not, also varies. Hospital administrators, academicians, clinicians, social psychiatrists, and even anti-psychiatry psychiatrists may all be found in positions of power. Each state seems to develop a flavor and approach of its own. Some states have no psychiatric input; some have idiosyncratic input from their ranking psychiatrists; others reflect traditional or organizational value systems from the same sources. If organized psychiatry within a given state has access to the departmental decision-makers, then relationship between state government and organized medicine may be collaborative, rather than conflictual.

The state programs can be affected by their executives in one of two ways — through administrative rulings and policies and through the recommendation of legislative acts, often with the endorsement of the highest executive, the governor. Particularly where the executive and the legislature are of the same party or where the departments are respected by the legislature, the legislature may react sympathetically to proposed legislation from the executive departments.

The Legislature

Legislation is introduced by an individual or a group of individuals, either in the senate or the lower house or assembly. It is referred to the appropriate legislative committee for review. That committee holds periodic public hearings and invites the public (interested parties) to attend. The committee system is a most important part of the process. Most legislation that will not pass is “killed” at the committee level. The committee has a greater opportunity to hear and review the merits and demerits of specific legislation. The committee also has the benefit of having more knowledgeable representatives than those to be found in the legislature at large, as many members will remain on a given committee for a number of years and become familiar with that area of state function. If the administration (governor) wishes to propose legislation, he or she will have the bills introduced by specific legislators. The same is true of various executive departments. Similarly, legislators with a specific interest will initiate legislation. Motivations vary — from sincere efforts to meet a public need to the seizing of a public issue that will bring meritorious publicity to the payback of a political favor or to meet the needs of a friend or associate in the community at large. Often

most legislators know little about a given issue, particularly a technical issue, and respond to a legislative member who has developed a reputation in a given field.

Input from the Outside

Outsiders attempt to influence legislators in a number of ways — to introduce legislation, to push it through committee, and to vote in a certain way or to amend legislation when it reaches the floor. Legislators are most suspicious of all who attempt to influence legislation and perceive such efforts to be reflective of selfish interests, particularly in terms of money or power. Such a perception, of course, is quite accurate. Altruism and totally objective public betterment are human qualities to be treasured in their rarity. Additionally, one must be alert to the fact that policies altruistically or humanely pursued may not be the best social policy and that policies endorsed by groups who would benefit from such policies are not necessarily bad policies.

Each group at interest, professional or not, wishes to influence public policy. Proposed legislative acts may be introduced and sent to committees for review; if those interested do not know of the existence of such legislation, then the bill may be acted upon by the committee before the groups at interest (or pressure groups) have had the opportunity to respond. Since committees are small and knowledgeable, the moment for intervention is past if the committee has already acted and the bill is now before one of the houses of the legislature. The New Jersey committees dealing with health matters have five members.

If a bill is scheduled to be heard by the committee, then it behooves those interested, whether as individuals or as representatives of groups, to send representatives to such hearings. Such hearings are often brief or postponed or occur on varying days so that it is particularly difficult for professional groups to send individuals who can attend the various hearings. Thus most professional associations have a representative or lobbyist or public relations person in the state capitol to stay abreast of legislative developments and to represent their groups formally or informally. This provides a degree of efficiency and input. The representative, particularly if he or she is not a person of the profession involved, must be educated about the technical issues and the reasons for the professional stance. The representative has the advantage of knowing the legislators personally and the likelihood of effect of a given intervention. The representative has the disadvantage of being recognized as a paid or unpaid proponent of a given group and of not being technically versant or qualified in the issues at hand. Often a given representative testifies on behalf of a number of different associations for whom he may be the agent; he may even represent two groups with opposing stances.

Thus it is that an association must augment its legislative activities with testimony by members on its own behalf. Usually such representation

is done by the president, other officer, and head of a committee within the association. Such representatives may or may not be articulate or eloquent spokesmen. On the other hand, sincerity and knowledgeability are attributes desired in any witness. Oft-times, the representative chosen is one who could go that day to the state capitol.

A Proposed Commitment Bill

A totally revised commitment bill was introduced in the New Jersey Senate with the active support of the majority leader. The bill went through committee and then, by a unanimous vote, through the Senate (with a vote of 27 to 0 in favor with 13 abstentions). It was at that point that psychiatrists became aware of the pending approval by the state legislature of a very poorly drafted bill that would severely affect psychiatric services and availability of treatment, particularly in emergency situations. Much well-intentioned red tape would paralyze the handling of such patients; overemphasis on due process to the point of undue process reflected the role of certain legal ideologists in preparing that bill.

Having read the proposed legislation, I was distressed about its content. In discussing the matter with the New Jersey Psychiatric Association representative in the state capitol, I was told that the House committee would be reviewing the Senate bill on a specific date. (In order to present this matter adequately, I must present a personalized account of my endeavors.) I spelled out to the committee my criticism of the proposed legislation in specific terms. Unlike other witnesses who identified themselves as spokesmen for a given group, I identified myself as an interested and knowledgeable citizen, trained in psychiatry and the law, and a member of a medical school faculty. I did not care to be a representative for an organized group such as NJPA; as an individual, I had the flexibility to say what I thought without besmirching the Association. I did at different times discuss my activities with the officers of NJPA to ensure, if possible, that my recommendations were not in conflict with those of that group. I felt that proceeding as an individual with appropriate credentials from a "neutral" body — the Medical School, I received a more tolerant reception than I would have as a representative of a group perceived to have a vested interest. I also had the feeling that the Medical School had a higher status than might an ordinary state university or college whose faculty is often perceived as militant or demanding. To the contrary, medical school faculties seem to regard social intervention as unseemly or unprofessional. In any event, I think that medical school faculties should be less reticent to offer advice on public issues but that such offerings should be carefully structured in the highest professional manner so that credibility can be maintained.

I noted that two committee members, not including the chairman, were skeptical of the Senate bill and particularly its antimicrobial

flavoring. One legislator indicated that he felt that opposition to a proposed bill was not sufficient and that while the proposed bill had many defects, it did remedy some of the problems under existing law. He agreed that the handling of the mentally ill was primarily a medical problem to be handled by medical people. He suggested that I prepare a more reasonable bill and that if he thought it worthy he might introduce such a bill. I might add that this particular legislator had had extensive experience in both mental health and community medical problems, stemming from his work as a county administrator.

While the hearings of the committee were continued to a later time, an extensive letter-writing campaign was directed at both the members of the committee and other key legislators. The spouses' auxiliary of NJPA was quite active in this regard.

In the meantime, I worked on a draft of a new commitment bill for the State. This took about one month and many hours a week (in addition to extensive personal correspondence to legislators). The writing of a bill is a major endeavor. Numerous sections must be made compatible not only with other parts of the bill but with the requirements of other laws already on the books.

Not having a committee to prepare a bill was most advantageous. For example, the efforts of committees of the American Psychiatric Association in preparing bills on recommended legal policies have been both slow and inefficient. For good or bad, all the language stemmed from one source, and the likelihood of conflict or inconsistent language is much less than that of a committee effort. Bills are complicated enough. If the bills are too legalistic, no one will read them. As each committee is likely to have two or three attorneys, one must be careful in using language appropriate to the law.

In preparing the new law, I followed the format of the Senate bill section by section so that the two could easily be compared. I retained many of the recommendations, particularly those dealing with due process, where they were both beneficial to patient rights and non-injurious to patient care. The prime focus was on patient care, efficiently delivered and administered, not on a conflict between law and psychiatry over technical legal issues.

The legislator with whom the bill was reviewed was enthusiastic, and together with another Assemblyman, he introduced the bill in the Assembly. Thus the situation had drastically altered; no longer was there just opposition to a proposed bill, there was now a valid alternative in addition to that involved in maintaining the status quo.

The new bill quickly drew some support — particularly from mental health clinic administrators and other mental health professionals. Psychologists were confronted with a dilemma. The new House or Assembly bill (to be called the A-Bill in comparison to the Senate bill or S-Bill) was clearly a better bill in terms of practicality. Under the S-Bill, psychologists would be allowed to be a second party to be required for

hospitalization certificates while under the A-Bill, psychologists would not have authority to commit.

In my original testimony I was particularly firm in questioning the capacity of psychologists to direct hospitalization of people that they could not treat and pointed out that the particular group likely to be committed, psychotic individuals with brain syndromes, schizophrenia, or manic-depressive illness, required a uniquely psychiatric intervention.

This paper cannot review in detail the problems with existing law and the total content of the A-Bill and the S-Bill. However, the gist of what was done is illustrated in the following section which summarizes a companion report which was distributed to committee members, key legislators, and legislators from that part of New Jersey adjacent to the Medical School. This report stressed the key differences between the A-Bill and the S-Bill. As the various bills were amended or re-introduced in later sessions, an up-dated comparison was drafted.

The following commentary is the same as that distributed to the legislators (aside from the use of A-Bill and S-Bill, referring to the Assembly and Senate bills without identifying number).

A Comparison of S-Bill and A-Bill

General Commentary

Both S-Bill and A-Bill purportedly attempt to simplify and clarify the commitment standards in New Jersey while conforming to current legal standards which would afford reasonable due process safeguards.

The impetus for change has resulted from the problems of application of existing laws which have been cumbersome, difficult to comprehend, slow in operation, and subject to criticism due to alleged misuse or inappropriate use. Some of the major problems have been alleviated by court decisions and orders, some by administrative fiat; others remain.

S-Bill, while well-intended, is legally cumbersome, expensive, and more seriously, reflective of an inappropriate and untenable concept of mental illness. By applying a model of social deviance, it will, in fact, assure inadequate and inappropriate treatment for those who are mentally ill. A-Bill, on the other hand, attempts to strike a reasonable balance between the medical needs of the mentally ill, the legal rights of the mentally ill, and the interests of society both in providing protection from adverse behaviors related to mental illness and in providing reasonable care and protection for those unable to do so for themselves.

S-Bill confuses criminal behavior and the behaviors of the mentally ill. In many places, its narrow focus on dangerousness (defined in inappropriate fashion and without adequate reference to mental illness) results in a model of social deviance which has been misused elsewhere — for example, in the Soviet Union. Further, the peculiar definitions in fact exclude many severely mentally ill people from the

commitment process, and thus can lead only to chronicity and more severe forms of illness.

The requirement of two examiners in emergency situations has no merit; the goal in handling an emergency is to provide rapid service in accord with reasonable practices. The fantasy that two heads are better than one has little statistical justification; what is more important is the quality of the heads utilized. The use of psychologists to make diagnoses outside their competence is more political than meaningful.

These and other matters will be discussed in detail under specific topics.

Purposes

The very first clauses of each proposed bill reflect their orientation. S-Bill speaks of procedures that are in full compliance with all the constitutional, legal, and civil rights of the individual (thus asserting in triplicate its legalistic concerns — since, in essence, the words all mean the same thing). A-Bill notes its purposes as the provision of appropriate care and treatment for persons with mental disorders, concern for protection of the individual and society, and safeguarding the rights of the individual.

Definitions of Mental Illness

S-Bill defines mental illness as “mental disease to such an extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others, or of the community, and shall include mental disorder.” The first part of the definition is the current legal definition which has created so much confusion and which is now utilized only through the interpretations placed upon it by the courts. It adds nothing to the operation of the law. Obviously, a statute would be more understandable if it defined mental disease, disorder, and illness as synonymous (which they are) and then added the qualifications necessary for legal justification for the use of involuntary hospitalization for a certain class of mentally ill.

S-Bill then defines mental disorder as “any organic, mental or emotional impairment which has substantial adverse effects on an individual’s behavior and actions.” The language is confusing and ill-advised. Does it mean that there are three types of disorders — organic, mental, or emotional? Does “mental” mean something different from “emotional”? Why does the definition focus only on behavior and action? The essence of mental illness is the presence of abnormal thought and judgmental processes whether or not related to an organic (or physical) disease process. Increasingly, certain severe mental illnesses are found to have a physical-biochemical etiology or causal factor. Arbitrary, non-scientific distinctions should be avoided.

In contrast, A-Bill uses not only a much clearer definition but one

which is compatible with the psychiatric concept of mental disease. It defines "mental illness" as a "substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life. It shall not include mental retardation, simple drug or alcohol intoxication, or personality disorders manifested only by social maladaptation, assaultive, or other aggressive behavior." It equates mental illness and mental disorder.

The S-Bill definition of mental disorder can be interpreted to apply to all criminals, even those not considered by the medical profession to be mentally ill. A-Bill carefully excludes criminality and simple intoxications. Otherwise the use of the mental health system as a means to control "dangerous" criminals without protection of criminal justice safeguards becomes a possibility, and the dreaded "preventive detention" a reality. This effect is certainly not one that libertarians would intend.

Dangerousness

Current trends in the law have stressed that the mental health system can use involuntary commitment for those who are mentally ill and "dangerous." The applicability of the concept of dangerousness must be carefully tailored to the realities of mental illness and to the question, "How mentally ill must a person be to justify deprivation of freedom for any purpose?" How is the "dangerousness" related to the mental illness?

S-Bill defines "dangerous" as suffering from a mental disorder and by reason of such disorder "posing a substantial risk in the foreseeable future of (1) attempting to commit suicide, as evidenced by behavior causing or threatening serious bodily harm upon oneself, (2) inflicting serious, unjustified bodily harm on another person, as evidenced by behavior causing or threatening such harm on others, or (3) impairing one's physical health or causing oneself substantial bodily injury, serious disease, debility or death from lack of self-control or judgment in caring for personal needs such as shelter, nutrition, and medical attention."

This definition has many reasonable elements; it simply is not broad enough. Both proposed bills refer to "medical attention," which reasonably must include psychiatric attention.

The A-Bill definition defines "dangerous" as "posing a substantial risk in the imminently foreseeable future of (1) attempting to commit suicide as evidenced by suicidal threat or attempt, suicidal preoccupation, significant depression, or attempted or potential serious bodily harm to oneself, (2) homicidal or assaultive preoccupation or inflicting or threatening serious bodily harm on another person or inflicting or threatening significant property damage, or (3) impairing one's physical health or causing oneself substantial bodily injury,

serious disease, or death from lack of self-control or judgment in caring for personal needs as shelter, nutrition, and medical attention. "Dangerous" for purposes of commitment shall be a criterion only in the presence of mental illness or mental disorder and shall be related thereto."

The two bills differ greatly. First, A-Bill refers to the "imminently" foreseeable future rather than the foreseeable future. This explicitly requires a current or impending risk. Many matters are foreseeable; the requirement of imminence would be both medically and legally more appropriate.

Second, the House bill is not nearly so rigid as the Senate bill and is more clinically oriented. The House bill, recognizing the nature of psychotic depression, refers to suicidal preoccupation, significant depression, and potential serious bodily harm to oneself. This would be more relevant to clinical reality. For example, an elderly, sickly, isolated white male who becomes depressed is a person with a high risk of successful suicide. Waiting until suicide has been attempted in order to hospitalize will become a death warrant under the Senate bill; suicide attempts in this group are likely to be successful. A-Bill recognizes that significant property damage can be a manifestation of serious mental illness without necessarily manifesting bodily harm. For example, psychotic persons on occasion have been involved in firesetting of various types — often in their own empty homes, schools, and churches. Despite such gross psychotic behavior, courts have been forced to debate the justification for hospitalization because of narrow dangerousness criteria of "bodily harm"; certainly, arson and property destruction as a symptom of mental illness should be justification for intervention. Similarly, manic patients may quickly and bizarrely dissipate their financial resources and impoverish their families. Under the Senate bill, there could be no intervention; under the House bill, appropriate steps could be taken.

Thirdly, the House bill carefully points out that for legal intervention a person must be both mentally ill and dangerous. The Senate bill in many places refers only to dangerousness. The House bill not only requires both but states that the dangerousness must be related to the mental illness. Some people are both mentally ill (for example, schizophrenic) and criminal (manifesting a psychopathic personality). The professional robber or thief who would seek refuge in the mental health system to avoid the penalties of the criminal justice system would not be allowed this route under the House bill. The Senate bill would force the mental health system to be a haven for the criminal offender while neglecting many of the severely mentally ill; the House bill would do the opposite.

Director

The Senate bill defines "director" as the chief administrative officer of a screening service or his designee. The House bill requires that this be a psychiatrist, a medical specialist in mental disease. Lack of professional psychiatric authority has already severely crippled state-run operations; to extend this to screening or evaluative procedures would ensure poor quality care.

Types of Admission

Although similar to the Senate bill, the House bill requires the person to be both mentally ill and dangerous to be institutionalized. The Senate bill refers only to dangerousness. This applies both to admission and discharge. A-Bill dealing with voluntary admission does not require that the individual be dangerous. Obviously, if the restriction of freedom is voluntary, then the legal strictures need not be imposed and would indeed be irrelevant.

A-Bill attempts to delineate much more clearly the types of admission and associated procedures, providing guidelines that S-Bill ignores.

A-Bill specifies three types of procedures:

- (1) emergency or referral commitment
- (2) temporary commitment or certification
- (3) indeterminate commitment

Emergency commitment would require certification by one psychiatrist or one physician, except for those held in jail where one psychiatrist or two non-psychiatric physicians would be needed for certification. The concept of emergency implies urgency, availability, and a mechanism to meet the need rapidly. The emergency certificate is valid for only three days (excluding holidays and weekends).

The Senate bill does not clearly delineate these different forms of certification. It requires action by a screening service or certification by a psychiatrist and either a physician or psychologist or two psychiatrists for a preliminary examination. The requirement for two examiners in an emergency situation is an example of unjustified redundancy; such a requirement would cripple the use of community hospital facilities and force greater reliance on governmental services. Because of the complexities of diagnosis and the problem of associated or inherent medical problems, the use of a psychologist for commitment purposes would not be appropriate to medical care. Even the Senate bill requires that discharge be accomplished by a physician. And most importantly of all, the significant psychotic disorders are not treatable by psychological counseling approaches. Underlying all of this is the manner in which severe mental disease is perceived. If it is perceived as a matter of social or interpersonal adaptation alone,

then treatment based on that approach alone can lead only to failure and neglect.

Thus the use of a psychologist is inappropriate for two reasons: (1) The concept of the requirement of multiple examiners is founded in surplusage; if an examination is competently done, multiple evaluators are not necessary. If examinations are not competently done, then doing it in large numbers does not enhance its worth. The problem historically has been quality. (2) As discussed above, diagnosis and treatment of mental disease, particularly the more severe disorders of psychotic degree, the type usually involved in commitment procedures, are medical matters requiring appropriate professional services.

Under A-Bill, admission requires medical review. Under S-Bill, the director of a screening center may admit a person for detention on application of a police officer alone. As noted, the director of a screening service under the Senate bill is not qualified professionally; thus, it would allow an act involving the reasonable belief that mental illness exists to be determined by a non-medical person, clearly a violation of any reasonable medical practices act.

S-Bill would require an examination to be conducted in the least possible restrictive setting. This is another example of unbridled legal ardor mixed with extreme naivete. What does this mean? An examination is usually conducted in an office for a relatively brief period. How is the concept of least restriction meaningful? Does it mean the psychiatrist should examine the person in an open space, a corridor, an open office, or a closed office? The Senate bill, as it does elsewhere, often uses nice-sounding words which on examination seemingly have no rational meaning at all.

The requirement for two physicians for emergency commitment for those held in jails (A-Bill) is to minimize the likelihood of claimed abuses in this area where those charged with crime are allegedly sent to psychiatric units for minimal reasons. As pointed out, the use of greater numbers in this type of situation is probably more ceremonial than realistic, and more costly than useful. The emergency provisions allow for a detention period of three days (excluding weekends and holidays) to allow for a more in-depth evaluation of the need for involuntary hospitalization; thus errors or misjudgments are likely to be quickly corrected.

A-Bill stipulates a three-day evaluation period. If the person is found not to be both mentally ill and dangerous, then he or she is to be discharged. If such a condition is found, then a two-doctor certificate will be filed at the holding facility (under A-Bill) to provide a basis for temporary certification and the holding of a commitment hearing not later than ten days after the issuance of the temporary order, with allowance for a fifteen-day extension by the attorney of the detained person.

S-Bill stipulates that a forty-eight hour period is allowed at a screening center, in contrast to A-Bill; this period is too short for adequate evaluation. S-Bill does not specify a time limit for examinations in a detention unit outside a screening center; A-Bill requires seventy-two hours for this purpose. Many would consider even seventy-two hours as too short or unworkable, but it has been commonly adopted elsewhere.

S-Bill requires certifications from a psychiatrist and either a physician or psychologist or two psychiatrists. This not only omits the physiologic-medical consideration in mental illness if psychologists are utilized but requires a statement as to the person's physical condition — clearly another inappropriate authority to be given to non-medical personnel.

Both acts allow the appointment of attorneys at each step and the right to a court-appointed expert (A-Bill to a psychiatrist, S-Bill for a psychiatrist or psychologist). The inappropriateness of psychologists for this purpose has already been discussed; parenthetically it might be added that in consideration of the need for hospitalization or alternatives, the use of drug or somatic treatments is now a frequent court issue, matters about which psychologists have no competence. As the due process steps dealing with attorneys are not related to treatment considerations, this will not be discussed at any length. A-Bill accepts the participation of attorneys at the time of the temporary certification hearing. Whether this is really meaningful in view of the overall circumstances and the soon-to-be-followed full court hearing is perhaps arguable.

More to the point are two other major differences. Not only does S-Bill require that the person be dangerous (without a mental illness requirement), but it uses a standard of beyond a reasonable doubt (Sec. 20c). The Federal courts have already clearly established that the standard is to be that of "clear and convincing evidence." This standard exemplifies the criminal law orientation of S-Bill and its effect in "criminalizing" the mentally ill. In contrast, A-Bill requires a finding of mental illness and dangerousness by clear and convincing evidence (Sec. 25b).

Both bills require the same time periods for subsequent court reviews.

S-Bill allows the court to designate non-residential modes of treatment which would meet the person's needs in the least restrictive setting. A-Bill uses the expression, "most beneficial alternative," a concept which includes consideration both of the least restrictive setting and the alternatives most beneficial to the treatment and management of the patient's condition.

Language

Each bill has a statement dealing with patient rights applicable to

persons admitted to a screening service. Interestingly, both bills provide for somewhat different rights in a screening center as compared to those in a hospital. S-Bill (Sec. 11f) provides that every person admitted to a screening service has a right to services and examinations provided in the person's primary means of communication or with the aid of an interpreter if such person is of such limited English-speaking ability or suffers from a speech or hearing impediment as to preclude an effective and objective determination of whether such person is dangerous (sic!). A-Bill unfortunately uses the same language; this is obviously an error in preparation, as all other sections of A-Bill refer to "mentally ill and dangerous." More importantly, A-Bill refers to the provision of such assistance "when feasible and appropriate" (Sec. 16f). Thus A-Bill is much more in tune with the realities of the provision of services. The presence of very large numbers of immigrants from many lands, spread geographically throughout the state, means that many individuals have indeed limited English ability; some of the many languages encountered are Spanish, French (Haitian), Polish, Slavic tongues, Hungarian, Chinese, and now other Asiatic tongues. The availability of interpreters must be a consideration, particularly since evaluation is to be completed in a three-day period. Thus, deference to feasibility must be recognized; it makes no sense to dictate by law that which cannot be done. Thus A-Bill recognizes a principle while not being unduly restricted depending on the circumstances. As in other areas of medicine, those responsible for services must do the best that they can under specific circumstances.

Summary

Some of the major differences between A-Bill and S-Bill have been presented. In all of the areas discussed, A-Bill is a more reasonable, relevant, and functional bill than S-Bill, which is not only unworkable but certain to lower the quality of care offered to the mentally ill should it become law. Careful consideration of the differences between these bills is urged. The defects of S-Bill are so great as to justify its defeat regardless of the option available in A-Bill. If the need to modernize and modify the current procedures is pressing, then clearly the Legislature should carefully consider the merits of the House bill which has directed itself so much more clearly to the issues in involuntary hospitalization.

Discussion

As a result of multiple intervention, the preparation of an alternate bill, and active committee review, neither the House nor the Senate bill was reported out of committee.

The failure of the S-Bill to pass was remarkable, particularly in view of its unanimous passage in the Senate, its promulgation by a respected

Senator, and at least tacit approval by the state department charged with mental health care. It was double striking when one considers the late point at which intervention was made. On the other hand, the failure of the S-Bill to pass is also a credit to the House committee which reviewed the legislation. Clearly the members recognized that the S-Bill was a shoddy piece of legislation, poorly prepared in wording, scope, and function.

Much time has transpired since the above events. The successors to the above bills still exist and are re-introduced each year. The failure of the S-Bill to pass the first year means that it must go through the entire legislative process. In the interim, the state department has reportedly been working on a new bill. During the period of time involved, administrative policy clarifications and legal decisions have minimized abuses of legal process so that the urgency for new legislation is somewhat diminished.

In any event, the House bill remains as an alternative superior either to the Senate bill or to the cumbersome existing statutes.

As is evident, the state has been fortunate in not having passed the original S-Bill. Crucial to its defeat was the elaboration of issues, delineation of its many defects, mobilizing of psychiatric and other mental health resources, and participation by concerned legislators. Many psychiatrists directly contacted their legislators on this issue. The NJPA public relations representative kept the psychiatrists informed of pending actions, spoke to key legislators, and became quite knowledgeable about the issues. The psychiatrists themselves, whether formally representing the Association or not, conferred with each other so that they were conversant with the issues and did not get into the awkward situation in which various professionals, alleging to represent a single group, take contradictory stands or emphasize different elements of a problem to the consternation of the legislators. Legislators like to please; they are likely to listen to a consensus when one is available. Legislators are more comfortable if they are clearly informed as to the merits and demerits of proposed legislation. However, they do not have the time to research technical matters. Thus, the more professional representatives establish a reputation for honesty, concern, technical competence, and controlled self-interest, the more likely they are to be consulted in the future. Many legislators themselves are sincerely interested in doing what is best for the most and welcome reasonable communication.

This experience in New Jersey is presented because it represents an occasion where professional intervention was successful in preventing harmful legislation. Perhaps psychiatrists in other states may find this experience helpful in their own efforts to contribute to the legislative and governmental administrative processes in their own states.