

Final Report of the Senate Task Force on Greystone Park Psychiatric Hospital



June 1996



New Jersey State Legislature
SENATE TASK FORCE ON
GREYSTONE PARK PSYCHIATRIC HOSPITAL
STATE HOUSE ANNEX
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TRENTON, NEW JERSEY 08625-0068

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June 17, 1996

President of the Senate
Members of the Legislature

Ladies and Gentlemen:

I am pleased to transmit with this letter the report of the recommendations of the Senate Task Force on Greystone Park Psychiatric Hospital.

The task force was created by the Senate President in January 1996. The task force conducted an intensive study of the problems concerning the facility and held three public hearings to gather information from hospital staff, Department of Human Services officials, local officials, patients, their families and community organizations.

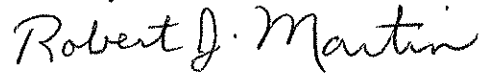
All of the recommendations presented in this report have been suggested by persons and organizations testifying at the public hearings held by the task force. A legislative package of bills, as listed in the appendix of the report, is currently being prepared and it is anticipated that it will be ready for introduction at the first fall Senate session.

I would like to thank my colleagues, Senators C. Louis Bassano and Richard J. Codey, who served with me on the task force, for their time, consideration and knowledgeable deliberations and contributions to this report.

On behalf of the task force, I would like to commend the work of the staff provided by the Office of Legislative Services. In particular, I would like to thank Irene M. McCarthy, Deputy Counsel, and Norma Svedosh, Senior Research Associate, for the assistance and information they provided to the task force.

I hope that the recommendations of the task force will assist the Governor and the Legislature in developing effective policies to improve the conditions at Greystone Park Psychiatric Hospital and at the other State institutions.

Sincerely,

A handwritten signature in cursive script that reads "Robert J. Martin".

Honorable Robert J. Martin
Chairman

**MEMBERS OF THE SENATE
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GREYSTONE PARK PSYCHIATRIC HOSPITAL**

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I. INTRODUCTION

The Senate Task Force on Greystone Park Psychiatric Hospital was created by the Senate President, Donald T. DiFrancesco, to review the operation of the Greystone facility, after a series of reported incidents of sexual abuse of patients and the escape of a criminally insane patient. Another disturbing event occurred just prior to the first scheduled hearing, when a patient committed suicide.

In order to gain firsthand knowledge of the operation of the Greystone Park Psychiatric Hospital, the task force members conducted on-site visits in December 1995, and in January and February 1996.

The task force held three public hearings: on February 27, 1996 at the Parsippany Municipal Building in Parsippany for the administrative staff of the hospital and the Department of Human Services, local officials and community organizations; on March 12, 1996 at the Parsippany Municipal Building in Parsippany for members of the public, hospital employees and patients and their families; and on April 17, 1996 at the Morris Plains Borough School in Morris Plains for members of the public, hospital employees and patients and their families. More than 60 persons testified at the hearings or submitted written materials to the task force. Everyone who wished to testify was given the opportunity to be heard.

Much of the testimony revealed that the atmosphere and conditions at Greystone were antithetical to what is necessary for quality treatment of some of our most vulnerable citizens. The incidents of repeated sexual assault, employee intimidation, lack of proper staff training and lack of productive activities for the patients render it impossible to provide first class treatment that the mentally ill patients in State psychiatric hospitals deserve. It is the responsibility of the State to make the necessary changes to ensure that the patients in our State psychiatric hospitals get the very best and not the very least in psychiatric care.

The task force extensively reviewed all of the testimony and written materials submitted and now proposes a series of recommendations. The recommendations address the following conditions: staffing and supervision, training of employees, security and patient treatment. While many of the recommendations can be accomplished through administrative measures by the Department of Human Services, some of the recommendations require legislative action, and a legislative package of bills will be introduced to meet these objectives. A listing of these legislative initiatives is included as an appendix to this report.

It should be emphasized, however, that no amount of recommendations or legislation can, by itself, provide assurances that New Jersey's State psychiatric hospitals will function as intended. In the final analysis, it is the commitment and dedication of supervisors and staff who determine the quality of patient care. The State, however, must provide the resources and ongoing monitoring to assure that those in charge and those on staff will get the job done.

II. PROBLEMS AND RECOMMENDATIONS

A. STAFFING and SUPERVISION

PROBLEM: Staffing Needs

Staffing levels are inadequate and are not in compliance with the Doe v. Klein consent order. Many units are understaffed and result in unsafe conditions, and the documented staffing plan frequently differs markedly from actual staff deployment.

Legislative Recommendation

1. Legislation should be enacted to require the Department of Human Services to conduct unannounced site visits of State institutions to randomly check staffing on the various shifts to determine proper deployment of the staff on a particular shift, including medical staff and direct care staff. The Department of Human Services should conduct undercover and other surveillance procedures on an ongoing basis to identify staffing and patient problems. Persons doing so should assume roles that will not suggest their actual functions. It is our belief that more frequent and intense monitoring of daily operations will provide enhanced patient care and reduce the frequency of patient abuse and neglect.

Administrative Recommendations

2. It is recommended that the Department of Human Services increase staffing levels at the hospital. Also, staffing and personnel records should be reviewed to determine if the actual staffing on all the shifts is meeting the current standards. Moreover, the staffing ratios should be examined and updated to reflect the changing population at Greystone, a population that is more impaired than the hospital's population may have been years ago when the staffing ratios were developed. We further recommend that a report be submitted to the Legislature, within 180 days, detailing the proposed changes in personnel.

3. If filling psychiatrist staff positions proves difficult because of low salaries, scheduling constraints and burnout problems, the Department of Human Services should consider contracting out these positions with either local hospital psychiatric departments or private psychiatric practitioners.

PROBLEM: Staff Supervision

Staff supervision is problematic and fraught with conflict of interest. Staff scheduling is not necessarily in the patients' best interests.

Legislative Recommendation

4. Legislation should be enacted to prohibit a hospital employee, including professional treatment staff, from having supervisory responsibilities over a family member. Included in this legislation should be a requirement that all hospital employees, as a condition of employment, report

all outside employment and the number of hours spent at that employment. Reports should be updated annually, or as often as there is a change in outside employment, and should be approved directly by the chief executive officer of the State psychiatric hospital to verify that there is no conflict or interference with duties, responsibilities or job performance at the State psychiatric hospital.

Administrative Recommendation

5. The Department of Human Services should provide more intense supervision of weekend and night employees as well as strengthen oversight of patient care areas.

PROBLEM: Reluctance to Report Abuse

The staff and patients appear reluctant to report instances of abuse for fear of retaliation. There appear to be practices of intimidation and fear of reprisals for initiating reports of abuse. It also appears that all allegations of sexual abuse at the hospital are not investigated in a prompt, independent manner.

Legislative Recommendation

6. The Legislature should enact legislation creating a comprehensive abuse reporting mechanism to provide for mandatory reporting of any information concerning alleged patient abuse or malpractice by a health care professional or paraprofessional. The Commissioner of Human Services should appoint a contact person at each State psychiatric hospital, who is independent of the hospital staff and who shall report directly to the Commissioner, or his designee, to whom reports of information concerning incidents of abuse can be made. This legislation should include a provision making it the responsibility of all personnel employed at a State psychiatric hospital to report information concerning abuse to the contact person. The contact person shall report substantiated incidents of abuse or malpractice to the appropriate professional licensing or certifying board. Failure to report instances of alleged abuse or malpractice shall be sanctioned. The Prosecutor's Office of each county in which a State psychiatric institution is located shall provide an independent review of all allegations of abuse.

Administrative Recommendation

7. The Department of Human Services should keep patients informed of actions they can take when they witness or experience abuse. The Department of Human Services should create an atmosphere of respect and concern for patients throughout the hospital and address the issues of appropriate behavior among patients.

PROBLEM: Hospital Admissions

All new patients, including criminally insane (Krol) and mentally ill chemically addicted (MICA) patients, are grouped together with other mentally ill patients when they are first admitted to the hospital. Also, new patients are not immediately tested for communicable diseases.

Administrative Recommendation

8. Upon admission, the Department of Human Services should immediately identify and segregate the Krol and MICA patients from the other new patients. All new patients should receive urinalyses and blood tests immediately upon admission to determine if a patient has a communicable disease.

B. TRAINING OF EMPLOYEES**PROBLEM**

Training programs have been cut back drastically and are no longer provided on-site at the psychiatric hospital. Instead, current employees are pulled from their normal work assignments and are used, in an unorganized fashion, to train new employees, which has resulted in inadequate orientation for these new workers. When outside agency trainers are utilized, they are not able to provide adequate institution-specific training. There is no formal abuse prevention program for staff and patients. All employees are not required to have a high school diploma, and are inadequately screened before being hired.

Legislative Recommendation

9. Legislation should be enacted to require the Department of Human Services to conduct in-service, on-site training concerning patient abuse for all employees, including support staff such as housekeeping, engineering, grounds and food service staff who have contact with patients. To accomplish this, the legislation should require the use of designated instructors from within the hospital or Department of Human Services, who have first successfully completed a training program. This legislation shall require that the in-service, on-site training be comprehensive and include:

- i. sensitivity training to encourage staff interaction with patients;
- ii. abuse prevention programs designed to educate and empower employees and patients, which shall include discussions in ward community groups concerning abuse, rights of staff and patients, and procedures for handling abuse;
- iii. an extensive orientation program for new hires;
- iv. cultural training which addresses racial issues;
- v. a G.E.D. program for staff who do not have a high school diploma; and
- vi. a requirement that employees successfully complete training programs, including G.E.D. programs, within time-limited goals. Insufficient progress in meeting the goals shall result in salary and promotion limitations, and to the extent possible, demotions and dismissals.

Administrative Recommendations**Screening and Hiring**

10. The Department of Human Services should institute comprehensive pre-employment screening of all employees, including psychological testing. It should also require a high school diploma for all new employees and perhaps an additional two years of schooling or training by the

Department of Human Services. If an applicant for employment does not have the requisite high school diploma or G.E.D., he may be hired provisionally for six months, during which time he must complete the G.E.D. program.

Training Programs

11. The Department of Human Services should take immediate steps to adopt a two-year plan to affiliate the State psychiatric hospitals with publicly supported universities, community colleges, professional training programs in medicine, nursing, psychology, social work and law, and other public and private institutions of higher education to begin the use of on-site instructors, intern programs and work-study arrangements at the State hospitals. It is hoped that those interns will not only provide additional assistance, but become persuaded to pursue professional careers at State facilities.

C. SECURITY: PATIENT AND SURROUNDING COMMUNITY

PROBLEM: Confinement of Sex Offenders

Currently, several sex offenders ("Megan's Law" offenders, P.L.1994, c.134) are being confined at Greystone. In some instances, these offenders have grounds privileges and may be able to leave the confines of the hospital. Community notification does not apply to these offenders who are committed to the State psychiatric hospitals. The State is not required to notify a victim's family of any civil commitment hearing or change of status at the hospital regarding sex offenders or other violent offenders.

Legislative Recommendations

12. Current law allows the institution of civil commitment proceedings against sex offenders who are to be released from the Adult Diagnostic and Treatment Center (Avenel). Legislation should be enacted to require the continuous confinement of sex offenders, who are deemed in need of involuntary commitment, at a secure facility, such as the Forensic Psychiatric Hospital at Trenton.

This legislation should also require that a victim's family be notified of any civil commitment hearing or change of status relative to "Megan's Law" offenders or other violent crime offenders.

PROBLEM: Criminal History Record Background Checks

Under current law, criminal history record background checks are required for new employees who work in State psychiatric hospitals. An employee, however, may be convicted of a criminal offense after employment commences, and the Department of Human Services may not be aware of this criminal record.

Legislative Recommendation

13. Legislation should be enacted to require the Department of Human Services to conduct criminal background checks on employees at least biennially.

PROBLEM: Investigations

The investigation of sexual abuse and the confinement of patients who have violent criminal backgrounds require specific training. The State psychiatric hospitals continue to have "elopements," or escapes, which could be dangerous to residents in the neighboring communities. At Greystone Park Psychiatric Hospital, abandoned, deteriorated buildings remain on the grounds and provide hiding places for illicit activities. These buildings are not adequately patrolled by the Human Services Police.

Legislative Recommendations

14. Legislation should be enacted to require current and newly hired Human Services Police officers to complete a training program, approved by the Police Training Commission, at designated police academies within a specified period of time. The training program shall include sensitivity training to ensure that the officers are prepared to encounter abuse situations between employees and patients, and among patients at the State psychiatric hospitals. The training also shall prepare the Human Services Police to deal with patients with violent criminal backgrounds.

Administrative Recommendations

15. The Department of Human Services should ensure that all "elopements" are investigated thoroughly, including the reason for the escape.

16. The Department of Human Services should establish a timetable for the removal of all abandoned buildings and, in the meantime, the Human Services Police should regularly patrol the abandoned buildings.

D. PATIENT TREATMENT

PROBLEM: Patient Programs and Activities

Many patients have complex problems which involve mental illness and chemical addiction (MICA). Often, their treatment programs do not adequately address these complexities. The hospital does not have adequate therapeutic programs for the patients. Instead of being engaged in productive activities, patients are found idle and dozing in the common recreation areas in front of the television sets while the staff are gathered in another area, conversing among themselves. Although a work program is currently available, it is not as strong as it should be.

Administrative Recommendations

17. The Department of Human Services should reestablish intensive treatment programs for

MICA patients. Also, it should revitalize patient work program initiatives with community corporations and businesses who are willing to provide jobs, such as packaging and assembly work, for patients to perform. The administration at Greystone should contact local community corporate and business leaders to initiate a strong work program at Greystone.

18. The Department of Human Services should explore the possibility of patients performing maintenance and other work at the facility, as it would be therapeutic and also help defray the costs of hospitalization. This could maximize use of existing resources.

PROBLEM: Exposure to AIDS and other sexually or blood transmitted diseases

Patients who have communicable diseases, such as AIDS, hepatitis and other blood-borne pathogens as well as other sexually transmitted diseases, are not housed in segregated units, and the health of other patients may be at risk.

Legislative Recommendation

19. Legislation should be enacted to require testing for HIV, hepatitis and other blood-borne pathogens, as well as other sexually transmitted diseases (S.T.D.'s), as soon as patients are admitted and during their hospitalization, for the patient's health and for the safety and protection of other patients.

Administrative Recommendation

20. The Department of Human Services should mandate strict segregation by sex of all adult patients on the hospital wards. There may be exceptions in the cottages for higher functioning patients on the hospital grounds, provided that close supervision is available to ensure that there is no sexual abuse. The Department of Human Services should not permit patients with hepatitis, HIV and other S.T.D.'s to be placed in general patient units. The Department of Human Services should provide adequate treatment rooms for patients.

PROBLEM: Staff communications with patients

In many cases, treatment staff members are unable to orally communicate in an effective manner with patients because their English speaking skills are insufficient to ensure effective communications between staff and patients. An insufficiency in spoken English compromises patient treatment if the spoken language is difficult for a mentally ill patient to understand.

Administrative Recommendation

21. The Department of Human Services should require, as a condition of employment, that treatment staff speak easily understandable English. Also, the department should provide language training to current staff members whose English speaking skills need improvement.

E. OTHER ISSUES

PROBLEM: Alternatives to Psychiatric Institutions

While there are many patients at Greystone who are ready to be placed in the community, all too often they remain at the hospital because there are no community programs for them. The hospital census could be substantially reduced if there were adequate community residential placements for patients.

Administrative Recommendations

22. The Department of Human Services should continue to vigorously pursue the creation of small, community-based residential programs and housing, to the maximum extent possible, for persons with mental illness.

23. The Departments of Human Services and Health should work together to help community hospitals expand their intermediate and long-term psychiatric bed capacity, in order to provide more inpatient psychiatric care in the community.

PROBLEM: Oversight and Review

The task force recognizes that, even with the best of intentions of the Department of Human Services, the possibility exists that problems at the State psychiatric hospitals will continue to occur. Without continual monitoring, by the Legislature, which possesses the financial resources and legal power to effectuate change, some problems may continue to plague Greystone and other State psychiatric hospitals.

Legislative Recommendation

24. Legislation should be enacted to require the Senate and Assembly Standing Reference Committees which have jurisdiction over State psychiatric hospitals to review the Department of Human Services' progress in implementing the recommendations of the task force, which shall include hearing from patients and their families, employees and support groups associated with State psychiatric hospitals. The review shall include a public hearing and shall be conducted no later than one year after the enactment of this legislation and shall be conducted biennially thereafter.

APPENDIX A***SUGGESTED LEGISLATION***

Legislative Recommendation No. 1: (See Recommendation No. 1, pg. 2) The Department of Human Services shall conduct unannounced site visits of State institutions to randomly check staffing on the various shifts to determine proper deployment of the staff on a particular shift, including medical staff and direct care staff. The Department of Human Services shall conduct undercover and other surveillance procedures on an ongoing basis to identify staffing and patient problems. Persons doing so shall assume roles that will not suggest their actual functions. It is our belief that more frequent and intense monitoring of daily operations will provide enhanced patient care and reduce the frequency of patient abuse and neglect.

Legislative Recommendation No. 2: (See Recommendation No. 4, pg. 2) A hospital employee, including professional treatment staff, shall not have supervisory responsibilities over a family member. All hospital employees, as a condition of employment, shall report all outside employment and the number of hours spent at that employment. Reports shall be updated annually, or as often as there is a change in outside employment, and shall be approved directly by the chief executive officer of the State psychiatric hospital to verify that there is no conflict or interference with duties, responsibilities or job performance at the State psychiatric hospital.

Legislative Recommendation No. 3: (See Recommendation No. 6, pg. 3) The Department of Human Services shall create a comprehensive abuse reporting mechanism to provide for mandatory reporting of any information concerning alleged patient abuse or malpractice by a health care professional or paraprofessional. The Commissioner of Human Services shall appoint a contact person at each State psychiatric hospital, who is independent of the hospital staff and who shall report directly to the Commissioner, or his designee, to whom reports of information concerning incidents of abuse shall be made. It shall be the responsibility of all personnel employed at a State psychiatric hospital to report information concerning abuse to the contact person. The contact person shall report substantiated incidents of abuse or malpractice to the appropriate professional licensing or certifying board. Failure to report instances of alleged abuse or malpractice shall be sanctioned. The Prosecutor's Office of each county in which a State psychiatric institution is located shall provide an independent review of all allegations of abuse.

Legislative Recommendation No. 4: (See Recommendation No. 9, pg. 4) The Department of Human Services shall conduct in-service, on-site training concerning patient abuse for all employees, including support staff such as housekeeping, engineering, grounds and food service staff who have contact with patients. Trainers shall be designated instructors from within the hospital or Department of Human Services, who have first successfully completed a training program. The in-service, on-site training program shall be comprehensive and include:

- i. sensitivity training to encourage staff interaction with patients;
- ii. abuse prevention programs designed to educate and empower employees and

patients, which shall include discussions in ward community groups concerning abuse, rights of staff and patients, and procedures for handling abuse;

iii. an extensive orientation program for new hires;

iv. cultural training which addresses racial issues;

v. a G.E.D. program for staff who do not have a high school diploma; and

vi. a requirement that employees successfully complete training programs, including G.E.D. programs, within time-limited goals. Insufficient progress in meeting the goals shall result in salary and promotion limitations, and to the extent possible, demotions and dismissals.

Legislative Recommendation No. 5: (See Recommendation No. 12, pg. 5) Sex offenders, who are deemed in need of involuntary commitment, shall be continuously confined at a secure facility, such as the Forensic Psychiatric Hospital at Trenton. A victim's family shall be notified of any civil commitment hearing or change of status relative to "Megan's Law" offenders or other violent crime offenders.

Legislative Recommendation No. 6: (See Recommendation No. 13, pg. 6) Legislation should be enacted to require the Department of Human Services to conduct criminal background checks on employees at least biennially.

Legislative Recommendation No. 7: (See Recommendation No. 14, pg. 6) Current and newly hired Human Services Police officers shall complete a training program, approved by the Police Training Commission, at designated police academies within a specified period of time. The training program shall include sensitivity training to ensure that the officers are prepared to encounter abuse situations between employees and patients, and among patients at the State psychiatric hospitals. The training also shall prepare the Human Services Police to deal with patients with violent criminal backgrounds.

Legislative Recommendation No. 8: (See Recommendation No. 19, pg. 7) All patients shall be tested for HIV, hepatitis and other blood-borne pathogens, as well as other sexually transmitted diseases (S.T.D.'s), as soon as they are admitted and during their hospitalization, for the patient's health and for the safety and protection of other patients.

Legislative Recommendation No. 9: (See Recommendation No. 24, pg. 8) The Senate and Assembly Standing Reference Committees having jurisdiction over State psychiatric institutions shall review the Department of Human Services' progress in implementing the recommendations of the task force, which shall include hearing from patients and their families, employees and support groups associated with State psychiatric hospitals. The review shall include a public hearing and shall be conducted no later than one year after the enactment of this legislation and shall be conducted biennially thereafter.

APPENDIX B***RECOMMENDED ADMINISTRATIVE ACTIONS***

Administrative Recommendation No. 1 (See Recommendation No. 2, pg. 2) It is recommended that the Department of Human Services increase staffing levels at the hospital. Also, staffing and personnel records should be reviewed to determine if the actual staffing on all the shifts is meeting the current standards. Moreover, the staffing ratios should be examined and updated to reflect the changing population at Greystone, a population that is more impaired than the hospital's population may have been years ago when the staffing ratios were developed. We further recommend that a report be submitted to the Legislature, within 180 days, detailing the proposed changes in personnel.

Administrative Recommendation No. 2 (See Recommendation No. 3, pg. 2) If filling psychiatrist staff positions is difficult because of low salaries, scheduling constraints and burnout problems, the Department of Human Services should consider contracting out these positions with either local hospital psychiatric departments or private psychiatric practitioners.

Administrative Recommendation No. 3 (See Recommendation No. 5, pg. 3) The Department of Human Services should provide more intense supervision of weekend and night employees as well as strengthen oversight of patient care areas.

Administrative Recommendation No. 4 (See Recommendation No. 7, pg. 3) The Department of Human Services should keep patients informed of actions they can take when they witness or experience abuse. The Department of Human Services should create an atmosphere of respect and concern for patients throughout the hospital and address the issues of appropriate behavior among patients.

Administrative Recommendation No. 5 (See Recommendation No. 8, pg. 4) Upon admission, the Department of Human Services should immediately identify and segregate the criminally insane (Krol) and mentally ill chemically addicted (MICA) patients from the other new patients. All new patients should receive urinalyses and blood tests immediately upon admission to determine if a patient has a communicable disease.

Administrative Recommendation No. 6 (See Recommendation No. 10, pg. 4) The Department of Human Services should institute comprehensive pre-employment screening of all employees, including psychological testing. It should also require a high school diploma for all new employees and perhaps an additional two years of schooling or training by the Department of Human Services. If an applicant for employment does not have the requisite high school diploma or G.E.D., he may be hired provisionally for six months, during which time he must complete the G.E.D. program.

Administrative Recommendation No. 7 (See Recommendation No. 11, pg. 5) The Department of Human Services should take immediate steps to adopt a two-year plan to affiliate the State psychiatric hospitals with publicly supported universities, community colleges, professional training programs in medicine, nursing, psychology, social work and law, and other public and private institutions of higher education to begin the use of on-site instructors, intern programs and work-study arrangements at the State hospitals.

Administrative Recommendation No. 8 (See Recommendation No. 15, pg. 6) The Department of Human Services should ensure that all "elopements" are investigated thoroughly, including the reason for the escape.

Administrative Recommendation No. 9 (See Recommendation No. 16, pg. 6) The Department of Human Services should establish a timetable for the removal of all abandoned buildings, and in the meantime, the Human Services Police should regularly patrol the abandoned buildings.

Administrative Recommendation No. 10 (See Recommendation No. 17, pg. 6) The Department of Human Services should reestablish intensive treatment programs for MICA patients. Also, it should revitalize patient work program initiatives with community corporations and businesses who are willing to provide jobs, such as packaging and assembly work, for patients to perform. The administration at Greystone should contact local community corporate and business leaders to initiate a strong work program at Greystone.

Administrative Recommendation No. 11 (See Recommendation No. 18, pg. 7) The Department of Human Services should explore the possibility of patients performing maintenance and other work at the facility, as it would be therapeutic and also help defray the costs of hospitalization. This could maximize use of existing resources.

Administrative Recommendation No. 12 (See Recommendation No. 20, pg. 7) The Department of Human Services should mandate strict segregation by sex of all adult patients on the hospital wards. There may be exceptions in the cottages for higher functioning patients on the hospital grounds, provided that close supervision is available to ensure that there is no sexual abuse. The Department of Human Services should not permit patients with hepatitis, HIV and other S.T.D.'s to be placed in general patient units. The Department of Human Services should provide adequate treatment rooms for patients.

Administrative Recommendation No. 13 (See Recommendation No. 21, pg. 7) The Department of Human Services should require, as a condition of employment, that treatment staff speak easily understandable English. Also, the department should provide language training to current staff members whose English speaking skills need improvement.

Administrative Recommendation No. 14 (See Recommendation No. 22, pg. 8) The Department of Human Services should continue to vigorously pursue the creation of small, community-based residential programs and housing, to the maximum extent possible, for persons with mental illness.

Administrative Recommendation No. 15 (See Recommendation No. 23, pg. 8) The Departments of Human Services and Health should work together to help community hospitals expand their intermediate and long-term psychiatric bed capacity, in order to provide more inpatient psychiatric care in the community.