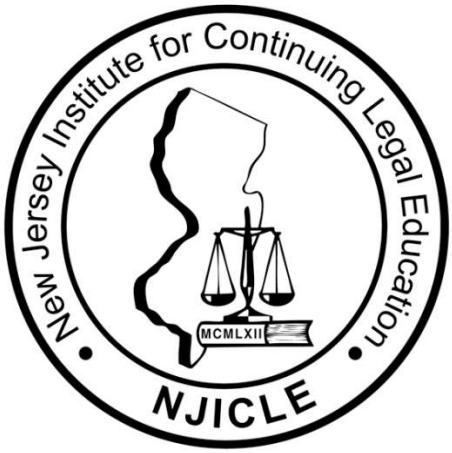
MENTAL HEALTH 101: WHAT TO DO WHEN YOU ENCOUNTER MENTAL ILLNESS IN YOUR CLIENTS OR FAMILY

2021 Seminar Material

M0369.21

New Jersey Institute for Continuing Legal Education

A Division of the State Bar Association
NJICLE.com



This page intentionally left blank

MENTAL HEALTH 101: WHAT TO DO WHEN YOU ENCOUNTER MENTAL ILLNESS IN YOUR CLIENTS OR FAMILY

Moderator/Speaker

Honorable Daniel D'Alessandro, JSC (Ret.)
Weiner Law Group LLP
(Jersey City)

Speakers

Sean Benoit, Esq.
Community Health Law Project
(Elizabeth)

Debra A. Clifford, Esq.
Gibbons Law, P.C.
(Red Bank)

Steven M. Fishbein, M.S., CRC, LRC
Division of Mental Health and Addiction Services (Trenton)

Hope Massa, MSW, LCSW
Capital Health Regional Medical Center
(Trenton)

Jessica S. Oppenheim, Esq.
The Arc of New Jersey
(North Brunswick)

Georgina Giordano Pallitto, Esq.
Certified by the Supreme Court of New Jersey as a Criminal Trial Attorney
Pallitto Law LLC
(Newark)

Rehana Rasool, Esq.
Community Health Law Project
(Bloomfield)

Cheyne R. Scott, Esq.
Chasan, Lamparello, Mallon & Cappuzzo, P.C. (Secaucus)

Brian Sperber, Esq.
Mental Hygiene Legal Service
(Elmhurst, NY)

John Verney
Department of Human Services, State of New Jersey (Trenton)

M0369.21

Table of Contents

What happens if your client gets committed across the Hudson River?

A brief look at New York State Retention (Commitment) Laws and Court Procedures

Brian Sperber

Retention vs Commitment

- In New York, when an individual is committed to a psychiatric facility for treatment against their will, they are considered "Retained" rather than "committed"

- This distinction is important because using improper terminology often results in facility staff confusion.

Retention Laws in New York

- All Law's Related to Involuntary Psychiatric Retention can be found in Article 9 of the New York State Mental Hygiene Law

FORMS OF RETENTION UNDER ARTICLE 9 OF THE MENTAL HYGIENE LAW

VOLUNTARY RETENTION

- Codified under Section 9.13 of the Mental Hygiene Law
- Legal Standard: An individual has a mental illness for which care and treatment are appropriate, and the person is suitable for admission on a voluntary basis.
- Voluntary admission in New York is indefinite. An individual can remain as a voluntary patient for as long as they desire/require treatment

Rights of the Voluntary Patient under 9.13 of the Mental Hygiene Law

- Voluntary Patients Can Refuse the Administration of Regularly Prescribed Medications.
  - Voluntary Patients cannot refuse the administration of PRN or single dose medications given in emergency situations.
- When a Voluntary Patient is ready for discharge, regardless of whether the treatment team agrees, they can submit"Notice of Discharge" to staff the facility where they are retained.
  - The Notice of Discharge must be in writing and include the name of the patient, the date and time, and their desire for release.
  - The receiving staff member must pass the Notice of Discharge to the Facility Director
- Upon receipt, the hospital has 72 hours to determine whether they want to pursue involuntary retention
  - 72 hours means 72 hours. There are no exceptions for weekends or holidays
- Should the facility wish to continue retention, the Facility Director must file a petition with the Supreme Court in the County where the hospital is located within the aforementioned 72 hours requesting an Order of Involuntary Retention.
- After receiving the petition, the Court will schedule hearing to determine if the patient meets the legal standard for involuntary retention

INVOLUNTARY RETENTION

- Legal Standard in New York: An individual has a mental illness for which care and treatment to a mental hospital is essential to his or her welfare and the person's judgement is too impaired for him or her to understand the need for such care and treatment and as a result of his or her mental illness the person poses a substantial threat of harm to self and others.

STATUTES ALLOWING FOR INVOLUNTARY RETENTION:

- The following Mental Hygiene Law statues allow for an individual's involuntary retention:
  - MHL 9.27
  - MHL9.39
  - MHL 9.37

9.27-Involuntary Retention-Two Physician Certificates

- Under 9.27 of the Mental Hygiene Law, a designated party who determines that an individual requires involuntary hospitalization makes an Application for to the Supreme Court for Retention.
- To complete the application, an individual must be evaluated by two New York licensed psychiatrists who determine whether the individual meets the legal standard for retention.
- Applications to the Supreme Court under MHL 9.27 are typically began in the Emergency Department , prior to a patients on a mental health unit
- Upon arrival to an inpatient unit, a staff psychiatrist must examine and certify that the individual meets the standard for involuntary retention.
- This psychiatrist must be somebody who did not complete the initial evaluation contained in the application.
- Under 9.27 a patient can be held for up to 60 days before a required Court review.
- If a facility believes an individual needs more treatment, they can apply for further retention for a period of up to 6 months under 9.33 of the Mental Hygiene Law.

EMERGENCY RETENTION UNDER THE MENTAL HYGIENE LAW

- Standard: Reason to believe that the person as a mental illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm to themselves or others
- Serious harm means that there is a serious risk of suicide, physical violence towards others, or other conduct demonstrating that the person is dangerous to him or herself.
- Emergency retention procedure is codified under both 9.37 and 9.39 of the Mental Hygiene Law.

9.37- Retention by Community Service Designee

- 9.37 allows a director of community services or their designee to make an application for involuntary retention.
  - This application is commenced by an individual's treatment provider and started in the community immediately before somebody is brought to the emergency room
- To begin the application, the director of community services or their designee conducts an evaluation to see whether an individual meets the aforementioned emergency retention standard
- After arrival at the hospital, a staff psychiatrist evaluates the patient to confirm the community designee's conclusion that they meet the involuntary retention standard.
- The confirmation examination must occur within 72 hours of the initial screening examination.
- After this occurs, a patient can be held for up to 60 days before a required court review.
- If the hospital feels an individual needs treatment beyond 60 days, they can petition the Supreme Court for a continued retention for a period of up to 6 months under 9.33 of the Mental Hygiene Law.

9.39- Emergency Retention

- Under 9.39 of the Mental Hygiene Law, the parties enumerated in 9.41, 9.43, 9.45, 9.55, and 9.57 of the Mental Hygiene Law may initiate retention
- There is no examination at the time of admission to the hospital.
- Prior to coming to the hospital, the aforementioned individuals must examine the patient and confirm that the patient meets the previously mentioned emergency retention standard
- Within the subsequent 48 hours, a staff psychiatrist must examine the patient and confirm the first doctor's finding.
- 9.39 allows for a patient to be held up to 15 days
- Prior to the expiration of the 15 day period, the treating psychiatrist must initiate the retention procedures codified under mental hygiene law 9.27

Parties that can Initiate a 9.39 Hold

- Peace Officers or the Police (MHL 9.41)
- The Court (MHL 9.43)
- Director of Community Services when it is brought to their attention that somebody is in need of emergency services by one of the following people: the individual's parent, adult sibling, spouse, adult child, legal guardian, NY licensed psychologist, registered nurse, current treating social worker, case manager, the police, or peace officer (MHL 9.45)
  - Under MHL 9.37 the director has personal knowledge, under MHL 9.39, they were informed of the need for retention.
- Qualified Psychiatrist (MHL 9.55)
- Emergency Room Physician (MHL 9.57)

CONTESTING INVOLUNTARY RETENTION IN NEW YORK

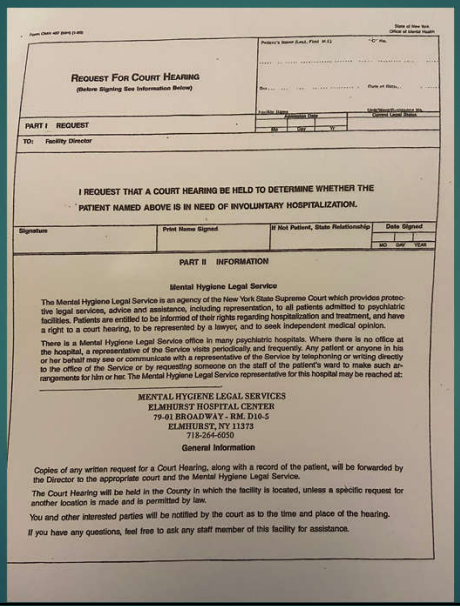
9.31-Client Petitioned Review

- Under the Mental Hygiene Law, a hospital is only required to petition the Supreme Court for an Order retaining an individual for involuntary psychiatric treatment if they want to continue to retain the person beyond 60 days.
  - The procedure for continued inpatient retention beyond 60 days is codified under MHL 9.33
- At any time, should a patient retained under MHL 9.27 or 9.37 wish to have a hearing regarding whether they meet the legal criteria for involuntary retention, they can petition the Supreme Court for a hearing pursuant to 9.31 of the Mental Hygiene Law
- The client, or Mental Hygiene Legal Service completes a "Notice of Hearing Request" for
- This form turns into a petition which is then filed with the Court.
- After processing and service, the requested hearing is supposed to occur within 5 days of the petition being filed, unless good cause is shown

Requesting a hearing under MHL 9.39

- A person retained under MHL 9.39 has the right to a hearing to determine whether they meet the emergency retention standard.
- The petitioning follows the same procedure as requesting a hearing under MHL 9.31
- Conversion to MHL 9.27 does not preclude somebody from having a hearing under MHL 9.39
- Should a client lose and be converted to MHL 9.27, they are entitled to another hearing pursuant to MHL 9.31

New York's Hearing Request Form



REQUEST FOR COURT HEARING
(Before Signing See Information Below)

PART I REQUEST

TO: Facility Director

I REQUEST THAT A COURT HEARING BE HELD TO DETERMINE WHETHER THE PATIENT NAMED ABOVE IS IN NEED OF INVOLUNTARY HOSPITALIZATION.

Signature | Print Name Signed | If Not Patient, State Relationship | Date Signed (MO DAY YEAR)

PART II INFORMATION

Mental Hygiene Legal Service

The Mental Hygiene Legal Service is an agency of the New York State Supreme Court which provides protective legal services, advice and assistance, including representation, to all patients admitted to psychiatric facilities. Patients are entitled to be informed of their rights regarding hospitalization and treatment, and have a right to a court hearing, to be represented by a lawyer, and to seek independent medical opinion.

There is a Mental Hygiene Legal Service office in many psychiatric hospitals. Where there is no office at the hospital, a representative of the Service visits periodically and frequently. Any patient or anyone in his or her behalf may see or communicate with a representative of the Service by telephoning or writing directly to the office of the Service or by requesting someone on the staff of the patient's ward to make such arrangements for him or her. The Mental Hygiene Legal Service representative for this hospital may be reached at:

MENTAL HYGIENE LEGAL SERVICES
ELMHURST HOSPITAL CENTER
79-01 BROADWAY - RM. D10-5
ELMHURST, NY 11373
718-264-6050

General Information

Copies of any written request for a Court Hearing, along with a record of the patient, will be forwarded by the Director to the appropriate court and the Mental Hygiene Legal Service.

The Court Hearing will be held in the County in which the facility is located, unless a specific request for another location is made and is permitted by law.

You and other interested parties will be notified by the court as to the time and place of the hearing.

If you have any questions, feel free to ask any staff member of this facility for assistance.

Miscellaneous New York Retention Law Information

- The legal standard for a retention hearing is Clear and Convincing Evidence
- There is no prohibition on a retained individual representing themselves at their hearing
- Under 9.35 of the Mental Hygiene Law, should a client lose, they are entitled to a de novo hearing before a different Judge of the Supreme Court in the County in which they are retained
  - At their de novo hearing, the client can request to have a jury of their peers determine whether they meet the standard for involuntary hospitalization
- Individuals are retained until discharged
- All proceedings under the Mental Hygiene Law occur at the County Courthouse where the hospital is located.

9.15-Informal Retention-A New York Quirk

- The Standard for informal retention is that a person has a mental illness for which care and treatment in a mental hospital is appropriate, the person is suitable for admission on an informal basis, and do not pose a substantial threat of harm to self or others
- This starts by the patient making an oral request for hospitalization
- A Psychiatrist should confirm that the individual meets the informal standard.
- A patient can remain indefinitely, but must be permitted to leave at any time.
- This status cannot convert to any form of involuntary retention.
- Should a psychiatrist not convert a patient's legal status within the allotted time, the patient becomes informal.

ASSISTED OUTPATIENT TREATMENT

- 9.60 of the Mental Hygiene Law governs court mandated outpatient treatment. (Kendra's Law)
- An Outpatient or AOT order can last for a period of up to one year and is indefinitely renewable.
- The AOT provider in the individual's county of residence must evaluate the client and should they feel the individual meets AOT criteria, petition the Court for a Hearing, where a determination must be made by a Judge of the Supreme Court that the individual meets AOT criteria.
- AOT orders can be transferred from county to county within New York ONLY
- AOT orders remain in effect should an individual become involuntarily hospitalized.

AOT CRITERIA

- 18 years or older
- Suffering from a Mental Illness
- Unlikely to Survive Safely in the Community without Supervision
- The patient has a history of a lack of compliance with treatment for mental illness that has
  - At least twice in the last 36 months been a significant factor in hospitalization not including a patient's current hospitalization, OR
  - Resulted in one or more threats or acts of serious violent behavior towards self or others within the past 48 months not including a patient's current hospitalization
- The patient is unlikely to voluntarily participate in treatment
- This is needed to prevent relapse
- The patient will likely benefit from AOT
- The AOT order is in conformity with any prior advanced directives the patient may

Mental Hygiene Legal Service

- The Mental Hygiene Legal Service (MHLS) is an agency within the Appellate Division of the Supreme Court of New York.
- We operate in every New York State County and handle the majority of retention hearings
- They are the equivalent to the Office of the Public Defender's Division of Mental Health Advocacy in New Jersey.

MHLS Contact Information

- The MHLS office for the First Judicial Department (Manhattan and the Bronx) can be found here: https://www.nycourts.gov/courts/ad1/Committees&Programs/MHLS/index.shtml
- The MHLS office for the Second Judicial Department (The rest of NYC, Long Island, Westchester, Rockland, Putnam, Orange and Dutchess Counties can be found here: https://www.nycourts.gov/courts/ad2/pdf/mhlsart10/mhls_ContactUs.pdf
- The MHLS office for the Third Judicial Department (Northern Hudson Valley, Albany, Binghamton, Ithaca, and the North County can be found here: http://www.courts.state.ny.us/ad3/mhls/index.html
- The MHLS office for the Fourth Judicial Department (Buffalo, Rochester, Syracuse, and Western New York) can be found here: https://www.nycourts.gov/courts/ad4/mhls/mhls-index.html

MEDICATION OVER OBJECTION

- In New York, hospitals are required to obtain an order from the Supreme Court to administer psychotrophic medications against a patient's will.
- The legal standard for the administration of psychotrophic medications is contained in *Rivers v. Katz* 67 NY2d 485 (1986)
- The hospital bears the burden of proving the foregoing by clear and convincing evidence

Criteria for Medicating Somebody Against their Will

- According to *Rivers,* in order to authorize the involuntary treatment of an objecting patient, the hospital must prove that:
- A)The patient lacks the capacity to make a reasoned decision with respect to the proposed treatment; and
- B) The proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest, taking into consideration all relevant circumstances, including (1) the patient's best interests, (2) the benefits to be gained from the treatment, (3) the adverse side effects associated with the treatment, and (4) any less intrusive alternative treatments.

NEW YORK COVID 19 RESOURCES

LINKS FOR ASSISTANCE

- The New York Legal Assistance Group: nylag.org/covid19/
- The Legal Aid Society of New York City: https://www.legalaidnyc.org/get-help/covid-19/covid-19-information-for-clients/
- The New York State Bar Association's COVID 19 Pro Bono Project: nysba.org/covidvolunteer/
- The Office of the New York City Comptroller's COVID 19 Resource Center: https://comptroller.nyc.gov/services/for-the-public/covid-19-resource-center/english/legal-support/

IN PATIENT CLIENT CONTACT DURING COVID-19

- All inpatient hospital units have patient phones which are available at all times and are free of charge for the patients
- Most nurses stations are good about getting transferring calls and connecting clients with their attorneys/representative
- The Mental Hygiene Part of the Supreme Court is still virtual, meaning all hospitals have the ability for virtual meetings conducted through Mircrosoft Teams

QUESTIONS?

Contact Info:

Brian Sperber

Senior Attorney with the Mental Hygiene Legal Service

Bsperber@nycourts.gov

718-264-6055

Mental Health Issues for People with Developmental Disabilities

Jessica S. Oppenheim, Esq.

Who Are We Talking About?

- People with Mental Illness
- People with Developmental Disabilities
- Mental Illness and Developmental Disability Are Not the Same Though They Can Co-Occur and Often Confused

Developmental Disability

- A broad "umbrella" terms used to describe medical conditions that affect can mental tasks, such as problem solving, reading comprehension, attention span, remembering, ie, Cognitive
- Can also affect mobility, speech

Developmental Disabilities

New Jersey Law (Title 30) states that a developmental disability is a chronic disability which:

- Is attributable to a mental or physical impairment
- Is manifested before age of twenty two
- Is likely to continue indefinitely
- Substantial functional limitation is three or more areas of major life activity

Examples

- Autism Spectrum Disorder
- Intellectual Disability
- Epilepsy
- Cerebral Palsy

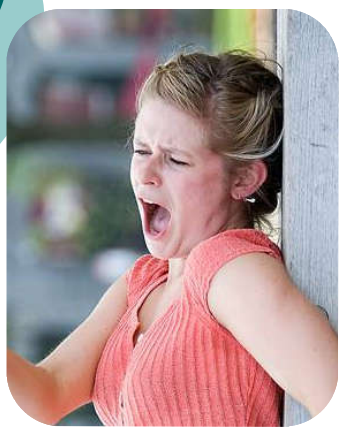
Autism Spectrum Disorder

- Fastest growing DD in the US
- CDC statistics: 1 in 66 Americans
- In New Jersey: closer to 1 in 44
- 4 times more common in males
- Higher risk of co-occurring mental health issues ie depression, anxiety

Autism Spectrum Disorder

- SPECTRUM of impairment from mild to severe may include:
- Rigidity in actions or thinking
- Obsessive interests: things or people
- Poor or different verbal/nonverbal communication
- Impulsivity/Unpredictable/Suggestible
- Sensitive to sensory experience

Common Triggers for Challenging Behaviors



- sudden transitions, taken by surprise
- misunderstood explanations; confusion
- not knowing/understanding order of events or expectations
- insufficient time to respond
- communication/situation is too complex; too many demands
- sensory overload
- too many expectations
- unfamiliar surroundings, people, situations

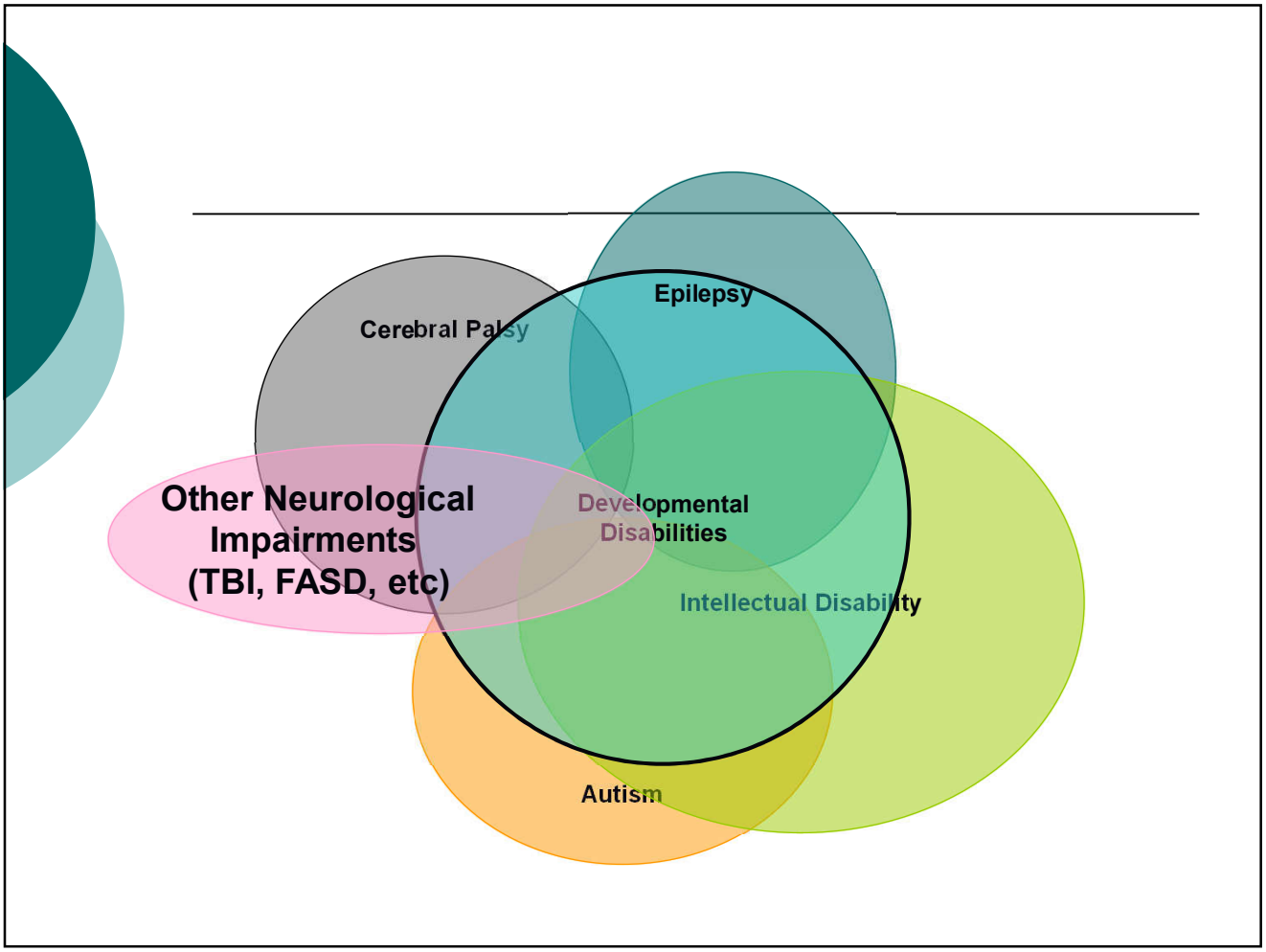
ASD and Challenging Behaviors

Not all challenging behaviors require medication or hospitalization

- Meltdowns may be person's response to frustration, limited communication skills, pain, etc.
- Functional assessments and behavioral intervention may reduce or eliminate these behaviors

Traumatic Brain Injury (TBI)

- Brain injury results in three major types of impairments:
  - Physical problems (such as full or partial paralysis);
  - Cognitive impairments (thinking and comprehending); and
  - Behavior disorders


Epilepsy
Cerebral Palsy
Other Neurological Impairments (TBI, FASD, etc)
Developmental Disabilities
Intellectual Disability
Autism

Mental Illness

- Examples include schizophrenia, depression, anxiety disorders
- Symptoms may be cyclical, temporary or episodic where I/DD is constant and permanent

Differences Between I/DD and MH

- Identify themselves as two different disability communities
- Receive different types of services and resources
- I/DD requires an onset before the age of 22, psychiatric disabilities do not
- I/DD are lifelong and permanent, psychiatric disabilities are more episodic
- People with I/DD often have difficulty with social/practical skills

Developmental Disability vs. Mental Illness

Developmental Disability

- Below average intellectual functioning
- Impairments in social adaptation
- Usually occurs during the developmental period. (At or near birth and is almost always recognized by school age)
- The person can usually behave rationally at his/her functioning level

- Mental Illness
  - Has nothing to do with IQ. May be a genius or below average intellect.
  - The person may be very competent socially
  - May strike at any time (Most often occurs in early adulthood or middle years.)
  - The person may vacillate between "normal" and irrational behavior

Developmental Disability vs. Mental Illness

Developmental Disability

- The person will not be violent except in those situations that cause violence in persons without I/DD
- Cannot be cured
- Education and training is provided to assist them to care for themselves to the highest degree possible

- Mental Illness
  - The person may be erratic, or even violent for no apparent reason
  - If treatment is successful, disorders disappear and the person returns to "normal"
  - Main treatment is usually by medication (e.g. anti-depressant, anti-psychotic drugs) and psychotherapy (help individuals understand their problems)

Dual Diagnosis

- Co-Existence of symptoms of a **developmental disability** and a **mental illness** or mental health disorder
- 30-35% of people with a DD also have a mental health disorder

Thanks To:

- Community Access Unlimited and the NJ Council on Developmental Disabilities
  - The **Revised Family Crisis Handbook**
  - Co Authors Donna Icovino and Lucille Esralew, PhD
  - http://www.caunj.org

Serving the Population

New Jersey Department of Human Services-

- Division of Developmental Disabilities (DDD)
- Division of Mental Health and Addiction Services (DMHAS)

NJ Department of Health- Psychiatric Hospitals

Juveniles: Children's System of Care in Department of Children and Families (includes ages **18** – **21**):

- **Performcare**: www.performcarenj.org

IDD System-Division of Developmental Disabilities

- Not historically created to work with criminal offenders
- No incentive to provide housing and services to offenders with IDD, often considered "high risk"
- **VOLUNTARY-Division of Developmental Disabilities (DDD) is a voluntary agency**

Major Changes to Service Delivery System

- Effects available services and how to obtain them
- Effects how quickly services can be accessed

Major Change #1

- Olmstead v. L.C. ex rel. Zimring, 527 U.S. 589 (1999)- People should live in the "least restrictive" environment possible for that individual
- End of large institutional living- Developmental Centers
- Small, **community-based** housing options
- Work First-community-based employment

Major Change #2

- Medicaid funded services
  - Comply with Center for Medicaid and Medicare Services (CMS) Federal agency
  - Must be Medicaid eligible
  - Fee for Service

Behavior and Behavioral Crisis

- It can be the person's behavior that draws attention–
  - Can be the presence of a MI
  - Could be behaviors caused by the disability
  - Can be both
  - Best option is professionals with experience with people with I/DD

Prevention

- Prevention is the best intervention for behavioral crisis
- Clinical Team Responses:
  - Under 21 yoa, Contact Mobile Response Stabilization Services (MRSS) through **performcare** 1-877-562-7624
  - 21 and older, contact Crisis Response and Enhancement Services (CARES) at 1-888-393-3007.

Behavioral Crisis Intervention

- Crisis response is the same
- Important for families calling 911 to tell dispatch that family member has IDD and what that is.
- Police may arrange transport to hospital/screening center- if not, family can call Mobile Outreach (908)994-7131 or CARES 888-393-3007.

Voluntary Admission v. Involuntary Commitment

- Adults (18 and older) with IDD who are own guardian can sign themselves into treatment
- Court-appointed guardians can sign person in for voluntary admission (but not Bureau of Guardianship Services)
- Does not apply to children under age 18.

Life Planning

- SSI/Medicaid
- DVRS-Division of Vocational Rehabilitation Services
- Service Delivery through DDD or CSOC/Performcare
- Develop a life plan – financial and otherwise

Guardianship v. Supported Decisionmaking

- Start with presumption that guardianship is not needed
- Consider less restrictive options like financial or health care power of attorney, advanced directive
- Supported decisionmaking considered less restrictive

What is it?

- Ethical principle that recognizes the rights and needs of individuals with mental health and developmental disabilities to make their own decision and choices and the obligation to help the person implement the decision they make.

- Individuals with developmental disabilities and mental illness take control of their own life and life decisions
- Do so with “Supported Decisionmaking”

Why?

- Olmstead v. L.C. ex rel. Zimring, 527 U.S. 589 (1999)
- Change in thinking—Live in "Least Restrictive Environment"

Guardianship

- Was the presumption for families to file for guardianship for child with I/DD
- Everyone presumed competent at 18 unless proven otherwise
- People with I/DD presumed to have competence unless proven otherwise

Supported Decisionmaking

- Alternative to Guardianship
- Allows person to work with a team and make choices about their life
- Person can designate a circle of support
- Maximized independence and promotes self-advocacy

Supported Decisionmaking v. Guardianship

Guardianship: puts decisionmaking in the hands of the guardian

Supported Decisionmaking: allows the person with the disability or mental illness to make life decisions

Supported Decision Making v. Durable Power of Attorney

- POA identifies the substitute decision maker for a person when they're incapacitated
- SDM identifies the person/people who will support the person with I/DD in making her/her own decisions.

Person Centered Planning

- Person Centered Planning is a tool that someone can use to help support their decisionmaking
- A type of SDM that uses all the people and tools to increase autonomy

Research

- Research shows that self-determination is related to positive quality of life outcomes
- More likely to live independently and work
- Less likely to suffer from depression or anxiety

Resources

- The Arc of New Jersey Family Institute- www.arcnj.org
- American Bar Association- www.ambar.org
- National Resource Center for Supported Decision-making- www.supporteddecisionmaking.org

Criminal Justice Advocacy Program of The Arc of NJ

- Four full time staff and one part-time assistant
- Over 35 Personalized Justices Plans accepted by the court yearly
- Worked with over 300 clients, 70 of whom were being monitored following their PJPs on probation or going through court
- Conduct trainings in New Jersey and nationally
- Provide technical assistance via phone to over 500 professionals, families, and clients on a yearly basis

Personalized Justice Plans (PJP)

- Each case is individual, no two personalized justice plans (PJP) will be the same.
- PJP must address the needs of the court. Accountability and responsibility must remain with defendant.
- PJP acts as a preventative tool for future criminal involvement.

PJP: Issues to be Addressed

- Offenders with developmental disabilities become involved with the criminal justice system because of one or more of the following factors:
  - **Social:** prefers juveniles for friends; hangs out with people who take advantage of them.
  - **Sexual:** Limited or no knowledge of appropriate/ inappropriate sexual behavior; lack of sex education; limited opportunities for appropriate sexual expression; increased risk of victimization.
  - **Addiction:** Alcohol or drug addiction is present and untreated.

PJP: Keep it Personal

- Address multiple areas and tailor it to meet the needs of each individual
- Draft a plan: include the input of all involved parties – most importantly the offender!
- If the person is not willing to follow the recommendations of the PJP it will not work!

PJP: Getting ready for court

- Finalize the plan in an advocacy letter.
- Detail all services in the PJP, specific facts of the case, describe the person's disability and provide contact information.
- Share letter with attorney prior to court for their review and comment.
- Send letter directly to the judge with copy to all parties.
- Appear in court if possible to explain PJP in person.

PJP: Approved

- **Case management**: client is placed on probation with PJP as a condition.
  - Contact probation officer or department.
  - Go with client to probation or speak with probation officer via telephone the day your client reports.
  - Provide progress reports to probation officer as requested.

Options Utilized

- Involuntary Outpatient Commitment (IOC)
- Mental Health Probation Officer
- Day Programs/Medication monitoring
- Behavioral Therapy Services
- Families

CJAP

- For more information or assistance contact
  - 732-828-0988 or joppenheim@arcnj.org
  - cjap@arcnj.org
  - 732-246-2525, ext. 36
  - Website: www.cjapnj.org

Encountering Mental Illness: A Crash Course on Getting Treatment for Clients or Family Members in Crisis

Division of Mental Health and Addiction Services

Steven M Fishbein, MS, CRC, LRC
Deputy Assistant Director
Office of Treatment and Recovery Support

Amy Dindak, Program Analyst
Office of Community Services

Mental Health Disorders

- Mental health disorders involve changes in thinking, mood and/or behavior that are linked to distress and impaired functioning.
- Mental health problems (e.g., symptoms, signs, and behaviors) exist along a continuum from normal health to severe distress and dysfunction.
- Mental health problems constitute a disorder when these are significant enough to interfere with the ability to work, carry out daily activities, and successfully engage in relationship.

Prevalence of Mental Illness

- According to the most respected national survey from SAMHSA, about 46.6 million U.S. adults (18.6%) had a mental illness.
- An estimated 4.5 % of U.S. adults had a serious mental illness in 2017.
- An estimated 45% of U.S. adults with a mental illness also have a co-occurring substance use disorder.
- In some subpopulations, the prevalence of mental illness is much higher.

Facts about Mental Illness

- While the underlying pathology may not be known, mental illnesses are known to have a biological basis.
- Mental disorders are connected to our physical health and wellbeing, and mental illnesses can show symptoms that mirror physical illnesses.
- Personal feelings and beliefs affect how we view these conditions and influence our interactions with mentally ill individuals.

Facts About Mental Illness

- Many factors contribute to mental illness and substance use disorders, including biological and genetic factors, physical illnesses, and experiences with trauma and abuse.
- Weakness and lack of will power have nothing to do with the causes of mental illness and substance abuse.
- People with mental illness and substance use disorders benefit from treatment and do recover.

Mental Illness and Violence

- People with mental illnesses are no more likely to be violent than anyone in the general population (Shern & Lindstrom, 2013)
- Only a small number of people with a mental illness contribute to the overall rate of violence in the U.S.
- People with serious mental illness are far more likely to be the victims rather than the perpetrators of violent crime. (Glied & Frank, 2014)

Recognizing the Symptoms, Signs and Behaviors of Mental Disorders

Mental Disorders

Symptoms

- What the person in distress experiences

Signs and Behaviors

- What is observed by others

Signs, Symptoms, and Behaviors of Mental Illness can present in several ways

- Appearance
- Cognition
- Attitude
- Affect/Mood
- Speech
- Thought Patterns and Logic
- Orientation and memory

Main Classifications of Mental Disorders

- Psychosis/Thought Disorders
- Mood Disorders
- Anxiety Disorders
- Personality Disorders
- Neurocognitive Disorders
- Developmental and Intellectual Disorders

Key Concepts of Psychosis

- Psychosis is a condition in which a person has lost some contact with reality and has severe disturbances in thinking, emotion, and behavior.
- Psychosis is usually a component of a chronic illness but it can also be episodic.
- Psychosis can occur as part of a thought disorder in schizophrenia, but also in several other disorders.

Psychosis/Thought Disorders

- Thoughts and language are disordered or illogical.
- Examples: delusional or bizarre content of thought, tangential thinking or thought derailment.
- Schizophrenia and other psychotic disorders are most often associated with thought disorders.
- Thought disorders can also occur with other disorders, such as mania and delirium.

Types of Disorders in Which Psychosis May Occur

- Schizophrenia
- Bipolar disorder
- Psychotic depression
- Schizoaffective disorder
- Drug-induced psychosis

Signs and Symptoms of Thought Disorders

- Hallucinations
- Delusions
- Inability to process information or make decisions
- Illogical speech (word salad, jumbled)
- Decreased working memory (immediate recall)
- Trouble with focus and attention

Mood Disorders

Characteristics of mood disorders:

- involve a serious change in mood, affect or emotions in a persistent manner
- are among the most common mental illnesses
- can be episodic or chronic conditions
- interfere with the ability to participate fully in daily life
- frequently co-occur with other mental health conditions

Types of Mood Disorders

- Major Depressive Disorder
- Bipolar Disorder
- Postpartum Depression
- Seasonal Depression
- Persistent Depressive Disorder (persistent but more mild depression)

Signs and Symptoms of Depression

- Loss of pleasure or joy in life
- Difficulty concentrating and making decisions; reading, or watching television can seem taxing
- Feeling hopeless and believing that there's no way to feel better
- Feeling worthless or a failure, and unable to see positive qualities in oneself

Signs and Symptoms of Depression

- Insomnia: Falling or staying asleep can feel nearly impossible
- Tired or fatigued: can't get out of bed, or feel exhausted all the time even when getting enough sleep
- Loss of appetite (or increased appetite): food is not appetizing (food can also be a comfort or coping tool for some, however)
- Somatic symptoms: body aches and other pains

Bipolar Mood Disorder (also referred to as Manic-Depressive Disorder)

Manic

- Feeling euphoric
- Delusions of grandeur
- Sudden feelings of:
  - Irritability or rage
  - Invincibility
  - Impulsivity/ Recklessness
  - Racing thoughts
  - Hyperactivity

Depression

- Intense sadness/despair
- Extreme lethargy
- Severe sleep issues
- Weight gain or loss
- Impaired thinking
- Suicidal thoughts/preoccupation with death

Depression and Suicide

Depression is more common than AIDS, cancer, and diabetes combined, and nearly 400,000 people attempt suicide in the U.S. every year.

- The annual suicide rate is **12.93 per 100,000** individuals.
- Men die by suicide **3.5x** more often than women.
- The rate of suicide is **highest in middle age** — white men in particular.
- White males accounted for **7 of 10** suicides in 2013.
- Firearms account for **almost 50%** of all suicides.

Source: American Foundation for Suicide Prevention

Anxiety Disorders

- Anxiety disorders are the most commonly diagnosed mental disorders.
- Anxiety vs. fear: some anxiety is productive; it helps keep us alert and out of danger.
- Anxiety disorders involve a constant, uncontrollable worry or feeling of dread that is not based on a rational fear.
- The signs and symptoms of anxiety disorders can mimic medical emergencies (e.g., panic attacks can present as heart attacks).

Anxiety Disorders

Physical Signs and Symptoms

- Palpitations
- Sweating or trembling
- Shortness of breath; feeling of being smothered or choked
- Constant muscle tension
- Nausea or abdominal distress
- Feeling dizzy or faint
- Weakness or fatigue

Types of Anxiety Disorders

22

- Anxiety Disorders (primarily differ from one another in the types of objects or situations that elicit anxiety)
  - Generalized Anxiety Disorder
  - Phobias and Social Anxiety Disorder (social phobias)
  - Panic Disorder
- Other Anxiety Related Disorders:
  - Obsessive-Compulsive Disorder
  - Dissociative Disorders and
  - Posttraumatic Stress Disorder

Trauma and Stress

- Stress-related trauma is a psychological response to events that are physically or emotionally harmful.
- Experiences that have negative long-term effects on an individual's physical and mental well-being.
- Causes feelings of constant powerlessness, fear, hopelessness, and a state of alert
  - Its impact is pervasive.
  - It shapes the world view of the individual.
  - Many people cope or heal while others get stuck.

2016 Council of State Governments Justice Center

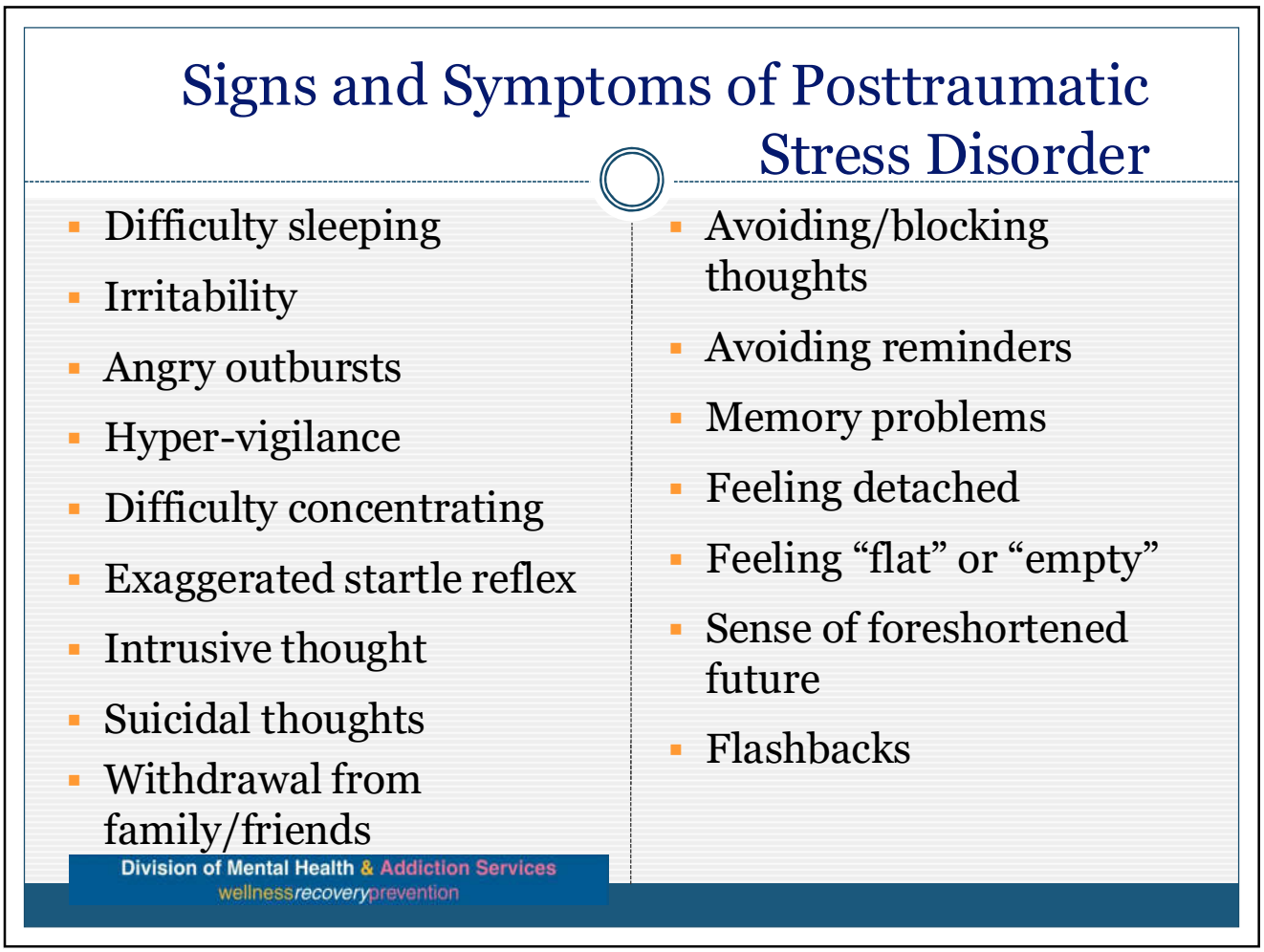
Impact of Trauma

- Short-term effects of trauma can include substance abuse, interpersonal violence, gambling, and other risky behavior.
- Long-term effects can include arrest, incarceration, and recidivism.
- High ACE (Adverse Childhood Experiences) scores are associated with depression, suicide attempts, hallucinations, and various diseases (i.e. liver disease, heart disease, autoimmune disease, etc.).

2016 Council of State Governments Justice Center

Posttraumatic Stress Disorder

- Posttraumatic stress disorder (PTSD) is a type of anxiety disorder.
- PTSD is a health condition triggered by seeing or experiencing a traumatic event.
- It can occur from a variety of traumatic experiences such as: combat, motor vehicle accidents, natural disasters, physical/sexual assault, witnessing a violent death or injury.


Signs and Symptoms of Posttraumatic Stress Disorder
Difficulty sleeping
Irritability
Angry outbursts
Hyper-vigilance
Difficulty concentrating
Exaggerated startle reflex
Intrusive thought
Suicidal thoughts
Withdrawal from family/friends
Avoiding/blocking thoughts
Avoiding reminders
Memory problems
Feeling detached
Feeling "flat" or "empty"
Sense of foreshortened future
Flashbacks
Division of Mental Health & Addiction Services
wellnessrecoveryprevention

Personality Disorders

- An individual's personality is the person's way of thinking, feeling and behaving that makes them different from other people.
- A personality disorder is an ingrained pattern of thinking, feeling and behaving that
  - deviates from the norms of the culture
  - is typically present from adolescence
  - causes distress or long-term difficulties in personal relationships or in functioning in society

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). American Psychiatric Association. (2013).

Neurocognitive Disorders

28

- Neurocognitive disorder is a general term that describes decreased mental function due to a medical disease other than a psychiatric illness.
- It includes dementia as well as a variety of other conditions that affect memory, thinking and behavior.
- Neurocognitive disorders with prominent dementia include Alzheimer's Disease, Vascular Dementia, Parkinson's Disease, and other more rare forms of dementia

Intellectual and Developmental Disabilities

29

- Neurodevelopmental disorders are first manifested early in infancy/childhood and produce deficits in personal, social, academic/occupational functioning.
- Intellectual disability is characterized by limited intellectual capabilities and problems with adaptive functioning, such as managing money, responding to social clues, etc.
- Autism or autistic Spectrum Disorders are characterized by social communication deficits and specific behavioral features.

When a mental illness is affecting an individual's participation in their defense

- Speak slowly and clearly; avoid legal jargon.
- Explain what is happening.
- Write instructions down for the individual, if dates/address are involved.
- Point out discrepancies between goals and current behavior.
- Question, but do not confront, when individuals are expressing illogical or delusional ideas.
- Treat the individual with the respect and be empathic.

From the "Judges' Guide to Mental Illnesses in the Courtroom", APF, Justice Center, The National Judicial College & PRA

Bridging Communication Difficulties with individuals who have Mental Illness

- Always be respectful and acknowledge the person's concerns.
- Even if the person's communication is confusing, you will be able to understand if you listen carefully enough.
- Try to find out what reality-based needs you can meet by identifying the individual's most prominent needs or concerns, if these can be determined.
- The legal environment can be intimidating and discussing events can be re-traumatizing to individuals.

Use Reflective Language and Ask Open-Ended Questions

32

- Examples of reflective language:
  - I hear you saying that you want to …
  - It sounds like…
  - It seems as if…
  - I get the sense that…
- Examples of open-ended questions:
  - "What would you like to see different about the situation that you have described?"
  - "What do you want to see happen in your situation?"

If speech is disorganized, illogical or rambling:

- Respond in a direct, uncomplicated and succinct manner.
- Repeat yourself as necessary without frustration.
- Be patient and allow time for responses.
- When an individual has a flat affect and is not showing emotions, it does not mean that he or she does not have feelings.
- Do not assume the person cannot understand you, even if his/her responses are limited. Even when individuals are unable to respond, they may be clearly understanding everything that you are saying.

Talking with someone who has hallucinations or delusions

34

- If the person is talking to themselves, distracted and appears to be responding to internal stimuli, the individual is likely experiencing symptoms of hallucinations or delusions.
- Hallucinations or the delusions are experienced as real and part of their reality, so you should not directly challenge or try to talk them out these.
- You can communicate that you understand that they are experiencing those events. Do not pretend that you experience them.

Talking with someone who has paranoid thinking

35

- Never argue but try to re-direct the individual and to focus on what is real.
- Give the person enough personal space so that he or she does not feel trapped or surrounded.
- Move the person away from the cause of the fear or from noise and activity, if possible.
- If you feel threatened, make sure you have someone else with you before continuing the interview (have an emergency response plan worked out beforehand).

Setting Limits

36

- If needed, set limits with the person as you would others. Examples:
  - "I only have a half an hour to talk to you, so we need to move on to another issue"
  - "If you scream, I will not be able to talk to you."
- Avoid getting into a “tug of war” over issues (occurs when the interviewer has different priorities or goals and struggles in getting clients to align themselves with this).

Psychiatric Medications

- Psychiatric medications "treat" but typically do not "cure" mental illnesses. Examples include antipsychotic, antidepressant, and antianxiety (anxiolytic) medications, as well as lithium and anticonvulsants (for mood disorders).
- Side effects of psychiatric medications can be significant, and can mimic the symptoms of medical and mental illness, especially if used in combination.
- Recreational substances and "social" substances often interact with psychiatric medications.
- Older people, people with health problems, brain injuries, and intellectual disabilities may be more sensitive to psychiatric medications and their side effects.

About Psychiatric Medications

- Psychotropic medication are drugs capable of affecting the mind, emotions, and behavior.
- Medications are one tool among many that may lessen mental distress.
- Medicines are usually more effective when combined with psychotherapy
- All medications have “side effects.”
- The effects of psychiatrics medications on individuals are unique.

Mental Health Services

- A continuum of outpatient, residential, and inpatient mental health services exists in each county.
- Individuals with acute or emergency psychiatric needs can be assessed and treated at designated screening centers.
- Many outpatient clinics offer co-occurring treatment services
- Housing and peer-run recovery supports programs, can support individuals with mental illness.


Continuum of Mental Health Services
Our goal is to provide the appropriate level of care in the least restrictive environment necessary to meet the individual's needs. Mental Health Services are structured to prevent unnecessary hospitalizations, and return individuals to the community as soon as possible, with the supports necessary to live successfully in the community.
Division of Mental Health & Addiction Services
wellnessrecoveryprevention
Screening and Crisis Intervention
Inpatient Treatment
Outpatient Treatment
Rehabilitative Services
Advocacy, Linkage and other supports
Self-Help

Mental Health Crises

A mental illness crisis may result from a physical condition or reaction that triggers a mental response. This involves a situation which:

- A person's behavior puts them at risk of hurting themselves or others.
- The person cannot resolve the situation on their own.
- Behaviors and emotions may be escalated by interactions with others.

Screening and Crisis Intervention

- Designated Screening Services and Affiliated Emergency Services
- Crisis Diversion Programs (Ocean, Mercer, Union)
- Crisis and Peer Respite Residences (Regional)
- Involuntary Outpatient Commitment (IOC)
- Early Intervention and Support Services (see next slide)
- Suicide Prevention Hopeline
  - 855-NJ – Hopeline or 855-654-6735

Early Intervention and Support Services

- Short-term Outpatient Treatment (30 days) with case management support and linkage to on-going services
- Intended to avert use of more intensive services such as screening and inpatient

- Atlantic
- Bergen
- Camden
- Cumberland (plus Salem)
- Essex
- Hudson
- Mercer (plus Burlington)
- Middlesex
- Monmouth
- Morris
- Ocean

Rehabilitative Services

- Partial Care
  - Up to five hours per day, five days per week, group-based services, with medication management and transportation included
- Supported Employment
  - An approach to vocational rehabilitation for individuals with Serious Mental Illness that uses the "choose, get, keep" approach to successful competitive employment
- Supported Education
  - Helps individuals with Serious Mental Illness develop a sense of self-efficacy and pursue their individual educational goals

Rehabilitative Services (cont'd)

- Community Support Services (CSS)
  - Rehabilitative service model designed to assist individuals in successfully remaining in independent living setting of their choosing
- Community Residences for Adults with Mental Illness
  - Group Homes and Apartments
  - Level of On-site supervision varies from 24/7 to 4 hours per day
  - Per regulations, priority for admission given to individuals being discharged from state hospitals

Advocacy, Linkage and other supports

- Integrated Case Management Services (ICMS)
- Programs for Assistance in Transition from Homelessness (PATH)
- Legal Advocacy
- Justice Involved Services
- NJ Mental Health Cares – Information & Referral
  - 1-866,202-HELP; njmentalhealthcares.org
- Family Support Services
  - Intensive Family Support Services
  - Acute Care Family Supports

Community Services Regional Offices

Northern Region

- Bergen, Passaic, Essex, Union, Hudson, Morris, Sussex, Hunterdon, Somerset and Warren Counties
- 973-977-4397
- Vacant, Regional Coordinator
- Theresa Wilson, Assistant Regional Coordinator

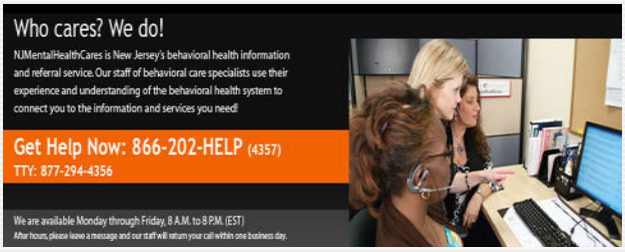
Southern Region

- Atlantic, Cape May, Cumberland, Salem, Burlington, Camden, Gloucester, Mercer, Ocean, Middlesex and Monmouth Counties
- 609-567-7352
- David Helfand, Regional Coordinator
- Ron Roebuck, Assistant Regional Coordinator

Finding Mental Health Treatment Services

48

- NJMentalHealthCares has behavioral health specialists available by phone to make referrals for mental health services.
- Available Monday to Friday from 8AM to 8PM (responds to messages left after hours).



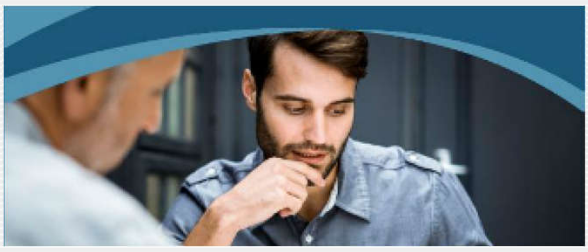
Finding Help for Substance Use Disorders

49

- ReachNJ has counselors available 24/7 to assist callers and provide a "warm handoff " to a treatment program.

CALL 1-844-**ReachNJ**

https://reachnj.gov/



This page intentionally left blank

OBSERVATIONS THAT INDICATE A DEFENDANT MAY HAVE A MENTAL ILLNESS

When Mental Illness Seems to be a Factor, Consider:

Prevalence:

- **Serious Mental Illness:** 17% of adults booked into jails (31% of women; 15% of men)
- **Substance Use Disorder:** 65% of adults in U.S. corrections systems
- **Co-Occurring Mental Illness/Substance Use Disorder:** 72% of adults with serious mental illnesses in jail also had co-occurring substance use disorders

Contextualizing Observations: *While these categories of observation are provided to alert judges that an individual may have a mental illness that requires different judicial action and/or attention by a mental health professional, they are not definitive signs of mental illness. Certain contextual elements are important to remember:*

- Appearing in court is an anxiety-provoking experience for most people.
- Individuals may not be prepared to navigate a system as complex and demanding as the criminal justice system.
- Individuals may bring to court skills that have allowed them to survive in their communities but are poor fits for interacting with the court (e.g., toughness, argumentativeness, silence).

Categories of Observation: *Do you see something in one of the following areas <u>that does not make sense</u> in the court context?*	**Courtroom Observations:** *Examples of how behaviors in the observational areas can indicate that the individual may have a mental illness:*
Appearance: Age, hygiene, attire, ticks/twitches	• Looks older/younger than the listed date of birth • Wears inappropriate attire (e.g., multiple layers of clothing in the summertime) • Trembles or shakes, is unable to sit or stand still
Cognition: Understanding/appreciation of situation, memory, concentration	• Does not understand where s/he is • Seems confused or disoriented • Has gaps in memory of events • Answers questions inappropriately
Attitude: Cooperativeness, appropriate participation in court hearing	• Stays distant from attorney or bench • Acts belligerent or disrespectful • Is not attentive to court proceedings
Affect/Mood: Eye contact, outbursts of emotion/indifference	• Does not make eye contact with judge or court staff • Appears sad/depressed, or too high-spirited • Switches emotions abruptly • Seems indifferent to severity of proceedings
Speech: Pace, continuity, vocabulary *(<u>Note:</u> Can this be explained by discomfort with English language?)*	• Speaks too quickly or too slowly • Misses words • Uses vocabulary inconsistent with level of education • Stutters or has long pauses in speech
Thought Patterns and Logic: Rationality, tempo, grasp of reality	• Seems to respond to voices/visions • Expresses racing thoughts that may not be connected to each other • Expresses bizarre or unusual ideas

JUDICIAL INTERACTIONS

Before Interacting with a Defendant, Consider:

- **How the courtroom environment is affecting the defendant:**
  - Are there noises or distractions in the courtroom that are negatively affecting the defendant?
  - Is there a family member or defense attorney who can help calm the person?
- **Safety** for yourself, the court staff, and the individual.
- **What is being asked and said in open court** and how this may affect future proceedings.

While Interacting with a Defendant, Consider:

Courtroom Situations: *Examples of commonly-observed scenarios*	**Immediate Reponses:** *Recommendations for immediate situation management*

When a mental illness is affecting a defendant's courtroom participation	• Speak slowly and clearly
	• Avoid jargon
	• Explain what's happening
	• Write instructions down if dates/address are involved
	• Treat individual with the respect you would give other adults
	• If appropriate, use principles of Motivational Interviewing:*
	  • Express empathy
	  • Point out discrepancies between goals and current behavior
	  • Roll with resistance
	  • Support self-efficacy

Loss of Reality:** *When the defendant appears confused or disoriented*	• Ground defendant in the here and now**
Loss of Hope: *When the defendant appears sad, desperate*	• As appropriate, instill hope in positive end result • To extent possible, establish a personal connection
Loss of Control: *When the defendant appears angry, irritable*	• Listen, defuse, deflect • Ask defendant about why s/he is upset • Avoid threats and confrontation
Loss of Perspective: *When defendant appears anxious, panicky*	• Seek to understand • Reassure and calm defendant • Deflect concerns

When Taking Action, Consider:

- **Having defendant approach the bench:** Would this de-escalate the situation or create a safety risk?
- **Re-calling the case later in the session/calendar:** Could this help the defendant calm down?
- **Determining whether to proceed:** Is a fitness or competency evaluation appropriate?
- **Setting conditions of release:**
  - Does defendant have capacity to understand conditions?
  - Does defendant have ability to adhere to conditions?
  - What effect will these conditions have on regularity of treatment?
  - What effect will time in jail have on mental health, access to medication, benefits maintenance, etc.?
  - How will conditions/time in jail affect the defendant's access to a primary caregiver?
- **Requesting mental health information:** What exactly do you need to make the decision facing you?
- **Making a referral (to mental health services provider or other services):**
  - What are the goals of the referral?
  - How might the defendant's cultural background and linguistic needs impact access to services?
  - What are the expectations for reporting back to the court?

* Motivational Interviewing is a counseling approach initially developed by William R. Miller and Stephen Rollnick.

**The Loss of Reality, Hope, Control, and Perspective and the immediate responses are based on the LOSS Model developed by Paul Lilley.

A Judges' Primer

on Mental Illness, Addictive Disorders, Co-occurring Disorders, and Integrated Treatment

Understanding and Recognizing Mental Illness

Mental illnesses are neurobiological diseases of the brain, but the precise causes of mental disorders are complex and still not well understood. Like many physical illnesses, they are believed to be determined by an interplay of biological, psychological, and social factors. No single gene is likely to cause a particular mental illness; rather, the interaction of multiple genes and environmental stressors increase the risk of mental disorders.

Anxiety, anger, and despair are normal reactions to the stressful experience of being arrested. Even when exaggerated, these symptoms by themselves may not constitute a diagnosable mental disorder. Only through a clinician's careful evaluation of the nature and severity of symptoms, and the resultant impairments they cause, can a mental disorder be diagnosed.

The Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association is considered the definitive text on the different diagnosis of mental disorders in both children and adults.[1] It defines a *mental disorder* as:

> ...a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event.

Severe mental illnesses are long-term and disabling and include the following diagnoses: schizophrenia, schizoaffective, severe depression, bipolar disorder, and some severe anxiety and personality disorders. Any of these illnesses can co-occur with any combination of addictive disorders.

Understanding and Recognizing Addictive Disorders[2]

Addictive disorders are separated in the DSM-IV into "substance-induced" and "substance use" disorders. A diagnosis of "substance-induced disorder" implies that observed abnormalities in mood, thought, or behavior are directly the result of an ingested substance. This includes intoxication and withdrawal symptoms which resolve after the substance is cleared from the brain. For example, acute and prolonged use of cocaine can cause paranoia, which would be diagnosed as a substance-induced delusional disorder rather than a serious mental illness. The appropriate treatment for this condition is prolonged abstinence from cocaine.

The substance use disorder diagnosis is further divided into "substance abuse" and "substance dependence" disorders. Whereas substance abuse is defined as a "pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances," substance dependence is a cluster of symptoms that indicates that an individual has lost the ability to control his or her use of a substance despite significant substance-related problems.

Substance use disorders can involve any of the following substances:

- Alcohol
- Amphetamine
- Caffeine
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- Nicotine
- Opioids
- Phenyclidine
- Sedatives, hypnotics, or anxiolytics

Understanding and Recognizing Co-occurring Disorders

There is a high prevalence of substance use disorders among people with severe mental illnesses. In criminal justice settings, three out of four people meeting criteria for a severe mental illness simultaneously meet criteria for a substance use disorder.[3] A diagnosis of both mental illness and substance use disorder is often referred to as a "dual diagnosis," and individuals with a dual diagnosis are often said to have

"co-occurring disorders." According to the federal Substance Abuse and Mental Health Administration (SAMHSA), a co-occurring disorder exists "when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from [a single] disorder." Because the symptoms of addictive disorders can mimic those of a psychiatric disorder, a substance-induced disorder must be ruled out as the primary cause for disturbances in mood, thinking, or behavior.

Despite significant similarities in symptoms and treatment approaches, addiction and mental health treatment services are for the most part administered, licensed and funded separately. The separate treatment of mental illness and substance use disorders has proven ineffective for the large number of individuals with co-occurring disorders; as a result, these individuals seldom achieve stable recovery. Research has consistently demonstrated that *integrated treatment,* in which both mental illness and substance use disorders are addressed concurrently, is the most effective response to the needs of individuals with dual diagnoses.[4]

What Is Integrated Treatment and Why Does it Matter?

Research conducted over the last decade has shown that, without integrated services, people with co-occurring disorders have higher rates of hospitalization, homelessness, serious medical conditions, and incarceration.[5] Given the large number of people with mental illness that have co-occurring substance use disorders, integrated substance abuse treatment is a critical element in a comprehensive system of care for people with mental illness.[6]

Integration requires that providers develop a single treatment plan that addresses each set of conditions and outlines a plan for formal interaction and cooperation among all service providers in the ongoing reassessment and treatment of the individual. In many cases, integration also requires modifications to traditional treatment approaches. Successful programs involve family supports, provide intensive case management (as described below), use motivational interventions, and take a long-term treatment perspective.[7]

Few individuals with co-occurring disorders have access to integrated treatment, despite solid evidence that it is required to achieve effective outcomes. A recent report by SAMHSA indicates that, of the 4 million adults with co-occurring disorders, 52 percent received no treatment at all and only 12 percent received both mental health and substance use treatment.[8]

INTEGRATED TREATMENT

Integrated interventions are specific treatment strategies or therapeutic techniques in which treatment for all co-occurring diagnoses or symptoms are combined. Integrated treatment requires the participation of treatment providers trained in both substance abuse and mental health services, and the development of a single treatment plan addressing each set of conditions.

ACHIEVING INTEGRATED TREATMENT

Generally, a single agency or entity must provide integrated services in order to effectively treat individuals with co-occurring disorders. This often requires discretionary or blended funding to cover the cost of multiple services and dually trained treatment personnel.

Example: Assertive Community Treatment (ACT) (sometimes referred to as Program of Assertive Community Treatment [PACT]), is a team-based approach to the provision of treatment, rehabilitation, and support services. ACT/PACT models are built around a self-contained multidisciplinary team that serves as the single point of responsibility for a fixed group of individuals. With this approach, normally reserved for clients with severe and persistent mental illness, the treatment team typically provides all services using a highly integrated approach to care.

1 American Psychiatric Association. (1994). *Diagnostic and Statistical Manual on Mental Disorders* (4th ed.). Washington, D.C.: American Psychiatric Association.

2 Adapted from: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration and Center for Mental Health Services. (2005). *Definition and Terms Relating to Co-Occurring Disorders: Co-Occurring Center for Excellence Overview Paper No. 1.* Rockville, MD.

3 Abram, K.M. & Teplin, L.A. (1991). Co-occurring Disorders Among Mentally Ill Jail Detainees. *American Psychologist, 46*(10), 1036–1045.

4 Drake R.E., Essock, S.M., Shaner, A., Carey K.B., Minkoff K., Kola L., et al. (2001). Implementing Dual Diagnosis Services for Clients with Severe Mental Illness. *Psychiatric Services*, 52(4), 469–476.

5 *Ibid.*

6 *Ibid.*

7 Drake, R.E., Goldman, H.H., Leff, H.S., Lehman, A.F., Dixon, L., Mueser, K., et al. (2001). Implementing Evidence-Based Practices in Routine Mental Health Service Settings. *Psychiatric Services*, 52(2), 179–182.

8 Epstein, J., Barker, P., Vorburger, M., & Murtha, C. (2004). *Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders, 2002.* (2004). Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

"Lawyering" in the Moment: Stress Management and Mindfulness for Lawyers

Cheyne R. Scott, Esq.

Presentation Questions

- What is mindfulness?
- How can you incorporate mindfulness into your practice and daily life?
- How can understanding your "lawyer brain" help you to improve productivity, meaning and happiness in your life?

Opening Meditation

- Voluntary breathing exercise
- Sit up in your chair
- Feet firmly planted on the floor
- Hands gently placed in lap
- Close your eyes
- Breathe

What is Mindfulness?

- Attending to the present moment and cultivating an attitude of curiosity, openness and acceptance in one's experience.[1]
- Mindfulness is a mental state achieved by focusing one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts, and bodily sensations, used as a therapeutic technique.[2]

Why is Mindfulness Important?

- Improves cognitive performance[3]
- Increases focus & reduces stress[4]
- Reduces anxiety[5]
- Decreases depression[6]
- Leads to healthier responses to challenging social situations[7]
- Reduces implicit bias[8]
- Increases compassionate responses[9]

Why is Mindfulness Important to Lawyers?

- Studies show that mindfulness can mitigate some of lawyers' biggest challenges and have a positive impact on lawyer wellbeing and success.

Why is Mindfulness Important to Managing Partners?

- Mindfulness can lead to higher productivity and overall job satisfaction.
- Failure to consider the mental health of lawyers can lead to litigation.
  - NJLAD prohibits discrimination in the workplace against disabled workers
  - According to the New Jersey Office of the Attorney General, disability includes "any mental, psychological or developmental disability that results from conditions that prevent the normal exercise of any bodily or mental function…"[10]

2017 ABA National Taskforce on Lawyer Well-Being

- 21-36% Problem Drinkers [10]
- 28% Depression
- 23% Elevated Stress
- 25% Work Addiction
- 11.5% Reported Suicidal Thoughts

Understanding Stress, Anxiety and Other Emotions

- **The Model**[11]
  - Circumstances
  - Thoughts
  - Feelings
  - Actions
  - Results

Understanding Stress, Anxiety and Other Emotions

- **The Model**
  - **Circumstances:** Things that happen in the world that we cannot control.
  - **Thoughts:** Sentences that happen in your mind.
  - **Feelings:** One-word descriptions of the sensations in your body—caused by thoughts.
  - **Actions:** Behavior—what we do or don't do in the world.
  - **Results:** What we see in the world (our lives) as an effect of how we act. The result will always be evidence for the original thought.

Understanding Stress

- **Fight or Flight Response**
- **Reacting vs. Responding**
- **Stress can make you sick**

Common Stressors for Lawyers

- Perfectionism
- Worst Case Scenario Thinking
- Addiction to Panic
- Lack of Boundaries
- Loneliness
- Victim Mindset

Perfectionism

- Refusal to accept any standard short of perfection.
- A doctrine holding that religious, moral, social, or political perfection is attainable.

Perfectionism

- Do not make "failure" mean something bad about you
- Accept the lack of control over circumstances
- Learn how to accept the behavior of others

Perfectionist Model

C: Assignment for [Perfectionist Partner] is due tomorrow.

T: If I do not complete this assignment perfectly, the Partner is going to be upset.

F: Anxiety

A: Procrastinate and then rush to complete the work. Overlook mistakes in the writing.

R: I complete the assignment in a rush and my Partner is upset.

C: Assignment for [Perfectionist Partner] is due tomorrow.

T: I have no control over what the Partner thinks. I am doing the best I can.

F: Deliberate

A: Stay focused on completing the assignment. Complete it in enough time to thoroughly proofread it.

R: I take control over the assignment and you do the best I can.

Perfectionist Model

C: I gave my client advice. My client did not act in accordance with that advice.

T: I hate cleaning up the messes of people who ignore my advice.

F: Resentment

A: Complain to other people about how terrible your clients are. Watch Netflix instead of working on the assignment. Procrastinate until the last minute.

R: I make your client's lack of perfection the reason that I feel resentment.

C: I gave my client advice. My client did not act in accordance with that advice.

T: If clients did not make mistakes, I would not have work to do.

F: Acceptance

A: Speak with the client, discuss the next steps. Add the next steps to your to-do list. Document my previous attempts to counsel this client.

R: I have more work to do and that's great news.

Worst Case Scenario Thinking

- Catastrophizing
- Inability to turn off issue-spotting

Worst Case Scenario Thinking Model

C: I sent an email to several attorneys referring to an important document and forgot to attach that document to the email.

T: They probably think I am an idiot.

F: Embarrassed

A: Catastrophize about being fired for being so careless and embarrassing the firm like this.

R: I think I'm an idiot.

C: I sent an email to several attorneys referring to an important document and forgot to attach that document to the email.

T: I forgot to attach a document to the email, and that's ok.

F: Calm

A: Send a second email with the document attached. Decide that most of the people on the email thread did not even notice.

R: I do not allow mundane workday occurrences lead to catastrophizing.

Addiction to Panic

- Becoming emotionally attached to case outcomes.
- Panic cycle
- Judith Orloff, MD Psychology Today Article "Are You Addicted to Anxiety?"[12]

Addiction to Panic Model

C: Adversary has called demanding to know where overdue discovery is and your client has not returned your repeated calls regarding the discovery.

T: I must respond now to calm the adversary down and to prevent motion practice.

F: Panic

A: Answer the call. Argue with the adversary. Ruminate about the argument.

R: I make myself responsible for the actions of my adversary and my client.

C: Adversary has called demanding to know where overdue discovery is and your client has not returned your repeated calls regarding the discovery.

T: I am not responsible for the actions of my adversary or my client.

F: Acceptance

A: Limit communications with the adversary to email only. Follow up with the client every two weeks regarding discovery. Expect to receive the discovery motions.

R: I only take responsibility for what I have control over.

Lack of Boundaries

- Boundary: A limit defining you in relationship to someone or something
- Common Boundaries Lawyers Should Set Are With:
  - Clients
  - Adversaries
  - Partners
  - Family, Friends, Significant Others

Boundaries Model

C: A friend calls saying he needs a contract-just something quick. He says he does not want to pay an overpriced greedy lawyer for something so simple.

T: I don't want my friend to think I am greedy.

F: Anxiety

A: Agree to do the contract for free. Field several phone calls from friend asking for additional revisions and miscellaneous free advice.

R: I allow my greedy friend to get free legal advice.

C: There is nothing you could have done and no other person you could have been.

T: My legal services are valuable and I do not provide them for free.

F: Confidence

A: Tell the friend what my rates are. Send him a retainer to sign prior to working on the contract.

R: I set a boundary around my time and money.

Loneliness

- Harvard Business Review Article: Lawyers are among the loneliest professionals along with doctors.[13]
- Legal Practice Rewards Isolation
  - Less social interactions = More billable hours
  - Grumpy at home
  - Declining social gatherings
- This may Contribute to Depression and Increased Rates of Suicide Among Lawyers

Loneliness Model

C: A non-lawyer friend texts on a Tuesday and asks if you want to meet with a group of friends for dinner and drinks.

T: I cannot go out because I have too much work to do.

F: Loneliness

A: Continue working. Ruminate about how much work I have to do and how my non-lawyer friends have it easier than me.

R: I don't see my friends.

C: A non-lawyer friend texts on a Tuesday and asks if you want to meet with a group of friends for dinner and drinks.

T: If I do not have an emergent deadline, I can find time to spend with friends and make time to complete my work later.

F: Connected

A: Look at my schedule, confirm I can get the work done tomorrow. Go out with friends.

R: I find the time to spend with my friends.

Victim Mindset

- Viewing negative circumstances as things that are happening to you, things that you are not responsible for and things you are powerless to overcome
- Three Main Components
  - Victim
  - Villain
  - False Savior

Victim Mindset Model

C: 5 Briefs due in one week.

T: I have too much work to do and not enough time to complete it.

F: Anxiety

A: Panic. Feel paralyzed. Scroll through social media. Complete other non-emergent tasks. Complain to others. Believe that once you get this assignment done, you will never get into this situation again.

R: I do not have enough time.

C: 5 Briefs due in one week.

T: I have time to get everything done.

F: Intentional

A: Contact adversaries for adjournments. Start working on the assignments that are not adjourned. Stay focused and off social media and away from distractions.

R: I have the time and I get it all done.

Victim Mindset Model

C: I completed an assignment and my boss did not thank me.

T: My boss does not appreciate me.

F: Resentment

A: Show up to work grumpy. Become less productive and less motivated. Fall behind on work.

R: My boss has less reason to appreciate me.

C: I completed an assignment and my boss did not thank me.

T: I appreciate the work that I do.

F: Appreciation

A: Show up more focused and deliberate. Become be more productive and positive at work.

R: I appreciate my work. I get more appreciate from others because of the way I show up, not because I am seeking it out.

How to Get Started with Mindfulness

- Identify a mindfulness technique that works for you.
- Awareness
- Acceptance
- Willingness to change

Common Mindfulness Techniques

- Meditation[14]
- Yoga
- Gratitude Journaling[15]

Other Mindfulness Techniques

- Exercise
- Non-Legal Reading
- Removing Stressors from Your Life

References

1. Bishop,S.R., Lau, M.A., Shapiro, S.L., Carson, L., Anderson, N.D., Carmody, J.Devins, G. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology*, 11, 230-241. Doi:10.1093/Clipsy.bph077
2. "Mindfulness." Merriam-Webster.com. 2018
3. Zoogman S, Goldberg SB, Hoyt WT, Miller L. Mindfulness Interventions with Youth: A Meta-Analysis. *Mindfulness*. 2014. Doi: 10.1007/s12671-013-0260-4.
4. Chiesa, A., & Serretti, A. (2009). Mindfulness-based Stress Reduction for Stress Management in Healthy People: A Review and Meta-Analysis. *The Journal of Alternative and Complementary Medicine*, 15(5), 593-600.
5. Belinger, D. (2015) Mindfulness, Anxiety, and High-Stakes Mathematics Performance in the Laboratory and Classroom. Consciousness and Cognition. December 2015, 123-132.
6. Brensilver, M. (February 22, 2016) What is the Best Mindfulness Practice? Retrieved from mindfulschools.org
7. Holzel, Britta K.; Lazar, Sara W.; Gard, Tim; Schuman-Olivier, Zev; Vago, David R.; Ott, Ulrich (2011) How Does Mindfulness Meditation Work? Proposing Mechanisms of Action from a Conceptual and Neural Perspective. *Perspectives in Psychological Science*. 2011; 6(6); 537-559.
8. Lueke, Gibson B. (2015) Mindfulness Meditation Recused Implicit Age and Race Bias. *Social Psychological and Personality Science*; 6(3); 284-291
9. Condon P, Desbordes G, Miller WB, DeSteno D. (2013) Meditation Increases Compassionate Responses to Suffering. *Psychological Science*. 24(10); 2125-2127
10. New Jersey Office of the Attorney General Civil Rights Fact Sheet – Disability Discrimination – Know your Rights (2015) https://www.nj.gov/oag/dcr/downloads/fact-Disability-Discrimination.pdf
11. The Model, Brooke Castillo, The Life Coach Schoola
12. Orloff, Judith, MD (April 11, 2011); Psychology Today "Are You Addicted to Anxiety? Learn How Not to Be" https://www.psychologytoday.com/us/blog/emotional-freedom/201104/are-you-addicted-anxiety-learn-how-not-be
13. Achor, Shawn; Rosen Kellerman, Gabriella; Reece, Andrew; Robichaux, Alexi America's Loneliest Workers, According to Research (March 19, 2018) https://hbr.org/2018/03/americas-loneliest-workers-according-to-research
14. McGreevey, Sue (2011) Eight Weeks to a Better Brain. The Harvard Gazette https://news.harvard.edu/gazette/story/2011/01/eight-weeks-to-a-better-brain/
15. Emmons, Robert; McCullough, Michael E. (2003); Counting Blessings Versus Burdens: An Experimental Investigation of Gratitude and Subjective Well-Being in Daily Life; Journal of Personality and Social Psychology; Vol. 84, No. 2, 377–389

Find Me Online

- **Website:** www.SpiritualLitigator.com
- **Instagram:**
  www.instagram.com/SpiritualLitigator
- **Facebook:**
  www.facebook.com/SpiritualLitigator

"Lawyering" in the Moment: Stress Management and Mindfulness for Lawyers

Cheyne R. Scott, Esq.
Chasan Lamparello Mallon & Cappuzzo, PC
cscott@chasanlaw.com

This page intentionally left blank

Mental Health Challenges Resulting from Covid

Presented by:

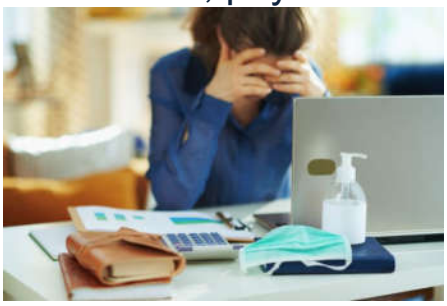
Debra A. Clifford

Introduction

- COVID-19 has had a significant impact on students' mental health.
- As schools reopen, students face uncertainty as to what next year will bring, further exacerbating mental health issues.
- Are schools prepared to deal with the increased need for mental health services?

COVID STRESSORS

- The unpredictability of COVID caused fear and anxiety.
- The quarantine imposed feelings of isolation and loneliness.
- Students who lost loved ones are grief-stricken.
- Difficult living situations due to financial stress, physical and emotional abuse.



Social, Emotional and Mental Health Needs

- As a result of COVID students have suffered disruptions in learning, physical isolation and lack of socialization, all of which affect their mental health.
- Underserved students have shouldered a disproportionate burden.
- Some students have simply disappeared, having never shown up for virtual learning and efforts to connect with the students have failed.
- The impact of COVID is different for every student.
- USDOE has suggested that initial focus on the social and emotional needs of students may provide the foundation for improved academics.

Social, Emotional and Mental Health Needs

- Schools are faced with the challenge of creating programs that best serve the needs of all students.
- To do so, schools must understand the COVID experience of their students.
- COVID has highlighted the importance of social, emotional skills to help students cope with life's challenges.
- Absent established social-emotional learning (SEL) protocols, schools will have to provide extensive professional development to ensure a coordinate approach.
- Mental health professionals may be required to address the most urgent needs.

USDOE RECOMMENDATIONS TO SUPPORT SOCIAL EMOTIONAL LEARNING

- Measure social and emotional well-being through the use of engagement surveys;
- Provide time for regular check-ins with students and families;
- Implement restorative circles or “mindful moments” that provide students with space to self-regulate emotions;
- Establish morning or closing meetings, or other rituals within each school day; and
- Provide opportunities for student voices to be represented in the classroom or with school decision-making.

Student Mental Health Issues on the Rise

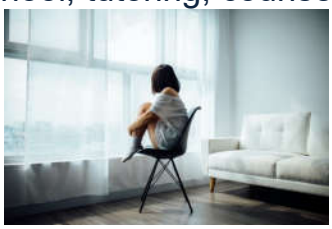
- In a 2020 survey of 3,300 students, 33% said they had feelings of depression and anxiety.
- In late April/early May 2020, another survey reported that nearly 1 in 3 children were feeling unhappy or depressed.
- The CDC reported that children ER visits increased dramatically during the pandemic.

Student Mental Health Issues on the Rise

- As of December 2020, 84% of elementary school principals reported concerns about mental health and 68% state that they do not have sufficient mental health professionals in school to meet student needs.
- Many students went without mental health services during the pandemic because their sole source of service comes from school.

School Mental Health Supports Or Lack Thereof

- Schools are seriously lacking in mental health professionals.
- The current school psychologist to student ratio in this country is roughly 1,400 to 1, while experts say it should be at most 700 to 1.
- Fewer than half of schools in the US offer mental health treatment.
- NJ is funneling $105 million in federal coronavirus education relief funds to help students with learning and mental health issues.
- California has passed legislation that requires 20% of federal funds be used for summer school, tutoring, counseling or mental health services.



Destigmatize Mental Health Support

- Students need to feel comfortable accessing mental health supports.
- Schools need to destigmatize mental health support.
- Presently only approximately 20 states require mental health education.
- The American Psychological Association recommends that school leaders and educators:
  - Share educational resources with staff and students that provide a better sense of what mental health means;
  - Talk about mental health and allow students the opportunity to speak openly about life, school, the future, and anxiety; and
  - Let students know they are not alone and that others are going through similar situations and provide them the time needed to heal.

How States Are Supporting Student Mental Health

- New York state's reopening guidance requires all school districts and schools to establish a comprehensive developmental counseling plan; establish an advisory council of students, parents, teachers and school mental health professionals; and provide professional development to all school staff on how to help students develop coping and resiliency skills.
- New Jersey has recommended a three tier approach for attending to student mental health including planned check-ins, identifying at risk students, individual counseling and referrals to out-patient programs.

AMERICAN RESCUE PLAN ACT OF 2021

- Congress recently passed the American Rescue Plan Act of 2021 (ARPA) which provides federal funding to support the safe reopening of schools.
- USDOE has recognized that physically returning students to school will not "address the full impact of COVID-19 on students' social, emotional, physical, mental health, and academic needs or the impact on educator and staff well-being."

AMERICAN RESCUE PLAN ACT OF 2021

USDOE believes funding under the ARPA can be used to:

- Provide afterschool or other out-of-school programs that address students' social emotional and academic needs; and
- Address the mental needs of students, including the hiring of counselors and other staff;

SOURCES

- https://www.extendednotes.com/after-school-articles/social-emotional-effects-of-covid-19-on-children-and-adolescents
- https://insidesel.com/2020/11/19/the-impact-of-the-covid-19-pandemic-on-student-learning-and-social-emotional-development/
- https://joebiden.com/education/
- https://edsource.org/2021/california-schools-to-get-15-3-billion-in-federal-aid-under-american-rescue-plan/650944
- https://www.childtrends.org/blog/as-schools-reopen-addressing-covid-19-related-trauma-and-mental-health-issues-will-take-more-than-mental-health-services
- https://injury.research.chop.edu/blog/posts/suicide-risk-children-during-pandemic
- https://www.reuters.com/investigates/special-report/health-coronavirus-students/
- https://www.today.com/health/today-analysis-more-states-requiring-mental-health-education-law-t162822

Disclaimer

- This material and presentation should not be used as a substitute for competent legal advice from a licensed professional attorney of your state.

This page intentionally left blank

Compassionate Advocacy and Representation for Clients with Mental Health Disorders

Presented by:

Rehana Rasool, Esq. and Sean Benoit, Esq.

Community Health Law Project

CHLP is a non-profit organization that provides legal and advocacy services to residents of New Jersey with disabilities.

We serve consumers with mental health services, people with physical disabilities, developmental disabilities, as well as visual and hearing impairments, in a variety of matters involving Social Security benefits, Welfare, food stamps, and other entitlements; housing habitability and landlord-tenant disputes; foreclosure defense; DDD guardianship and document preparation; consumer protection and debt collection; child support and domestic violence; Medicaid, Medicare, and other health insurance issues.

Holistic Needs Approach:

- We look to what issues the client may have outside of what they may originally have come for
- Example: Client has a landlord/tenant matter, but their health needs are not being addressed (i.e. their private duty nursing hours have been reduced by Medicaid).

Community Health Law Project

We service the entire state of New Jersey with several regional offices:

Administration – 185 Valley Street, South Orange (973-275-1175)

North Jersey – 650 Bloomfield Ave., Suite 210, Bloomfield (973-680-5599)

East Jersey – 65 Jefferson Ave., Suite 402, Elizabeth (908-355-8282)

Shore Area – 1 Main Street, Suite 413, Eatontown (732-349-6714)

Central Jersey – 225 East State Street, Suite 5, Trenton (609-392-5553)

South Jersey – 900 Haddon Ave., Suite 400, Collingswood (856-858-9500)

Representing Clients with Mental Health Impairments

- **Communication**
  - Client may manifest symptoms including hostility, delusions, paranoia, and confusion.
  - Client may be confused and unsure of facts.
  - Client may come to our office without any family or support network.
  - A letter to the client outlining their needs and goals and our plan to represent helps clients better understand how we can assist.
  - Clients sometimes lose contact and are nowhere to be found.
- **Logistics**
  - We may meet clients at their homes or a hospital, local library, group home, or an assisted living facility.

Representing Clients with Mental Health Impairments

- **Evidence**
  - Identify who has medical records including treating doctors, therapists, hospitals, treatment providers, etc.
  - Identify family members or service providers who can assist in locating records and other supporting documentation.
  - Release forms
- **Testimony**
  - Client may not be able to explain in a linear narrative. Client may know what they want to say but have difficulty expressing it.
  - Client may become combative and hostile during examination.

Representing Clients with Mental Health Impairments

- Client experience at court
  - Confusion
  - Exacerbation of mental health conditions
  - Discrimination
  - Harassment by adversaries
- Working with agencies
  - Multiple employees on same case (“team approach”)
- Clients may return to our office many times
  - We are often times their source of stability
  - Housing, Medicaid, Social Security cases

Representing Clients with Mental Health Disorders in Social Security Hearings

- SSI (Supplemental Security Income) and SSD (Social Security Disability)
- Social Security Listing – Lists different mental health impairments and the criteria needed to be met https://www.ssa.gov/disability/professionals/bluebook/12.00-MentalDisorders-Adult.htm
- Have client's psychiatrist fill out a mental impairment questionnaire

How To Assist Client's In Planning
Surrogate Decision Making

Non-Judicial

Does not need to be ordered by a Judge. If a person can understand what he or she is signing and can consent to it, these documents may prevent the necessity of Court action for Guardianship.

- Durable Power of Attorney
  - Appoint agent to make decisions regarding financial, legal, and other personal affairs when person unable to do so.
- Advance Directive / Healthcare Proxy
  - "Living Will"
- Supported Decision-Making – relying on friends/family, professionals, etc., to help a person make their own decisions (retains personal decision making)
- Representative Payee for SSD/SSI Benefits

Judicial

The following must be ordered by a judge:

Conservatorship - NJSA 3B:13A; R. 4:86-11

- Court appointment of an individual to manage the financial responsibilities of a person unable to do so, with consent of the person.

Special Medical Guardianship - R. 4:86-12

- Limited to the rendering of medical treatment if person is unable to consent to treatment.

Limited Guardianship - NJSA 3B:12-24.1(b)

- A person may need assistance in only certain areas, i.e. residential, educational, medical, legal, vocational, financial.
- A limited guardian's limitations are specified in the Court order.

Plenary (or General) Guardianship - NJSA 3B:12-24.1(a)

- Applies to a person who cannot make any decisions. The guardian is authorized to make legal, medical, financial, and personal decisions for the person deemed by a Judge to be "incapacitated".
- Guardian of the "person" and "property"

Incapacity

- "Incapacitated individual" means an individual who is impaired by reason of mental illness or intellectual disability to the extent that the individual lacks sufficient capacity to govern himself and manage his affairs. N.J.S.A. 3B:1-2
  - Guardianship is necessary only for an individual who lacks the ability to make decisions in some or all areas.
  - Many individuals are capable of making their own decisions, with appropriate support and advice, and do NOT need a guardian.
  - A thorough assessment should be made of the individual to determine what if any capacity he/she has in making decisions in certain areas, eg. finances, health care, living situation, etc.

  Assess the potential guardian – consider adding a co-guardian
  - Guardianship cannot be passed on through a will

Initiating Guardianship for a Person Alleged to Be Incapacitated R. 4:86-2

File Complaint in the County Court, Chancery Division, Probate Part where alleged incapacitated person resides.

- Forms to be mailed to the Surrogate's office which will submit them to the Court if all papers are in order.

Complaint Must Include the Following Information

- Identifying info for all parties, immediate family members, and agencies involved
- Type of Guardianship Requested
  - General or Limited
  - Initial Application, Addition of Co-Guardian, Substitute Guardian
- Reason for Request
- Statement regarding need for guardianship of Person and Property or only of Person
- All other information listed in R. 4:86-2

Additional documents to be filed with complaint

- Case Information Statement
- Proof of DDD status if applicable (ISP, letter of acceptance)
- Any will, power of attorney, health care directive, or trust previously executed by the person
- Proposed Order Fixing Hearing Date and Appointing Attorney for Alleged Incapacitated Person
- Proposed Judgment of Incapacity and Appointment of Guardian of the Person and Property (or Person Only)
- Attach the Filing Fee; Proposed Guardian can file a Certification of Indigency if he/she cannot afford to pay Filing Fee.

Supporting Affidavits to be Attached to Complaint

1. Affidavit/Certification of alleged incapacitated person's income and assets - R. 4:86-2
   - Not always required when only filing for Guardian of the Person. Please call your County Surrogate before filing to confirm.

Supporting Affidavits to be Attached to Complaint

2. Affidavits from professionals detailing facts supporting the belief that the alleged incapacitated person: suffers from a significant functional impairment to such a degree that the person either lacks the cognitive capacity to make decisions or to communicate, in any way, decisions to others

- **For non-DDD Individuals** - Affidavits from 2 physicians; or 1 physician and 1 psychologist who have examined the individual not more than 30 days prior to filing Complaint - R.4:86-2(b)(2)
- **For Individuals Receiving Services from DDD** - Affidavits from 2 physicians or 2 psychologists (or one physician and one psychologist) who have examined the individual not more than 6 months prior to filing Complaint – R. 4:86-10
  - In lieu of a 2nd physician or psychologist affidavit, can submit Affidavit from:
    - a) CEO, Medical Director, or other officer having administrative control over program providing functional or other services provided by DDD; or
    - b) Designee of DDD with personal knowledge of functional capacity of individual (includes evaluator, care manager, case manager, or other employee or contractor affiliated with DDD); or
    - c) Copy of IEP and relevant reports prepared not more than 2 years prior to filing Complaint; or
    - d) Licensed care professional with personal knowledge of functional capacity of individual (includes, but not limited to, APN, OT, PA, SW, board certified behavior analyst, family counselor).

Supporting Affidavits to be Attached to Complaint

3. Affidavit/Certification setting forth the criminal and civil judgment history of each proposed guardian - R. 4:86-2(b)(3)

- Does not need to be done if the proposed guardian is the parent of the AIP; an individual married to the AIP; pendente lite temporary guardians; authorized agencies.

Next Steps

- File Pleadings with Court - Court will return signed Order Fixing Hearing Date
- All interested parties must be served with the Pleadings and Order Fixing Hearing Date
- Alleged incapacitated person must be served with the Pleadings and Order Fixing Hearing while being read the contents of Notice of Hearing
- Must file Proof of Service with Court indicating that you served all interested parties and alleged incapacitated person

Duties of Court-Appointed Attorney – R. 4:86-4(b)

Visiting the alleged incapacitated person and conducting a thorough investigation, including but not limited to:

- Speaking to family members and other interested parties
- Locating any will, power of attorney, health care directive, or trust previously executed by the person not already provided in the application
- Any other pertinent information

Making recommendations and filing report with the Court regarding

- Issue of Capacity
- Preferences of alleged incapacitated person
- Suitability of less restrictive alternatives to guardianship or recommendation for limited guardianship if person can make decisions in limited circumstances
- Who should be appointed the individual's guardian
- Other issues as necessary

Additional Steps Before Hearing

- Obtain and review report of court-appointed attorney
- Complete guardianship training by viewing video tutorial posted on judiciary website along with other training materials
  - Certain counties require the proposed guardians to submit an executed "Certification of Review"

Appearance at Hearing

DDD

When there are no objections from the court-appointed attorney:

- Appearance of alleged incapacitated person is not required
- Appearance of proposed guardians depends on county preference

Non-DDD

- Court-appointed attorney testifies (sometimes by phone)
- Proposed guardian testifies
- Alleged incapacitated person should also be present (unless there are extenuating circumstances) and Court may question him/her

After Hearing – R. 4:86-6

- If Court is satisfied that person is incapacitated and with appropriateness of proposed guardians, the Judge will sign the Judgment of Incapacity and the Appointment of Guardian(s)
  - Must serve all interested parties with Judgment of Incapacity and Appointment of Guardian(s)

- QUALIFICATION OF GUARDIAN(S):
  - The guardian(s) must "qualify" within 30 days of the Judgment of Incapacity and Appointment of Guardian(s) being entered. The Judgment will be void if qualification is not completed in a timely fashion.
    - Issuance of Letters of Guardianship with gold seal (to be kept in secure location)
    - Short Certificates – Contains basic information about appointment of guardian for incapacitated person and can be provided to individuals and facilities such as doctors, care facilities, banks, etc.

Post-Judgment reporting and changes in capacity

- Guardian(s) must carefully review Judgment of Incapacity and Appointment of Guardian(s) to determine responsibilities and specific reporting requirements
- Must use court-approved forms:
  - Report of Well-Being for Guardian(s) of the Person - usually annually
  - Inventory of Assets and Income for Guardian(s) of the Property - usually within 90 days
  - Report of Accounting for Guardian(s) of the Property - usually annually
- Forms are submitted to the County Surrogate.
- The guardian(s) are required to involve the person in decision-making to the extent that his/her abilities permit.
- Terminating or Modifying Guardianship - R. 4:86-7(b)
  - Return to Competency
  - Changing Plenary Guardianship to Limited Guardianship
  - Must go back to Court to file Application to Terminate or Modify Guardianship and must include supporting Affidavit(s)

Legal Arguments in Support of Clients with Mental Health impairments

- The Fair Housing Act 42 U.S.C. 3601 et seq.
  - Prohibits discrimination in housing based on race, religion, gender, national origin, familial status or disability.
  - The trial court must determine if a reasonable accommodation exists which will provide the tenant with an equal opportunity to use and enjoy the housing at issue.

    Douglas v. Kriegsfeld Corp., 884 A.2d 1109 (D.C. 2005)

    Example: Reasonable accommodation for:
    - tenant with a hoarding disorder who begins receiving medical treatment
    - tenant with bipolar disorder who fails to take medication begins to receive medication management and monitoring

Legal Arguments in support of clients with Mental Health impairments

- **New Jersey Law Against Discrimination (LAD) N.J.S.A. 10:5-1 et seq.**
  - Prohibits unlawful discrimination in employment, housing, places of public accommodation, credit and business contracts based on disability.
  - Example: School was found liable under LAD where student with special needs was bullied and the school failed to intervene.

    L.W. v. Toms River Regional Board of Education, 189 N.J. 381 (2007)
  - Example: landlord refuses to accept tenant with a disability

    Franklin Tower One, LLC v N.M., 157 N.J. 602 (1999).

- **Consumer Fraud Act (CFA) N.J.S.A. 56:8-2**
  - an unlawful practice
  - an ascertainable loss and
  - a causal relationship between the unlawful conduct and the loss, is entitled to legal and/or equitable relief, treble damages, and reasonable attorneys' fees

Assisting Client's with Mental Health Disorders with Landlord/Tenant Issues During the Covid-19 Pandemic

Tenants' Rights during the Covid-19 Pandemic

- NJ Governor's Executive Order 106 – Moratorium on Residential Evictions
  - Will last until two months after Governor Murphy declares an end to the Covid-19 public health crises which is currently set to expire on June 13, 2021, unless extended
  - Covers most types of evictions, except situations the Court determines are "emergent" (non-payment of rent is not emergent)
  - Tenants still owe rent; landlords are allowed to file eviction complaints
  - Landlord/Tenant Courts are holding remote intake and pretrial/settlement conferences. Tenants may receive a notice from the court; objective is to discuss settlement of a case that has been filed
  - Tenants are not required to enter into a settlement; cases not settled will be scheduled for trial when the courts start holding eviction trials again

(Con't) Assisting Client's with Mental Health Disorders with Landlord/Tenant Issues During the Covid-19 Pandemic

Tenants' Rights during the Covid-19 Pandemic

- Hotel / Motel Residents
  - Executive Order 106 doesn't protect transient guests but does protect longtime hotel and motel residents
  - Administrative Order 2020-9 clarified that any individual who does not have permanent housing to which they may safely and lawfully return and live at a hotel or motel on a continual basis are not considered "transient guests or seasonal tenants", and thus are entitled to protections against evictions under EO 106. See: https://nj.gov/governor/news/ao/docs/AO2020-9.pdf
  - CDC Order stopping residential evictions through June 30, 2021
    - A federal district court held that the CDC moratorium is invalid and the Department of Justice has appealed the decision

(Con't) Assisting Client's with Mental Health Disorders with Landlord/Tenant Issues During the Covid-19 Pandemic

Tenants' Rights during the Covid-19 Pandemic

- Illegal Lockouts
  - Only the courts can order evictions, and only government officials can remove tenants from their home
  - Tenants should call the Police if a landlord illegally locks them out
    - Attorney General Grewal issued a directive with guidance to law enforcement on their obligations to protect tenants from illegal evictions

(Con't) Assisting Client's with Mental Health Disorders with Landlord/Tenant Issues During the Covid-19 Pandemic

Other Help for Tenants

- Rental Assistance through Counties/State
- Security Deposit – Executive Order 128 allows tenants to request in writing (including by email or text) that their security deposit be applied to unpaid rent during the public health emergency and for up to 60 days afterwards. If the lease is renewed, the landlord may also require the tenant to post a new security deposit.

Electricity, Gas, & Water

- March 13, 2020 – New Jersey's electric and gas utilities voluntarily suspended utility shut-offs
- March 3, 2021 – Executive Order 229 suspends residential utility and water shut-offs until June 30, 2021; no late fees; cable providers must offer payment plans; not allowed to terminate customers if they are making payments; internet providers may not terminate if school aged children are using the internet for school

Thank you for being with us and stay safe!

Community Health Law Project

Rehana Rasool, Esq.
rrasool@chlp.org
(973)680-5599 x310
&
Sean Benoit, Esq.
sbenoit@chlp.org
(908)355-8282 x407

Mental Health Issues in the Chancery Division, Family Part, and General Equity

Daniel D'Alessandro, J.S.C. (Ret.)
Ddalessandro@weiner.law
551-430-7080

This page intentionally left blank

What to Say to a Grieving Person + How to Support One Another

What To Say + Do

1. Treat others the way they want to be treated. If you are not sure, ask "what do you need from me right now?"

2. Families, workplaces, community organizations might consider setting a regular check-in time where individuals can openly talk about their feelings, stresses and struggles.

3. Express empathy verbally and with your facial expressions. Say things like "It's really hard for you right now"

4. Ask "How are you feeling today?"

5. Just sit quietly with the person.

6. Follow the lead of the person who is expressing feelings. (If I want to talk, sit and listen to me. If I don't want to talk, give me space.)

7. Listen to their story, their questions, their feelings, their fears without trying to respond or fix them

8. Listen some more (see poem on the back)

9. Be vulnerable yourself. Share how you are feeling after the person has had a chance to feel heard and supported.

10. Remember that feelings aren't right or wrong. They just are. And like the weather, they will change.

What NOT to Do

1. Don't try to cheer me up or tell me not to feel the way I do. Let me have all my feelings.

2. Don't give me advice or tell me what you think I should do.

What NOT to Say

1. "Well, at least……" or "If you think you have it bad, I know a family…."

2. "Be positive". "You should be grateful for….."

3. "God never gives us more than we can handle."

4. "Everything happens for a reason."

5. "Be strong."

6. "I know how you feel."

7. "Something good will come of this."

8. "Everything will be okay."

Please contact us for more information, to view our educational webinars or to schedule individual support

Please Listen

A Poem By Leo Buscaglia

When I ask you to listen to me
and you start giving me advice,
You have not done what I asked.

When I ask you to listen to me
and you begin to tell me why
I shouldn't feel that way,
you are trampling on my feelings.

When I ask you to listen to me
and you feel you have to do something
to solve my problem,
you have failed me,
strange as that may seem.

Listen! All I ask is that you listen.
Don't talk or do - just hear me...

And I can do for myself; I am not helpless.
Maybe discouraged and faltering,
but not helpless.

When you do something for me that I can and need to do for myself,
you contribute to my fear and Inadequacy.

But when you accept as a simple fact
That I feel what I feel,
No matter how irrational,
Then I can stop trying to convince
You and get about this business
Of understanding what's behind
This irrational feeling.

And when that's clear, the answers are obvious and I don't need advice.
Irrational feelings make sense when
we understand what's behind them.

So please listen, and just hear me.
And if you want to talk, wait a minute
for your turn- and I will listen to you.

In re S.D.

Superior Court of New Jersey, Appellate Division

February 14, 2017, Submitted; March 16, 2017, Decided

DOCKET NO. A-1534-15T2

Reporter
2017 N.J. Super. Unpub. LEXIS 646 *; 2017 WL 1021957

IN THE MATTER OF THE COMMITMENT OF S.D.

Notice: NOT FOR PUBLICATION WITHOUT THE APPROVAL OF THE APPELLATE DIVISION.

PLEASE CONSULT NEW JERSEY *RULE 1:36-3* FOR CITATION OF UNPUBLISHED OPINIONS.

Prior History: [*1] On appeal from a Municipal Court of New Jersey, Docket No. 15-7115.

Core Terms

patient, medications, talks, clear and convincing evidence, involuntary commitment, verbally, becomes, mental illness, threatening, foreseeable, psychiatric

Counsel: Joseph E. Krakora, Public Defender, attorney for appellant (Rihua Xu, Assistant Deputy Public Defender, of counsel and on the brief).

Courtney M. Gaccione, Essex County Counsel, attorney for respondent (Thomas M. Bachman, Assistant Essex County Counsel, of counsel and on the brief).

Judges: Before Judges Koblitz and Rothstadt.

Opinion

PER CURIAM

S.D.[1] appeals from an October 21, 2015 municipal court order of involuntary commitment.[2] Because the County did not demonstrate by clear and convincing evidence that S.D. was a danger to himself, others or property, we reverse.

S.D. is a thirty-five-year-old man diagnosed with schizophrenia,[3] who has a long history of hospitalizations. A manifestation of S.D.'s symptoms is that he talks aloud to himself, sometimes quite loudly.

On September 23, 2015, S.D. was released from the psychiatric ward of Newark Beth Israel Medical Center (Medical Center) on condition that he take his prescribed medication, reside at the Restoration Center shelter and follow up with the Program of Assertive Community Treatment

[1] Appellant's initials are used to protect his privacy. *R. 1:38-3(f)(2)*.

[2] This direct appeal to the Appellate Division from an order entered by a municipal court judge is permitted pursuant to *N.J.S.A. 30:4-27.15*, and the definition of "court" contained in *N.J.S.A. 30:4-27.2(f)*, as Superior Court or municipal court.

[3] The mental condition schizophrenia was characterized during the commitment hearing as a disorder in which the individual has "hallucinations, delusions, disorganized behavior, disorganized thought or negative symptoms."

According to the Mayo clinic:

> Schizophrenia is a severe mental disorder in which people interpret reality abnormally. Schizophrenia may result in some combination of hallucinations, delusions, and extremely disordered thinking and behavior that impairs daily functioning, and can be disabling.
>
> Schizophrenia is a chronic condition, requiring lifelong treatment.

[*Diseases and Conditions: Schizophrenia*, Mayo Clinic [*2] (Oct. 11, 2016), *http://www.mayoclinic.org/diseases-conditions/schizophrenia/home/ovc-20253194* .]

(PACT). At the end of September, a week after his conditional release, S.D. was sent from Newark Penn Station back to the Medical Center for an emergency screening.

At the commitment hearing, Dr. Sostre, S.D.'s treating psychiatrist at the Medical Center, was qualified as an expert in psychiatry and testified as the only witness for the County. S.D. testified on his own behalf. Dr. Sostre described S.D. as "guarded." He stated that although S.D. denies any auditory or visual hallucinations or "any suicidal or homicidal ideations," "he has been observed to be talking to himself, at times loudly, on the unit." According to Dr. Sostre, this response to internal stimuli indicates that S.D. is "psychotic" with poor insight into his illness.

Dr. Sostre testified that he believed S.D. would be a danger to others if discharged from the hospital and recommended that S.D. be referred to a long-term, [*3] inpatient treatment center. Dr. Sostre stated that he based his opinion on:

> S.D.'s history of . . . non-compliance with medications and follow-up, as he's refused to follow up with the PACT team, and his rapid decompensations, as evidenced by the fact that he was discharged just one week prior to this admission to the hospital and he was readmitted because of his threatening and agitative behavior at Penn Station.

On cross-examination, Dr. Sostre admitted that "[t]he reports were vague coming from Penn Station, but [his] understanding [was] that [S.D.] was verbally threatening people at Penn Station." Dr. Sostre also testified that S.D. had never been physically abusive or threatening toward any staff member or patient in the hospital. When asked by defense counsel if on the day in Penn Station it was "possible that [S.D.] was simply being loud, as he's demonstrated in the hospital?" Dr. Sostre replied "possibly."

No testimony was adduced at trial regarding S.D.'s danger to himself except the following.

> [Dr. Sostre]: He's a danger to himself and others -- because he becomes non-compliant with medications and [h]e becomes threating towards other people in the community, specifically Penn Station [*4] this last time.

S.D. testified that he did not remember the events of that day, but maintained he did not threaten anyone. He further testified he had never been verbally abusive toward anyone, never intended harm against another individual, and never intended to harm himself. On cross-examination, S.D. claimed that he had filled his prescription upon discharge and was taking his medication. No evidence was given concerning whether the PACT team had an opportunity to contact S.D. during the week he was out of the Medical Center.

After closing statements, and before announcing her findings, the municipal court judge asked S.D. some questions and made the following remarks:

> [The Court]: The problem, [S.D.] and counsel, is that [S.D.] is among the vast sea of humanity that is kind of lost because he is mentally ill, he is psychotic. I'm not saying that he's dangerous to the point where he has actively injured anybody, but we all know the phenomenon of people who are drawn to linger, loiter, hangout in public spaces and especially find Penn Station particularly appealing, and especially with the winter coming.
>
> And I think that the confrontations with commuters comes about in the panhandling [*5] context, although there has been not a word of testimony suggesting that. So it could either be soliciting food or money from strangers, which is bothersome, or just talking to them. He admitted that he talks to people. I don't want to suggest that talking to people means that you should be locked up in an institution, but it's the combination [of] factors here.
>
> [S.D.] is an articulate young man. He's 35 years old. He says that he has reported to the Restoration Center and is staying there every night, but why do you have to keep going to Penn Station, [S.D.]? Tell me that.

The judge then asked S.D. what he did to obtain money, to which S.D. responded: "I receive benefits from Social Security." After further discussion on the symptoms of schizophrenia the

court characterized S.D.'s testimony.

> [The Court]: All right. Well, I understand, [defense counsel's] argument that just because somebody is different, he talks to himself and he wanders around and he — he's not likely to take his meds, that, . . . in and of itself, is not a sufficient reason to commit him. However, this is not speculation when it comes to [S.D.]. He does not take his meds. He is recommitted as regularly as clockwork. [*6]
> And I find his testimony a mixture of credible and incredible. The incredible part is that he doesn't go to Penn Station every day. I think he goes there with a purpose and his purpose is to preserve his life, get money, get — maybe get food, go in the garbage, whatever people do —
> . . . .
> Well, sir, I understand your dilemma, but when you come into confrontations with the public, it is a threat to the safety and the good order of the people who are commuting.

The judge went on to make a finding that S.D. was "aggressive and threatening toward commuters at Newark Penn Station." She further found that "even though [S.D.] puts a more benign spin on his talking to people, [the court] find[s] that that's not exactly how he was perceived by others. And that being the case, he is lacking in judgment and insight."

The judge ordered S.D. to be civilly committed "by virtue of his mental illness, dangerous as he is to himself and others." The court ordered that the "doctor's report [be] amended to add danger to self by virtue of [S.D.'s] provocative behavior."

S.D. was transferred to a long-term locked institution and subsequently discharged.

S.D. raises the following issues on appeal:

> *POINT ONE*: The Trial [*7] Court Erred by involuntarily confining S.D. in a locked psychiatric facility and ordering him to be transferred to a long term institute without clear and convincing evidence that he presented a danger to himself, others, or property as required by *N.J.S.A. 30:4-27.15(a)* and *30:4-27.2(m)*.
>
> *POINT TWO*: The trial court committed reversible error when it entered a civil commitment order that was rooted in a multitude of baseless speculation devoid of any supporting evidence or valid factual basis to merit a continuation of civil commitment.
>
> *POINT THREE*: S.D.'S APPEAL IS NOT MOOT.

"The scope of appellate review of a commitment determination is extremely narrow and should be modified only if the record reveals a clear mistake." *In re D.C., 146 N.J. 31, 58, 679 A.2d 634 (1996)*. While the reviewing court should "give[] deference to civil commitment decisions and reverse[] only when there is clear error or mistake," it should also "consider the adequacy of the evidence." *In re Commitment of M.M., 384 N.J. Super. 313, 335, 894 A.2d 1158 (App. Div. 2009)*.

"Because commitment effects a serious deprivation of liberty, citizens are entitled to 'the meticulous protection of both procedural and substantive due process.'" *In re Commitment of J.R., 390 N.J. Super. 523, 533, 916 A.2d 463 (App. Div. 2007)* (quoting *In the Commitment of R.B., 158 N.J. Super. 542, 547, 386 A.2d 893 (App. Div. 1978))*. Reviewing courts "have not hesitated to reverse involuntary commitments when the record failed to contain clear and convincing evidence [*8] of 'a substantial risk of dangerous conduct within the reasonably foreseeable future.'" *In re Commitment of T.J., 401 N.J. Super. 111, 119, 949 A.2d 286 (App. Div. 2008)* (quoting *In re S.L., 94 N.J. 128, 138, 462 A.2d 1252 (1983))*.

The provisions of *N.J.S.A. 30:4-27.1 to -27.23* and *Rule 4:74-7* govern the process of involuntary commitments. For a court to order involuntary commitment, it must find "by clear and convincing evidence":

> that the patient is in need of continued involuntary commitment by reason of the fact that (1) the patient is mentally ill, (2) mental illness causes the patient to be dangerous to

> self or dangerous to others or property as defined in N.J.S.A. 30:4-27.2(h) and -.2(i), (3) the patient is unwilling to be admitted to a facility for voluntary care, and (4) the patient needs care at a short-term care or psychiatric facility or special psychiatric hospital because other services are not appropriate or available to meet the patient's mental health care needs.
>
> [R. 4:74-7(f)(1).]

Under N.J.S.A. 30:4-27.2(m), a person is "[i]n need of involuntary commitment" when "mental illness causes the person to be dangerous to self or dangerous to others or property[,]" and the person is unwilling to be voluntarily admitted to a facility for care. The burden is on the County to prove "the grounds for commitment by clear and convincing evidence." *In re Commitment of J.R., supra, 390 N.J. Super. at 529*.

Furthermore, the dangerousness must be "relatively [*9] immediate" and "[t]here must be, in fact, a 'substantial risk of dangerous conduct within the reasonably foreseeable future.'" *Id. at 530* (first quoting *In re Commitment of N.N., 146 N.J. 112, 130, 679 A.2d 1174 (1996)*, then quoting *In re S.L., supra, 94 N.J. at 138*).

According to N.J.S.A. 30:4-27.2(h) "dangerous to self"

> means that by reason of mental illness the person has threatened or attempted suicide or serious bodily harm, or has behaved in such a manner as to indicate that the person is unable to satisfy his need for nourishment, essential medical care or shelter, so that it is probable that substantial bodily injury, serious physical debilitation or death will result within the reasonably foreseeable future.

S.D. maintains that "there is not a single shred of testimony or evidence presented by the [County]" that S.D. cannot care for himself or has threatened or attempted self-harm. The County relies on Dr. Sostre's response to cross-examination that S.D. is "a danger to himself and others . . . because he becomes non-compliant with medications and he becomes threatening towards other people in the community."

Under N.J.S.A. 30:4-27.2(h) danger to self may be established if the patient "is unable to satisfy his need for . . . essential medical care." However, the record must contain clear and convincing evidence of a substantial risk [*10] of dangerous conduct within a foreseeable future. *J.R., supra, 390 N.J. Super. at 530*.

In *J.R.*, the court's "finding of dangerousness was based essentially on the judge's belief that if [the patient] fail[ed] to take his medication, he can become agitated and manic." *Ibid.* The lower court rationale was that the patient's "behavior could lead to someone assaulting him, which could cause him to be dangerous to himself as well." *Ibid.* We found this "inadequate" to meet the State's burden. *Id. at 531*. Likewise, in this case, Dr. Sostre testified that S.D. becomes dangerous to himself "because he becomes non-compliant with medications."

In her findings, the judge stated: "I understand that just because somebody is different, he talks to himself and he wanders around" and is unlikely to continue taking medication, "in and of itself is not a sufficient reasons to commit him." She committed S.D. nonetheless, because of the frequency of his prior commitments. The judge went on to order, without a request from the County, that the "doctor's report" be amended to "add danger to self by virtue of [S.D.'s] provocative behavior."

N.J.S.A. 30:4-27.2(i) states:

> "Dangerous to others or property" means that by reason of mental illness there is a *substantial likelihood that the [*11] person will inflict serious bodily harm* upon another person or cause serious property damage within the reasonably foreseeable future. This determination shall take into account a person's history, recent behavior and any recent act or threat.
> [Emphasis added.]

We have held that in rare instances the statute could be satisfied if the "substantial likelihood of psychological harm to others [was] so severe as to inflict 'serious bodily harm upon another person.'" *In re Commitment of A.A., 252 N.J. Super. 170,*

179, 599 A.2d 573 (App. Div. 1991) (quoting N.J.S.A. 30:4-27.2(i)). Merely characterizing language as "aggressive" is not enough, however, to establish that a "verbal assault" occurred that reached the level of serious bodily harm. J.R., supra, 390 N.J. Super. at 532. In *J.R.*, the patient was accused of making verbally abusive statements to the medical staff; however, no evidence was presented "regarding the nature" of these comments or "the context in which they were made, or even the demeanor and tone used." Id. at 532. We found that this evidence was insufficient to satisfy N.J.S.A. 30:4-27.2(i). *Ibid.*

Similarly, in In the Commitment of W.H., 324 N.J. Super. 519, 524, 736 A.2d 529 (App. Div. 1999), we found the testimony of the appellant's doctor that when the patient does not take his medications he becomes "delusional and talks to himself" insufficient to meet the standard of dangerousness to self or others. Suffering from [*12] a mental illness alone is not sufficient for involuntary commitment. S. L., supra, 94 N.J. at 137-38 (citing *O'Connor v. Donaldson*, 422 U.S. 563, 575-76, 95 S. Ct. 2486, 2493-94, 45 L. Ed. 2d 396, 406-07 (1975)).

Here, no testimony was presented about the content of the comments made at Penn Station. Dr. Sostre himself characterized the reports as "vague" and could not relay them with any specificity. Dr. Sostre acknowledged it was "possible" that S.D. was merely "being loud." Furthermore, when Dr. Sostre testified that S.D. "was threatening other commuters at Penn Station," S.D.'s counsel objected to the testimony as hearsay. The court allowed the comments because the doctor "utilize[d] that screening information for the purposes of diagnosis — only[.]" As the County concedes, "a judge must take care to avoid any use of an expert's testimony about the foundation for an opinion as proof of facts that are neither derived from nor established by otherwise admissible evidence." M.M., supra, 384 N.J. Super. at 335.

Dr. Sostre admitted on cross-examination that he had never witnessed S.D. verbally abusing anyone at the hospital. Therefore, his evidence that S.D. was dangerous to others was based only on the report from Penn Station and the fact that S.D. responds to verbal stimuli. J.R. requires that verbal threats be more than just generally categorized as "aggressive." [*13] J.R., supra, 390 N.J. Super. at 531. Without a finding of dangerousness based on clear and convincing evidence, S.D. should not have been involuntarily committed.

"It is well settled in New Jersey that an appeal in these types of cases is not moot, even if the patient is no longer confined, when the patient remains liable for his or her hospital bill, and a finding in the patient's favor will entitle the patient to a credit for any period of illegal commitment." In re Commitment of B.L., 346 N.J. Super. 285, 292, 787 A.2d 928 (App. Div. 2002). Although New Jersey has repealed the automatic lien provisions formerly contained in N.J.S.A. 30:4-80.1, other statutes render patients liable for all or part of the costs of their hospitalization. *See* N.J.S.A. 30:4-60(c)(1) (establishing liability for cost of treatment, maintenance and all related expenses for treatment in a psychiatric facility); N.J.S.A. 30:4-70 (requiring payment upon subsequent discovery of patient funds).

Furthermore, "even if appellant had no liability for hospital costs, we 'should nevertheless decide the issue [if] it implicates a committee's constitutional right to liberty. . . .'" T.J., supra, 401 N.J. Super. at 118 (quoting In re Commitment of G.G., 272 N.J. Super. 597, 600 n.1, 640 A.2d 1156, (App. Div. 1994)). Finally, if the correctness of the challenged commitment affects the nature of future placements the matter should not be considered moot. M.M., supra, 384 N.J. Super. at 322, n.3; *see* N.J.S.A. 30:4-27.5 ("If a person has been admitted three times or has [*14] been an inpatient for 60 days at a short-term care facility during the preceding 12 months, consideration shall be given to not placing the person in a short-term care facility.").

Reversed.

End of Document

In the Matter of the Civil Commitment of A.P.

Practice Area: HEALTH CARE LAW
Date Filed: 2021-06-07
Court: Appellate Division

Petitioner appealed from her order of involuntary civil commitment, seeking to remove the involuntary commitment from her record. Petitioner, then 16, was admitted to a child psychiatric unit on a voluntary parental admission submitted by her mother, who stated that petitioner suffered from depression and anxiety.

At the commitment hearing, counsel asserted that there were significant differences between petitioner's, her mother's, and the hospital's version of the events that led to petitioner's hospitalization. Both petitioner and her mother opposed involuntary commitment. Petitioner's psychologist testified that she had been hospitalized due to increasing depression, suicidal thoughts, and auditory hallucinations. The doctor diagnosed petitioner with major depressive disorder with psychotic features. The doctor opined that petitioner was still a danger to herself, despite being compliant with her medication regimen.

Over counsel's objection, the trial court permitted the doctor to testify that petitioner had reported suicidal thoughts as recently as the morning of the hearing. Petitioner's mother testified that she took petitioner to the hospital because petitioner had run out of medication and could not obtain any at the pharmacy. The trial court ordered petitioner's continued commitment, finding her mother to not be credible and accepting the doctor's testimony, even though he was only a covering psychiatrist. Petitioner was discharged three days later.

On appeal, the court affirmed the trial court's order, finding it based on substantial credible evidence after the trial court rejected petitioner's mother's explanation for her voluntarily admitting petitioner to the hospital.

NOT FOR PUBLICATION WITHOUT THE
APPROVAL OF THE COMMITTEE ON OPINIONS

R. R. ,	SUPERIOR COURT OF NEW JERSEY
	HUDSON COUNTY
Plaintiff,	CHANCERY DIVISION: FAMILY PART
v.	DOCKET NO. FM-09-934-15
L. A. C. ,	CIVIL ACTION
Defendant.	OPINION

Decided: April 17, 2015
The Plaintiff was represented by
Kathleen Garvey, Esq.
The Defendant was self-represented.

D'ALESSANDRO, J.S.C.

INTRODUCTION

This case concerns the Court's authority to fulfill a Child's request to hug and see her Father.

THE PARTIES

The Plaintiff, R.R.[1], ("Father") is the non-custodial Parent. Although the Defendant, L.A.C., ("Mother") did not answer the Complaint, she attended the default divorce hearing and asked to speak. Father works full-time, ten hours a day, and lives alone. Mother works part-time, for minimum wage, and lives with the parties' daughter, Gabriela. Mother testified that she cannot work full-time because of Gabriela's needs, explaining that "the time I provide to my daughter is worth it because it is improving her health."

Father requested a divorce, with the possibility of future parenting time "when I am ready." Mother listened attentively and softly replied: "we do not have joint property or belonging[s]; but we do have a daughter of the two of us." Mother asked the Court for assurances that Gabriela's Father would help her and raise Gabriela if she was unable to. Mother voiced the worry of parents who struggle to raise children alone: "I am not a person made out of steel. I may get sick. Who will look after our daughter, if something happens to me?"

FINDINGS OF FACT

Father emigrated from Peru and arrived in the United States in 1987. He returned years later and the parties married on August 12, 1993 in Peru. They lived separate and apart throughout most of their marriage after he returned to the United States in 1997. He occasionally returned to Peru before Gabriela was born on December 23, 1999. He returned a few more times between 2000 and 2002. He did not see his wife and daughter from 2002 to 2013, except when

[1] For privacy, the parties are referred to as Mother and Father. The pseudonym "Gabriela" is used for their child.

they lived together in Peru for a month in 2008. He sponsored their emigration from Peru to the United States. They arrived on July 2, 2013.

Gabriela had no recollection of her Father. He was a stranger except in her heart. Unhappy differences between Father and Mother, and between Father and Gabriela arose immediately. Father intended that Mother would come to the United States only as "friends" to give her and Gabriela the chance to live and prosper here. Mother had other expectations. She intended to live with him and Gabriela as a family. Instead, Father lived separately in one room of a small apartment. Mother and Gabriela lived separately in another room.

When Gabriela arrived in the United States, she was thirteen years old. Instead of being reunited with her Father, she was isolated from him again. Her parents lived under the same roof as angry strangers. Marital discord intensified. Mother, Father and Gabriela quarreled. The arguments were heated. The police were called. Mother obtained a temporary restraining order which was subsequently dismissed at her request. The Division of Child Protection & Permanency ("DCP&P") intervened and provided services and evaluations. During her evaluation, Gabriela expressed a poignant wish: "to have a Dad." Her wish was not fulfilled. Her parents separated less than two months after Gabriela arrived in the United States.

While flailing helplessly in the maelstrom of marital discord at home, Gabriela found no comfort at school. She was taunted and bullied because of her cleft palate, hearing loss and impaired speech. In desperation, Mother sent her back to Peru to live with her maternal Grandmother to escape the bullies and for medical treatment that she could not afford in the United States. Within a few months, Gabriela left her home in Peru for the United States; had her hopes for a family dashed; was bullied at school; and boarded a plane back to Peru without her Mother. Four months later, she returned to the United States at age 14. She is in therapy to

ease the pain of separation, bullying, her many challenges and adolescent angst. She had cleft palate surgery. Surgical repairs, speech rehabilitation and dental restoration beckon.

Soon after the hearing began, the Court noticed someone whose head was down while rocking back and forth in the back of the courtroom. Mother had brought Gabriela to court. The Court asked why. Mother responded that Gabriela's psychologist told Gabriela that she had every right to come to court to ask the Judge her questions. The Court closed the proceeding.

Gabriela cautiously approached counsel table. She spoke with the assistance of the court interpreter. Now age 15, she is in the 8th grade and will attend high school in the fall. During gentle questioning by the Court, Gabriela explained that she came here "to ask [the Court] if it is possible for him [Father] to see me once a week." Gabriela hesitated before her evocative second request: "and I would like to give him a hug."

A hungry person does not want a dissertation on the socio-economic causes of poverty. There will be time enough for that after the hunger pangs subside. A hungry person wants something to eat. Gabriela came to a Court believing that a Judge could and would help her. She did not seek an explanation of why some parents do not see their children. Gabriela stood courageously before strangers risking rejection, disappointment and more heartbreak if her requests were denied. Gabriela's heart hungered to know and hug her Father.

The Court thanked Gabriela and invited her to join staff in chambers. After Gabriela left, the Court questioned her parents. Father explained that he is leery and uncomfortable about seeing his daughter. "I am not ready. I need psychology. Someone to speak to. I don't hate her. I know she is my daughter. I brought her here to make something different for her."

Through colloquy with the Court, Father began to see things through his daughter's eyes instead of his own. Father acknowledged that Gabriela was without him for most of her life

wondering what she did wrong to explain his absence. He acknowledged that Gabriela might have been justifiably angry when she called him bad names in the past because she was unable to express her pain in a way that he approved of. Gabriela worried about her appearance, her prior surgeries and the surgeries to come. She suffered at school. She was depressed and attempted to harm herself. She was reminded why each time she spoke and whenever she saw her image in the reflection of her tears.

Before Gabriela returned to the courtroom, Mother said that she had a "gift" for Father. Her "gift" was to let him know that Gabriela is now considered a genius at school, and that she is a photographer and a poet whose poetry may soon be featured in the New York Times.

Gabriela returned and cheerfully acknowledged her love of photography and poetry. The Court then asked Father if he was ready to share the "gift" that was discussed while Gabriela was in chambers. Father quickly walked toward Gabriela as she rushed toward him. They sobbed heartily and hugged for a long time.

LEGAL ANALYSIS

A custodial Parent is entitled to the non-custodial Parent's assistance raising their Children. Non-custodial Parents (who have not been declared unfit) should assist custodial Parents in raising and nurturing their Children unless there is a Court order prohibiting them from doing so. Custodial Parents need a parenting break too. Parents should communicate and work together in their Children's best interest despite their differences.

The Court, as *parens patriae*, protects Children. When a custodial Parent violates a parenting time Order, the Court has the right to impose substantial sanctions.[2] The Court also has the equitable authority to facilitate parenting time between children and absent parents, to order counseling, and to require parents to complete parenting programs. "In promoting the child's welfare, the Court should [make] every effort to attain for the child the affection of both parents." In re Jackson, 13 N.J. Super. 144, 147-48 (App. Div. 1951). Today's Order strives to do so.

"The Family Court possesses broad equitable powers to accomplish substantial justice." Finger v. Zenn, 335 N.J. Super. 438, 446 (App. Div. 2000), certif. denied, 167 N.J. 633 (2001). The Court has the authority to facilitate and grant Gabriela's request that her Father see her once a week. Father requested counseling and expressed his desire to establish a relationship with Gabriela. The Court granted his request. Consistent with ever-evolving notions of therapeutic courts, Father and Daughter took that first step and embraced. Today's Order establishes a parenting schedule, provides counseling and a path toward enhanced parental commitment.

Father shall call Gabriela frequently and see her weekly. The Court has identified low-cost counseling and a program designed to foster fathering skills. Father shall promptly begin individual counseling and complete the "Fatherhood Program" at Visiting Homemaker Service

[2] Rule 5:3-7(a): (1) compensatory time with the children; (2) economic sanctions, including but not limited to the award of monetary compensation for the costs resulting from a parent's failure to appear for scheduled parenting time or visitation such as child care expenses incurred by the other parent; (3) modification of transportation arrangements; (4) pick-up and return of the children in a public place; (5) counseling for the children or parents or any of them at the expense of the parent in violation of the order; (6) temporary or permanent modification of the custodial arrangement provided such relief is in the best interest of the children; (7) participation by the parent in violation of the order in an approved community service program; (8) incarceration, with or without work release; (9) issuance of a warrant to be executed upon the further violation of the judgment or order; and (10) any other appropriate equitable remedy.

of Hudson County, Inc. He shall send the Court proof that he completed the program by August 14, 2015. Gabriela is doing well in therapy. Father and Mother shall contact Gabriela's therapist and participate in her therapy if asked to do so.

CONCLUSION

Courage takes many forms and comes in all sizes. Gabriela's courageous words were riveting. The tears that she and her Father shared were inspirational. Mother cried afterwards "that seeing my daughter happy makes me happy." The Court thanks this beautiful child for her gift of hope. Tear-moistened soil is often fertile soil.

This page intentionally left blank

RECORD IMPOUNDED

NOT FOR PUBLICATION WITHOUT THE
APPROVAL OF THE APPELLATE DIVISION

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NOS. A-4684-17T2
A-4699-17T2
A-0015-18T2

IN THE MATTER OF THE
CIVIL COMMITMENT OF C.M.

IN THE MATTER OF THE
CIVIL COMMITMENT OF M.H.

IN THE MATTER OF THE
CIVIL COMMITMENT OF C.R.

APPROVED FOR PUBLICATION

April 15, 2019

APPELLATE DIVISION

Argued April 2, 2019 – Decided April 15, 2019

Before Judges Fisher, Hoffman and Geiger.

On appeal from Superior Court of New Jersey, Law Division, Camden County, Docket Nos. CASC-561-18 and CASC-426-18; and Salem County, Docket No. SACC-168-18.

Amy B. DeNero, Assistant Deputy Public Defender, argued the cause for appellant C.M. (Joseph E. Krakora, Public Defender, attorney; Amy B. DeNero and Purificacion V. Flores, Assistant Deputy Public Defender, on the brief).

Purificacion V. Flores, Assistant Deputy Public Defender, argued the cause for appellant M.H. (Joseph E. Krakora, Public Defender, attorney; Amy B.

DeNero, Assistant Deputy Public Defender, and Purificacion V. Flores, on the brief).

Lorraine Hunter Hoilien, Deputy Public Defender, argued the cause for appellant C.R. (Joseph E. Krakora, Public Defender, attorney; Lorraine Hunter Hoilien, on the brief).

Respondent State of New Jersey has not filed a brief.

The opinion of the court was delivered by

FISHER, P.J.A.D.

Considering the important liberty interests that were at stake – and likely infringed – in these matters, we conclude the trial judge erred in refusing to vacate commitment orders solely because appellants had already been released from confinement. The existence of an unlawful commitment order is a matter of public importance and, in light of the circumstances asserted, capable of recurring; yet – if the judge's rationale for refusing to examine the legitimacy of the commitment orders is acceptable – an aggrieved individual's ability to challenge an unlawful commitment would repeatedly evade review. Even if there was available, as seems likely, no concrete remedy – other than an order declaring the wrong done – and even if, for that reason, the dispute was technically moot, we conclude the judge still should have ruled on the merits of

appellants' motions to vacate. And, so, we vacate the orders under review and remand for further proceedings in conformity with this opinion.

We start with a recognition that bedrock liberty interests are threatened whenever the State seeks an involuntary commitment. That threat obligates the State to provide sufficient procedures and limits to prevent liberty restraints disproportionate to the undertaking. See Addington v. Texas, 441 U.S. 418, 425 (1979) (declaring that "commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection"); In re S.L., 94 N.J. 128, 137 (1983) (recognizing that "because commitment effects a great restraint on individual liberty, th[e] power of the State is constitutionally bounded"). To be sure, the individual's "deprivation[] of liberty" must be balanced against the public interest in "the need for safety and treatment" of the individual and others, but the weighing of those interests presupposes a need for strict adherence to the "clear standards and procedural safeguards that ensure that only those persons who are dangerous to themselves, others or property, are involuntarily committed to treatment." N.J.S.A. 30:4-27.1(b). To vindicate those interests, it is well-established that the existing procedural safeguards "must be narrowly circumscribed because of the extraordinary degree of state control it exerts over a citizen's autonomy." S.L., 94 N.J. at 139.

With these policies and interests in mind, we observe that the process in place allows a facility to hold an individual for twenty-four hours while a screening service "provid[es] . . . treatment and conduct[s] [an] assessment." N.J.S.A. 30:4-27.5(a). If – after performing an examination – a psychiatrist finds a need for involuntary commitment, a screening certificate must be completed. N.J.S.A. 30:4-27.5(b). The facility may then "detain" the individual "involuntarily by referral from a screening service without a temporary court order," but "for no more than 72 hours from the time the screening certificate was executed." N.J.S.A. 30:4-27.9(c); accord N.J.A.C. 10:31-2.3(g); R. 4:74-7(b)(1). During that seventy-two-hour period, the facility must initiate involuntary committal court proceedings. N.J.S.A. 30:4-27.9(c).

The appellate record reveals these protections were not likely afforded. C.M. (Carol[1]) was admitted to the emergency room at Virtua Hospital in West Berlin and screened the same day; a psychiatrist, however, did not examine Carol or execute a certificate for eight days, and a judge did not enter a temporary order of commitment until the ninth day of detention. M.H. (Morgan) was brought to the emergency room at Jefferson Health Hospital in Cherry Hill

[1] The names we use for appellants are fictitious so as to preserve their privacy. We identify the facilities where they were held.

and screened the day of his arrival. Like Carol, Morgan was not examined and no certificate was executed for nine days; a commitment order was entered a day later. C.R. (Carl) was brought to the emergency room at Memorial Hospital in Salem County and kept involuntarily without a court order for six days. If these facts are true, appellants were involuntarily detained without a court order – and without the appointment of counsel[2] – for longer than the law allows.

These three cases were adjudicated in a similar way, with the same judge reaching the same result. The details vary only slightly. Approximately a week after entry of a temporary order of commitment, Carol filed her motion to vacate. She was released before the motion's return date, so the judge found the application moot and denied the motion. Morgan, who was still confined, unsuccessfully moved at the initial commitment hearing for a directed verdict in light of the alleged procedural violations. Before a later review hearing could occur, Morgan was discharged from the facility and his motion to vacate was denied as moot. Carl objected to commitment at an initial hearing, prompting

[2] In constitutional terms, the importance of a timely temporary commitment order cannot be understated. Such an order provides for the appointment of counsel for the held individual, R. 4:74-7(c)(2), and fixes the date for an adversarial hearing for no later than twenty days from the initial commitment, R. 4:74-7(c)(1).

an adjournment. He then moved to vacate the temporary commitment order that was denied as moot because, by then, he had been discharged.

In appealing the orders denying their motions to vacate, Carol, Morgan, and Carl separately but similarly argue[3] that we should insist on a disposition on the merits because, in this setting, it is crucial – notwithstanding technical mootness – that our courts recognize, declare, and enforce the legal limitations, constitutional guarantees, and important public policies that underlie the applicable procedures. We agree.

To be sure, we recognize that civil actions become moot when, through evolving events, courts lose the power to practically effect the parties' rights or interests. See Reilly v. AAA Mid-Atl. Ins. Co. of N.J., 194 N.J. 474, 484 (2008); Oxfeld v. N.J. State Bd. of Educ., 68 N.J. 301, 303 (1975); see also De Vesa v. Dorsey, 134 N.J. 420, 428 (1993) (Pollock, J., concurring). But, despite circumstances that preclude the availability of an effective remedy, courts may still decide a case when its issues are of "great public importance," Oxfeld, 68 N.J. at 303, or are "capable of repetition," In re Conroy, 98 N.J. 321, 342 (1985),

[3] Carol and Morgan's appeals were consolidated; Carl's was not, but we listed his appeal so it could be considered with the others. We now consolidate all three cases so they may be decided by this single opinion.

"yet [will] evade review," In re J.I.S. Indus. Serv. Co. Landfill, 110 N.J. 101, 104 (1988). Assuming the trial judge – when denying appellants' motions – properly recognized that the matters were technically moot,[4] we are nevertheless satisfied that the issues are of public importance; they are also capable of repetition while tending to evade disposition on their merits.[5]

Carol, Morgan, and Carl have shown that reasons for deciding these cases on their merits were present despite their technical mootness. The mere

[4] We are mindful there may be practical impacts caused by a judge's refusal to vacate unlawful or erroneous commitment orders. An order on the merits might be persuasive or preclusive in a subsequent civil action asserting an alleged wrongful confinement. Such an order might also effect a later dispute about the responsibility for an unpaid bill for services during the unwarranted confinement. In re Commitment of T.J., 401 N.J. Super. 111, 118 (App. Div. 2008); In re Commitment of B.L., 346 N.J. Super. 285, 292 (App. Div. 2002). And such an order might alter future hospitalizations. See N.J.S.A. 30:4-27.5(b) (recognizing that in screening a patient and assessing the proper environment for the patient, the screening should "tak[e] into account the person's prior history of hospitalization," and "[i]f a person has been admitted three times or has been an inpatient for 60 days at a short-term care facility during the preceding 12 months, consideration shall be given to not placing the person in a short-term care facility"). For present purposes, and because the record is unclear on any of these or other potential practical impacts, we assume the trial judge in these cases correctly concluded the matters were technically moot.

[5] Our courts have been particularly willing to decide technically moot matters in this and other similar settings. In re Commitment of N.N., 146 N.J. 112, 124 (1996); In re Civil Commitment of U.C., 423 N.J. Super. 601, 608 (App. Div. 2012); Betancourt v. Trinitas Hosp., 415 N.J. Super. 301, 311 (App. Div. 2010); In re Commitment of M.C., 385 N.J. Super. 151, 155-56 (App. Div. 2006).

existence of these three separate matters – all arising around the same time, with two occurring in the same county – demonstrates the likelihood that similar alleged deprivations will occur again.[6] And, if we were to allow their attempts to vindicate their liberty rights to be short-circuited through a broad view of mootness, courts similarly disposed would likely never reach the merits of such disputes. In other words, to endorse the trial judge's disposition, we would be creating a scenario by which those in breach could simply discharge a wrongly held individual before the day of reckoning without consequence. Although it is appropriate in many cases to reserve judicial resources for actual controversies, Cinque v. N.J. Dep't of Corr., 261 N.J. Super. 242, 243 (App. Div. 1993); Anderson v. Sills, 143 N.J. Super. 432, 437 (Ch. Div. 1976), important rights like those appellants would have honored through their trial court motions should not be diluted or simply ignored because their pursuit of a legal remedy could not keep pace with the ongoing circumstances.

The State's failure to respond to either the trial court motions or these appeals suggests its recognition that the temporary commitment orders should

[6] The parties' submissions advise there are two other similar pending appeals in this court arising from the same vicinage.

not have been entered.[7] Such an assumption might further suggest that we rule on the merits of appellants' motions now based on the factual assertions in the appellate record, but we think the better course is to compel the trial court's disposition of these motions on their merits in the first instance. See Estate of Doerfler v. Fed. Ins. Co., 454 N.J. Super. 298, 301-02 (App. Div. 2018).

* * *

The orders under review are vacated and the matters remanded. Appellants' motions should be scheduled and decided within thirty days of today's decision. We retain jurisdiction to consider – on an expedited basis – any appeal that may be filed by an aggrieved party following the trial court's entry of orders that finally dispose of appellants' motions to vacate on their merits.

[7] In each case, County Counsel advised that, having reviewed the appellant's submission, the State "takes no position."

This page intentionally left blank

In re Civil Commitment of J.A.G.

Superior Court of New Jersey, Appellate Division

April 26, 2021, Argued; May 12, 2021, Decided

DOCKET NO. A-3246-19

Reporter
2021 N.J. Super. Unpub. LEXIS 875 *; 2021 WL 1904558

IN THE MATTER OF THE CIVIL COMMITMENT OF J.A.G.

Notice: NOT FOR PUBLICATION WITHOUT THE APPROVAL OF THE APPELLATE DIVISION.

PLEASE CONSULT NEW JERSEY *RULE 1:36-3* FOR CITATION OF UNPUBLISHED OPINIONS.

Prior History: On appeal from the Superior Court of New Jersey, Law Division, Gloucester County, *Docket* No. GLCC-000143-20.[1] [*1] .

Core Terms

involuntary commitment, discharged, reconsideration motion, mental illness, cross-examination, convincing

Counsel: Carol J. Sands, Assistant Deputy Public Defender, argued the cause for appellant J.A.G. (Joseph E. Krakora, Public Defender, attorney; Carol J. Sands, of counsel and on the brief).

Judges: Before Judges Fasciale and Susswein.

Opinion

PER CURIAM

J.A.G. appeals from a February 25, 2020 order involuntarily committing her (just over an hour before she was administratively discharged) for two weeks, seeking to have the order of involuntary commitment removed from her record. J.A.G. asserts—and it is undisputed on appeal—that the judge violated her due process rights by ordering her involuntary commitment without clear and convincing evidence that she posed a danger to herself, others, or property, improperly shifting the burden of proof onto her, pressing the case for the State, preventing cross-examination of the expert witness, and disregarding expert witness testimony while crediting net opinion. We emphasize this appeal is unopposed. We agree and reverse.

On February 7, 2020, Northbrook Behavioral Health Hospital (NBHN) admitted J.A.G. The next day, the judge entered a temporary order for commitment [*2] and scheduled a February 25, 2020 hearing to address the issue of involuntary commitment.

At the February 25, 2020 hearing, counsel for J.A.G. and Dr. Thomas Campo were present, but County Counsel was not. The judge swore Campo in and admitted his expert report into evidence. In his expert report, Campo recommended that J.A.G. be involuntary committed for four weeks. However, at the hearing, counsel for J.A.G. informed the judge that J.A.G. "was under the impression that there was a discharge plan that was worked out with the treatment team . . . and there might be discharge relatively soon." The judge asked Campo whether there was a discharge plan put in place. Campo explained that J.A.G. would be

[1] In an August 3, 2020 letter, counsel that appeared in lieu of County Counsel on behalf of the State informed this court that because the subject of the appeal is the same as the motion for reconsideration below, which the State did not oppose, the State is not participating in this appeal and takes no position in this matter.

---

discharged to the care of her father.

Counsel for J.A.G. asked Campo whether there was a time frame for discharge. Campo confirmed J.A.G.'s understanding, testifying that she would be discharged in "[t]wenty-eight minutes or so," assuming nothing happened the night before that would jeopardize the discharge plan, such as J.A.G. "throw[ing] a chair or attempt[ing] suicide." The judge then interjected, stating "[w]ell, but [Campo] can do that with any patient at any time." At this point, the [*3] judge began questioning Campo regarding J.A.G.'s status prior to admission to NBHN and where she would reside after being discharged. Campo explained that J.A.G.'s "primary issue" was poor self-care. Counsel for J.A.G. attempted to reiterate that J.A.G. believed she was being discharged that day, and as a result counsel did not discuss her post-discharge living situation with her. The judge responded "[w]ell, maybe. There's no report that says that."

The judge issued an order involuntarily committing J.A.G. for two weeks. Counsel for J.A.G. again explained that J.A.G. believed that she would be discharged that same day, to which the judge responded he "would ascribe that to delusional behavior." The hearing concluded at 9:03 a.m. On the same day, at 10:21 a.m., NBHN administratively discharged J.A.G..

In March 2020, J.A.G. filed a motion for reconsideration and included documentation showing NBHN discharged her on the same day of the hearing. After the judge failed to respond to the motion for reconsideration for five weeks, J.A.G. filed this appeal. In April 2020, J.A.G. sent a letter to the judge notifying him that the State was no longer opposing J.A.G.'s motion for reconsideration [*4] and asked if he wanted to schedule a hearing on the motion for reconsideration. The judge did not respond.

In May 2020, counsel appearing in lieu of County Counsel on behalf of the State provided a letter stating that the State was not opposing J.A.G.'s motion for reconsideration. As of the filing of J.A.G.'s brief in this matter, there has been no response to the motion for reconsideration.

On appeal, J.A.G. raises the following points for this court's consideration[2]:

POINT I

THE [JUDGE'S] FAILURE TO PROVIDE A FAIR HEARING, AND ITS ORDER OF INVOLUNTARY COMMITMENT IN DISREGARD OF THE TESTIMONY THAT [J.A.G.] WAS GOING TO BE DISCHARGED WITHIN TWENTY-EIGHT MINUTES OF COURT, CONSTITUTED AN EGREGIOUS VIOLATION OF [J.A.G.'S] CONSTITUTIONAL DUE PROCESS RIGHTS.

POINT II

THE [JUDGE] VIOLATED [J.A.G.'S] PROCEDURAL DUE PROCESS RIGHTS BY CONDUCTING DIRECT EXAMINATION, INTERRUPTING CROSS-EXAMINATION AND ACTING AS OPPOSING COUNSEL IN ITS CONDUCT OF THE CASE.

POINT III

THE [JUDGE] IMPERMISSIBLY SHIFTED THE BURDEN OF PROOF FROM THE STATE TO [J.A.G.], FAILING TO APPLY THE CLEAR AND CONVINCING STANDARD OF PROOF OF MENTAL ILLNESS AND DANGEROUSNESS.

POINT IV

[J.A.G.] MAY SUFFER SERIOUS HARM DUE TO THE [JUDGE'S] [*5] IMPROPER RULING.

Our review of a judge's determination to commit an

---

[2] Although J.A.G. has been discharged and is no longer subject to involuntary commitment, her challenge to the order extending her involuntary commitment is not moot. If the February 25 order is allowed to remain on J.A.G.'s record, it could affect J.A.G.'s status if she were to be committed again. *N.J.S.A. 30:4-27.5(b)* (requiring that "[i]f a person has been admitted three times . . . at a short-term care facility during the preceding [twelve] months, consideration shall be given to not placing the person in a short-term care facility").

individual is "extremely narrow," *In re D.C., 146 N.J. 31, 58, 679 A.2d 634 (1996)*, and it may only be modified where "the record reveals a clear mistake," *In re Civil Commitment of R.F., 217 N.J. 152, 175, 85 A.3d 979 (2014)*. A judge's determination should not be disturbed if the judge's findings are "supported by 'sufficient credible evidence present in the record." *Ibid.* (quoting *State v. Johnson, 42 N.J. 146, 162, 199 A.2d 809 (1964)*).

"Involuntary commitment to a mental hospital is state action which deprives the committee of important liberty interests and, as such, triggers significant due process requirements." *In re Commitment of Raymond S., 263 N.J. Super. 428, 431, 623 A.2d 249 (App. Div. 1993)*. As a result, our Legislature and Supreme Court have promulgated *N.J.S.A. 30:4-27.1 to - 27.23* and *Rule 4:74-7* "to ensure that no person is involuntarily committed to a psychiatric institution without having been afforded procedural and substantive due process." *Ibid.* An adult is considered "in need of involuntary treatment" if they are

> an adult with mental illness, whose mental illness causes the person to be dangerous to self or dangerous to others or property and who is unwilling to accept appropriate treatment voluntarily after it has been offered, needs outpatient treatment or inpatient care at a short-term care or psychiatric facility or special psychiatric hospital because other services are not appropriate [*6] or available to meet the person's mental health care needs.
>
> [*N.J.S.A. 30:4-27.2(m)*; *see* *R. 4:74-7(f)(1)*.]

"Mental illness" is defined as "a current, substantial disturbance of thought, mood, perception, or orientation which significantly impairs judgment, capacity to control behavior, or capacity to recognize reality," not including "simple alcohol intoxication, transitory reaction to drug ingestion, organic brain syndrome, or developmental disability" unless that disability results in the impairment. *N.J.S.A. 30:4-27.2(r)*.

A judge may not commit a person to a psychiatric facility "without proof by clear and convincing evidence that the individual has a mental illness, and the mental illness causes the patient to be dangerous to self, to others, or to property." *Raymond S., 263 N.J. Super. at 431* (citing *N.J.S.A. 30:4-27.9(b)*; *N.J.S.A. 30:4-27.15(a)*; *R. 4:74-7(f)*).

If a judge "finds that there is probable cause to believe that [a] person . . . is in need of involuntary commitment to treatment," the judge "shall issue a temporary order authorizing the assignment of the person to an outpatient treatment provider or the admission to or retention of the person in the custody of the facility." *N.J.S.A. 30:4-27.10(g)*; *see* *R. 4:74-7(c)*. Commitment must be "both appropriate to the person's condition and . . . the least restrictive environment, pending a final hearing." [*7] *N.J.S.A. 30:4-27.10(g)*; *see* *R. 4:74-7(c)*.

Our review of the record leads us to the conclusion that the judge did not afford J.A.G. the due process rights owed to her as guaranteed by our Legislature and Supreme Court and did not satisfy the procedural requirements of *Rule 1:7-4(a)*.

First, the judge improperly shifted the burden of proof from the State to J.A.G. to show that she was not a danger to herself or others and pressed the case in favor of involuntary commitment. "The case for involuntary commitment must be presented by County Counsel." *Raymond S., 263 N.J. Super. at 432* (citing *N.J.S.A. 30:4-27.12*). The State bears the burden of establishing that the evidence is so clear and convincing "that the factfinder can 'come to a clear conviction' of the truth without hesitancy." *In re Civil Commitment of R.F., 217 N.J. 152, 173, 85 A.3d 979 (2014)* (quoting *In re Jobes, 108 N.J. 394, 407, 529 A.2d 434 (1987)*). It is inappropriate for a judge to advance the case for commitment rather than County Counsel because such conduct "places the judge in the role of an adversary rather than of a neutral decision maker." *Raymond S., 263 N.J. Super. at 432*.

Here, aside from Campo's expert report, which was contradicted by his hearing testimony, no evidence presented established that J.A.G. was a danger to

herself, others, or property. Instead, the judge insinuated that she failed to establish that she should be discharged because "[t]here's no report [*8] that says that." The judge also appeared to draw a negative inference against J.A.G. for not attending the hearing, explaining to counsel for J.A.G. that she "ha[s] to tell all [her] clients that they should appear in court even if it's for . . . a request from [Conditional Extension Pending Placement]." *See* N.J.S.A. 30:4-27.14(b) (noting that a person subject to an involuntary commitment hearing has the right, but not the obligation, to be present at the hearing). And when counsel for J.A.G. reiterated that J.A.G. believed that she would be discharged the same day as the hearing, the judge stated that he "would ascribe that to delusional behavior." There was no testimony or evidence presented to suggest that J.A.G. was delusional.

The judge also pressed the case for the State. County counsel was not present at the hearing and did not present a case for J.A.G.'s involuntary commitment. However, the judge questioned Campo regarding how many times J.A.G. has been hospitalized in the past two years, what her living situation would be, what the "primary issue" was related to J.A.G.'s commitment, what J.A.G.'s level of income was, and whether Campo believed J.A.G. was employable.

Second, the judge prevented counsel [*9] for J.A.G. from cross-examining Campo. A patient is guaranteed the right to cross-examine witnesses at a hearing determining whether involuntary commitment is appropriate. N.J.S.A. 30:4-27.14(d). Our Supreme Court has noted that "cross-examination is the 'greatest legal engine even invented for the discovery of truth.'" State ex rel J.A., 195 N.J. 324, 342, 949 A.2d 790 (2008) (quoting *California v. Green*, 399 U.S. 149, 158, 90 S. Ct. 1930, 26 L. Ed. 2d 489 (1970)). But the judge only permitted counsel for J.A.G. to ask a single question on cross-examination, which elicited that J.A.G. was likely to be discharged in "[t]wenty-eight minutes or so." When counsel for J.A.G. attempted to ask Campo another question, the judge interjected to note that Campo could discharge any patient at any time. From there on, the judge directed questions to Campo and counsel for J.A.G. before ordering J.A.G.'s continued involuntary commitment.

Third, the judge did not place his findings of facts and conclusions of law on the record or in the February 25 order. "In a nonjury civil action, the role of the trial [judge] is to find the facts and state conclusions of law." D.M., 313 N.J. Super. at 454 (citing R. 1:7-4). Whether stated on the record or in a written opinion, "there must be a weighing and evaluation of the evidence to reach whatever may logically flow from the aspects of testimony the [*10] [judge] accepts." Slutsky v. Slutsky, 451 N.J. Super. 332, 357, 167 A.3d 660 (App. Div. 2017). A judge's failure to state the relevant factual findings and the corresponding legal conclusions "constitutes a disservice to the litigants, the attorneys, and the appellate court." D.M., 313 N.J. Super. at 454 (quoting Curtis v. Finneran, 83 N.J. 563, 570, 417 A.2d 15 (1980)).

After questioning Campo, the judge simply stated "[a]ll right. . . . I'll do two weeks. Doctor was asking for four," and in the February 25 order, the judge provided no further information aside from the date of the next hearing and the fact that J.A.G. waived her appearance. The judge did not explain what evidence he considered or what portions of Campo's testimony he found credible or incredible, nor did he explain how he reached the conclusion that there existed clear and convincing evidence that J.A.G. was mentally ill and posed a danger to herself, others, or property.

Finally, the judge disregarded Campo's expert testimony and instead presumably credited his net opinion. Evidence demonstrating that a person is subject to commitment "must necessarily come from the testimony of an expert witness." Raymond S., 263 N.J. Super. at 432. N.J.R.E. 703 requires that an expert's opinion or inference be based on facts or data "perceived by or made known to the expert at or before the proceeding." A judge "must ensure that [*11] [a] proffered expert does not offer a mere net opinion." Satec, Inc. v. Hanover Ins. Grp., Inc., 450 N.J. Super. 319, 330, 162 A.3d 311 (App. Div. 2017) (alteration in original) (quoting Pomerantz Paper Corp. v. New Cmty. Corp., 207

N.J. 344, 372, 25 A.3d 221 (2011)). The net opinion rule "forbids the admission into evidence of an expert's conclusions that are not supported by factual evidence or other data." *State v. Townsend, 186 N.J. 473, 494, 897 A.2d 316 (2006)*. A conclusion that is "based merely on unfounded speculation and unquantified possibilities" is inadmissible. *Townsend v. Pierre, 221 N.J. 36, 55, 110 A.3d 52 (2015)* (quoting *Grzanka v. Pfeifer, 301 N.J. Super. 563, 580, 694 A.2d 295 (App. Div. 1997)*).

Campo's expert report recommended that J.A.G. be involuntarily committed for another four weeks. However, Campo's testimony contradicted this report, explaining that J.A.G. would be discharged in "[t]wenty-eight minutes or so." Campo noted that he "ha[d] no idea what [J.A.G.] did last night. She may have thrown a chair or attempted suicide." This statement is "unfounded speculation," as Campo explicitly stated that he did not know what, if anything, occurred the night before, and it would be inappropriate for the judge to rely on such speculation in ordering J.A.G.'s involuntary commitment.[3]

Based on our review of the record, and considering our extremely narrow standard of review, we conclude that the judge made clear mistakes in ordering J.A.G.'s involuntary commitment.

Reversed.

End of Document

---

[3] In response to counsel for J.A.G. reiterating that J.A.G. believed that she would be discharged on the day of the hearing, the judge stated "[d]octor indicates probably not." Because the judge did not place his findings of fact and conclusions of law on the record, it is unclear whether this statement is based on Campo's speculation as to something that could have happened the previous night, which would have jeopardized J.A.G.'s imminent discharge.

This page intentionally left blank

In the Matter of the Civil Commitment of J.S.

Practice Area: CRIMINAL LAW
Date Filed: 2021-05-24
Court: Appellate Division

Defendant appealed from the order of the trial court, which continued his designation as a sexually violent predator and his civil commitment.

Defendant had been convicted for committing various acts of sexual assault against multiple minor victims.
In support of defendant's civil commitment, the state presented the testimony of two expert witnesses who opined that defendant's various mental disorders, including pedophilic disorder, paraphilic disorder, and personality disorder with antisocial features, predisposed defendant to commit acts of sexual violence. The state's experts testified that defendant had difficulty controlling his sexually violent behavior, noting that even while under supervision and restrictions in the STU defendant continued to engage in inappropriate sexual behavior, including joining online religious groups to gain access to individuals that defendant then made harassing phone calls to. The experts also noted that defendant had been deemed to have refused treatment. The experts therefore opined that defendant would likely reoffend if released from his civil commitment.

On appeal, defendant alleged that the state had failed to provide effective treatment, which resulted in his civil commitment for more than 15 years. Defendant further claimed that he had been subject to abuse while in the STU. Defendant also argued that his counsel was ineffective for failing to assert claims of ineffective treatment in the STU. Defendant therefore contended that the trial court's determination that defendant was not likely to make progress in his treatment made his continued commitment punitive and unconstitutional.

The court rejected defendant's contentions and affirmed his continued civil commitment. The court found no prejudice to defendant from his counsel's performance during the commitment review hearing. The court noted that the trial court had found that defendant had refused to meaningfully participate in treatment in the STU. Therefore, the court ruled that the arguments defendant claimed that his counsel failed to make would not have impacted the trial court's determination that defendant required continued civil commitment due to his failure to make progress in his treatment.

This page intentionally left blank

About the Panelists…

Sean Benoit is a staff attorney at the Community Health Law Project in Elizabeth, New Jersey, where he provides legal representation for people with disabilities in numerous legal areas including landlord/tenant, consumer, family law and public benefits. He also conducts trainings and presentations on housing, guardianship, special education and public benefits legal topics, among others.

Mr. Benoit is admitted to practice in New Jersey and before the United States District Court for the District of New Jersey. Elected as a Councilman for the Borough of Garwood, he has also been a staff attorney for Disability Rights New Jersey since 2010.

Mr. Benoit received his B.A. from Boston College and his J.D. from Rutgers School of Law-Newark, where he was the recipient of the Deborah T. Poritz Public Interest Fellowship. While a law student, he interned for Essex-Newark Legal Services and the Essex County Prosecutor's Office, Appellate Division.

Honorable Daniel D'Alessandro, JSC (Ret.) is Of Counsel to the Weiner Law Group LLP in Jersey City, New Jersey, where he mediates/arbitrates family, civil and probate matters. He was formerly assigned to the Superior Court of New Jersey and served in the Chancery Division, Family Part, and the Law Division, Civil Part, in Hudson County, and sat in Jersey City, New Jersey. He has also been the designated *Open Public Records Act*s Judge and Family Part Intensive Settlement Conference Judge.

Judge D'Alessandro was a member of the Supreme Court Committee on Women and the Courts and the Administrative Director of the Court's Working Group to Address Technological Solutions. He was President of the Hudson County Bar Association, Vice Chair of the Fee Arbitration Committee, a member of the Ethics Committee and President of the Boys & Girls Clubs of Hudson County. Prior to his appointment to the Court in 2010, Judge D'Alessandro was a general practitioner for 35 years with extensive experience in civil and estate litigation, family law, commercial, and residential real estate litigation and development. He served as an Economic, Probate and Civil Mediator; a Civil Arbitrator; and a Matrimonial Early Settlement Panelist; and was appointed by the court as Presiding Condemnation Commissioner, Conservator and Guardian. Judge D'Alessandro began his career as Municipal Defender for the City of Jersey City and as Prosecutor for the Town of Secaucus after his judicial clerkship in the Juvenile and Domestic Relations Court. He served as *pro bono* counsel to domestic violence women's groups and established Jersey City's Office of Handicapped Advocacy, *pro bono.*

Judge D'Alessandro has lectured for ICLE, the New Jersey State and Hudson County Bar Associations, Lorman Education Services, Lawyers for Justice and the National Business Institute. He has been listed in *Who's Who in America* and *Who's Who in American Law*.

Judge D'Alessandro received his B.A. from St. Peter's College, his J.D. from Seton Hall University School of Law and his LL.M. in Criminal Justice from New York University School of Law. He also attended the National Judicial College on scholarship.

Debra A. Clifford is Director of Commercial & Criminal Litigation and Director of Professional Development, Retention, and Associate Recruitment of Gibbons P.C. in the firm's Red Bank, New Jersey, office. She is an experienced litigator who focuses her practice in general complex commercial litigation and education matters, serves as the leader of the firm's Child Advocacy Team and as a mother of children with special needs, understands the struggles parents encounter when advocating for their children. Ms. Clifford's commercial litigation practice encompasses a broad range of litigation matters for public and private companies and individuals. Throughout her career, she has represented clients in trial and appellate work in state and federal courts of New York and New Jersey and has handled a number of arbitrations and mediations.

Admitted to practice in New Jersey, New York and Idaho, and before the United States District Court for the District of New Jersey and the Southern, Eastern and Northern Districts of New York; and the District of Idaho, Ms. Clifford is a member of the American, New York State and Essex County Bar Associations. She is a member of the New Jersey State Bar Association's Privacy Law Committee, the Council of Parent Attorneys and Advocates, Inc. and the New Jersey Special Education Practitioners (NJSEP). Her articles have appeared in the *New Jersey Law Journal* and other publications, and she has lectured for professional organizations.

Ms. Clifford received her B.A. from the College of the Holy Cross and her J.D. from Fordham University School of Law, where she served as Editor-in-Chief of the *Fordham Intellectual Property, Media & Entertainment Law Journal*. She served as an intern to the Honorable Justice Richard Andrias, New York Supreme Court.

Steven M. Fishbein, M.S., CRC, LRC is Manager of Justice Involved & Veteran Services, Office of Treatment & Recovery Support, Division of Mental Health and Addiction Services (DMHAS), in Trenton, New Jersey. With more than 40 years of experience as a practitioner, supervisor, administrator and trainer in vocational and psychiatric rehabilitation, he is responsible for all the division's criminal programs, including coordinating substance abuse treatment services for Drug Court and the State Parole Board; overseeing jail diversion and re-entry services for persons with mental illness; and assisting in fostering police-based interventions, including Crisis Intervention Teams (CIT) throughout the state.

A Certified and Licensed Rehabilitation Counselor, Mr. Fishbein was a member of the Supreme Court Interbranch Advisory Committee on Mental Health Initiatives and has been Co-Chair of the Interbranch Implementation Committee. He is a former member of the Governor's Task Force on Reducing Recidivism and was appointed to the Study Commission on Violence. Mr. Fishbein has monitored the Copt 2 Cop helpline program contract and has been the liaison for veterans' services, where he has collaborated with the VA New Jersey Health Care System and the New Jersey Department of Military & Veterans Affairs. He previously managed the DMHAS Supported Employment (SE) in 21 counties and oversaw other mental health services including Illness Management and Recovery, Integrated Treatment for Co-Occurring Disorders through a learning community, and Wellness Coaching.

Mr. Fishbein has been trained by The National Gains Center, Policy Research Associates, to conduct Sequential Intercept Mapping of the Criminal Justice, Mental Health and Substance Abuse system. He has been an Adjunct Clinical Instructor in the Department of Psychiatric Rehabilitation & Behavioral Health Care of Rutgers-SHRP and is the recipient of several honors, including a Dean's Citation from Rutgers, the Mort Gati Award from NJPRA, the Rebecca

McDonald Leadership Award from NJAPSE and the New Jersey State Parole Board's 2009 Partnership Award.

Mr. Fishbein received his undergraduate degree from Rutgers University and his M.S. in Rehabilitation Counseling from Boston University.

Hope Massa, MSW, LCSW is a psychiatric social worker at Emergency Mental Health Services, Capital Health Regional Medical Center, in Trenton, New Jersey, and a former psychiatric screener.

Ms. Massa received her MSW from Rutgers University School of Social Work.

Jessica S. Oppenheim is Director of the Criminal Justice Advocacy Program of The Arc of New Jersey in North Brunswick, New Jersey, which provides advocacy to people with developmental disabilities who become involved with the criminal justice system.

Admitted to practice in New Jersey and Illinois, Ms. Oppenheim sits on the Boards of the Association for the Treatment of Sexual Abusers, the Middlesex County Bar Foundation and Women Aware, the Middlesex County service provider for survivors of family violence; and is a member of the New Jersey State Bar Association. Prior to joining The Arc, she served as an Assistant Prosecutor in the Middlesex County Prosecutor's Office, where she ran the Domestic Violence and *Megan's Law* Units, and was a Deputy Attorney General, New Jersey Division of Criminal Justice, in Trenton, New Jersey, for 20 years. Eventually rising to Assistant Bureau Chief and Bureau Chief of the Prosecutors Supervision and Coordination Bureau, Ms. Oppenheim oversaw the 21 County Prosecutors Offices and more than 500 municipal prosecutors and police departments, and was instrumental in the implementation of federal grants for law enforcement training in domestic violence, first response to individuals with developmental disabilities and human trafficking. She also represented the Attorney General on several task forces and councils, has taught in the Criminal Justice Studies Department at Fairleigh Dickinson University and helped develop *Law Enforcement Video: Effective Response to People With Developmental Disabilities*.

Ms. Oppenheim received her B.A. from Grinnell College and her J.D. from Chicago-Kent College of Law, Illinois Institute of Technology.

Georgina Giordano Pallitto, Certified as a Criminal Trial Attorney by the Supreme Court of New Jersey, operates her own firm Pallitto Law, LLC in Newark, New Jersey, and has also served as Assistant County Counsel for the County of Hudson, where she has represented the state in juvenile and adult civil commitment hearings. She has also been appointed as Assistant Municipal Prosecutor for East Hanover Township and Assistant Public Defender for the City of Hoboken.

Admitted to practice in New Jersey and before the United States District Court for the District of New Jersey, Ms. Pallitto has been a Trustee of the North Hudson Lawyers' Club, Treasurer of the New Jersey State Municipal Prosecutors Association and Secretary of the Morris County Municipal Prosecutors Association. She has also been a member of the New Jersey State, Hudson County and Essex County Bar Associations, and was an Assistant Prosecutor in Hudson

County. She was an Adjunct Professor in the Political Science Department at New Jersey City University.

Ms. Pallitto received her B.A. from the University of California at San Diego, spent a year working with Senator Robert Menendez in Washington, D.C., and received her J.D. from Seton Hall University School of Law. She clerked for the Honorable Michael A. Petrolle, J.S.C., Essex County, Criminal Division.

Rehana Rasool has been a Senior Staff Attorney at Community Health Law Project, in the organization's Bloomfield, New Jersey, office since 2016. She represents disabled clients in a variety of civil legal issues including family, housing and public benefit matters. She was formerly a staff attorney at Northeast New Jersey Legal Services in Paterson, New Jersey.

Ms. Rasool is admitted to practice in New Jersey and the District of Columbia. She completed mediation training through the Court system and spent several years volunteering as a Municipal Court Mediator, as a member of the Juvenile Conference Committee and on the Minority Concerns Committee.

Ms. Rasool received her B.A. from Simon Fraser University and her J.D. from Western Michigan University's Cooley Law School.

Cheyne R. Scott is a civil litigation attorney and a Partner in Chasan Lamparello Mallon & Cappuzzo, P.C. in Secaucus, New Jersey. She concentrates her practice in contracts, governmental entity representation, and labor and employment law; and represents individuals, municipalities, counties, authorities and school boards in litigation and compliance matters arising under New Jersey's *Tort Claims Act* (Title 59).

Admitted to practice in New Jersey and Michigan, and before the United States District Court for the District of New Jersey, Ms. Scott is Past President of the Hudson County Bar Association's Young Lawyers Division and has been a Trustee of the Association. She is a member of the New Jersey State Bar Association's Diversity Committee, the NJSBA Labor and Employment Law Section's Executive Committee and was selected by the Association as a 2016-2017 Leadership Academy Fellow.

Ms. Scott has lectured for ICLE on labor and employment matters and has also lectured and written on mindfulness and self-care for attorneys. Her article "Mindfulness: A Simpler Way to Alleviate Attorney Stress" was published in the American Bar Association's *GPSOLO Magazine* (July/August 2017). She is also the author of "The ABCs of Emotional Health" which appeared in the July 2019 issue of *New Jersey Lawyer*.

Ms. Scott received her B.A. from Michigan State University and her J.D., *cum laude*, from Thomas M. Cooley Law School. She served as a Judicial Intern to the Honorable Patrick J. Duggan, United States District Court for the Eastern District of Michigan. She was also Law Clerk to the Honorable Sheila A. Venable, Presiding Judge, Criminal Division, Hudson County, Superior Court of New Jersey.

Brian Sperber is Senior Attorney with the Mental Hygiene Legal Service in Elmhurst, New York, where he represents individuals committed to psychiatric hospitals, persons requiring

guardianships, people under court-ordered outpatient treatment, individuals receiving services from the New York State Office of Persons With Developmental Disabilities, and people committed for mental health treatment pursuant to Article 10 of the *New York State Mental Hygiene Law*. He formerly served with the Mental Hygiene Legal Service in Kingston, New York, where he performed similar services in Ulster, Greene and Sullivan Counties.

Admitted to practice in New Jersey and New York, Mr. Sperber was formerly an Assistant Deputy Public Defender at the Public Defender's Division of Mental Health Advocacy in Newark, New Jersey, where he covered civil commitment calendars at the Jersey City Medical Center, Hudson County Meadowview Psychiatric Hospital and the Hoboken University Medical Center, and represented clients under *Kro*l Supervision in Essex and Bergen Counties. He began his career as an attorney fellow in the Office of the Public Defender's Union County Trial Region.

Mr. Sperber received his B.A. from Emory University and his J.D. from the University of Miami School of Law. While in law school, he interned at public defender offices in Miami and Fort Lauderdale, Florida, as well as at the South African Litigation Centre in Johannesburg, South Africa.

John Verney is Program Development Specialist, State of New Jersey, Department of Human Services, in Trenton, New Jersey.

Mr. Verney is a Licensed Social Worker. Prior to joining the DHS, he was Program Coordinator of the Mental Health Association of Passaic County.

Mr. Verney received his B.A. and M.S.W. from Rutgers University.

This page intentionally left blank

About the Panelist…

Connie Palmer, MSW is Training Director at Imagine, a Center for Coping with Loss, in Scotch Plains, New Jersey. Image helps families, individuals and organizations develop resilience through education and the development of social skills to create and maintain healthy relationships.

Prior to joining Image, Ms. Palmer conducted seminars and retreats for businesses and religious organizations at Therapeutic Learning Connections in Union County. She was a school guidance counselor at Resolve Community Counseling Center, where she worked as a school guidance counselor at two elementary schools and provided individual counseling, group counseling, parenting training, referral service, coordination with staff and teachers. She also served as a Therapist for Catholic Charities.

Ms. Palmer received her M.S.W. from Rutgers Graduate School of Social Work.

This page intentionally left blank

Capital Health Regional Medical Center

MERCER COUNTY'S DESIGNATED PSYCHIATRIC SCREENING CENTER

capitalhealth

Screening Law

10:31-1.2 Purpose

(a) The purposes of the Screening and Screening Outreach Program are as follows:

- 1. To provide clinical assessment and crisis stabilization in the least restrictive, clinically appropriate setting, as close to the individual's home as possible, in a manner that is culturally competent and recovery-oriented and assists the consumer in achieving a self-directed transition to wellness;
- 2. To provide outreach to individuals who may need involuntary commitment and are unable or unwilling to come to the screening service location, as stipulated in N.J.S.A. 30:4-27.5(d);
- 3. To provide outreach for the purpose of crisis intervention and stabilization;
- 4. To assure referral and linkage, which is voluntary in nature to appropriate community mental health and social services;
- 5. To coordinate access, where appropriate, to the publicly affiliated acute care psychiatric resources serving a designated geographic area, that is, acute partial hospitalization/care, crisis housing or voluntary inpatient services;

Screening Law

- 6. To screen individuals, so that only those persons who are in need of involuntary commitment, as set forth in N.J.S.A. 30:4-27.2m, are committed;
- 7. To serve as the admission screener and primary route of access to the short term care facility, county psychiatric hospital, and State psychiatric hospital;
- 8. To provide training and technical assistance concerning psychiatric emergencies to other social service, law enforcement and mental health providers in the geographic area;
- 9. To coordinate a system for review and monitoring of the effectiveness and appropriateness of screening and screening outreach service use, including impact upon admissions to State and county psychiatric hospitals; and
- 10. To provide leadership within the acute care network of services and advocate for services to meet consumers' needs and encourage the system to respond flexibly.

Screening Service

- In the state of New Jersey, the Emergency Mental Health Psychiatric Screening service is a 24 hour 7 Day a week, 365 day a year mental health service available to the community and residents of the designated county that the screening center is located in.

Purpose of the Screening Service

- The purpose of the screening service is to determine need of level of care for the patient and provide linkage to either an inpatient psychiatric facility (Involuntary, Consensual, or Voluntary) or outpatient resources in the community.

How Screening Services Are Utilized

- Screening services are utilized through the emergency room or mobile outreach.

- All patients that are brought to the hospital through mobile outreach, police, ems, or walk in must go through a medical clearance in the ER before being screened in the Screening Center

Services Provided

- Mobile Outreach

Mobile Outreach requests can come from a community treatment provider, nursing homes, family or friends of the patient, or police.

The requests are triaged through the screening center's crisis hotline. Once all available information is collected and it is appropriate a Mobile Outreach will be offered. Mobile Outreach brings the psychiatric screening service into the community through a team of 1-2 screeners accompanied by police if in a community based non secured setting (private residence, community mental health agency, primary care doctors offices)

Once dispatched and on location screeners contact local police department (if applicable) for assistance with assessment of the patient. Once police arrive screening can take place.

If it is deemed that the patient meets criteria of involuntary inpatient psychiatric hospitalization a transport order can signed by a screener for the patient to some back to the hospital being transported by police.

Once the transport order is signed the patient must come back to the hospital being transported by police.

Screening Process

- The screening process consists of a psychosocial assessment (current psychiatric symptoms, psychiatric history, and demographics) current mental status, and most importantly assessment for dangerousness to self, others or property by reason of mental illness.
- Through this assessment need for level of care is determined.

Screening Process

- The screening service or affiliated emergency service procedures shall require recording of pertinent consumer information, where available, including, but not limited to:
- i. Basic identifying data as it relates to the presenting crisis;
- ii. The history and nature of the presenting problem;
- iii. The psychiatric and social history;
- iv. The medical history, including current medical status problems, allergies and current medication;
- v. The mental status and level of functioning;
- vi. Any drug and alcohol use and history;
- vii. Any indication of dangerousness;
- viii. Exploration of available resources and natural support system;
- ix. Preliminary diagnosis; and
- x. Whether or not the consumer has executed an Advance Directive for Mental Health Care.

Levels of Care

- Involuntary
  - Meets criteria of dangerousness to self, others, or property by means of mental illness
- Consensual
- Voluntary
- Outpatient Treatment- Outpatient, EISS (early Intervention Support Services), IOP, Partial Care, Involuntary Outpatient Commitment (IOC)
  - Care Management Teams- RIST, ICMS, PACT, Supportive Housing
  - Group Homes

Involuntary Commitment Process

- If a patient meets criteria for involuntary inpatient psychiatric admission a certified screener will complete a screening document recommending involuntary inpatient care.
- The patient then will be evaluated by a psychiatrist. If the psychiatrist agrees with the recommendation of the screener the psychiatrist will complete a Physician Certificate (PC). The patient will then be referred to the receiving Psychiatric facility.
- A second PC must be completed by a different psychiatrist within 72 hours. Screening Document , 2 PC's, and judges order are then sent to the court in order for judge to review and sign.
- The patient is then entitled to a court hearing within 20 days if still in need of further psychiatric hospitalization

Advanced Directives

- **Psychiatric/Mental Health Advance Directives (PAD): Refers to written instructions making a decision in advance about mental health treatment, including medications, voluntary admission to inpatient treatment and electroconvulsive therapy.**

Important Links

Designated Screening Centers by County

- http://www.state.nj.us/humanservices/dmhas/home/hotlines/MH_Screening_Centers.pdf

Department of Human Services General Definitions

- http://www.state.nj.us/humanservices/staff/opia/documents/DHS%20General%20Definitions.pdf