ILLINOIS STATE BAR ASSOCIATION

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# Mental Health Matters

The newsletter of the Illinois State Bar Association's Section on Mental Health Law



## Editor's Note

BY SANDY BLAKE

Last month's newsletter detailed some new laws that may affect mental health recipients and their agents or guardians. In this issue, Mark Heyrman, a veteran attorney with over 40 years of experience, writes about some more new laws, as well as proposed legislation to watch. He discussed these in detail during the Mental Health Law Section Council's May 13 live web program, "Brush Up on Mental Health Law."

This issue also includes the contribution of 2021 J.D. candidate Pat Graham, who is working under the supervision of Barbara Goeben of the Illinois Guardianship and Advocacy Commission, pursuant to Supreme Court Rule 711. He has summarized two appellate court decisions that were also discussed during the "Brush Up on Mental Health Law" program.

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## Recent and Proposed Changes in Illinois Mental Health Laws

BY MARK HEYRMAN

This article summarizes some of the key changes to mental health statutes enacted by the Illinois legislature during the 2019 legislative session and those currently under consideration.

### Laws Enacted in 2019

**Public Act 101-0251.** Creates the Mental Health Early Action on Campus Act. The Act requires public colleges and university: (a) to provide training and resources, including on-line resources and peer support services to students regarding mental illnesses and (b) to create collaborations with local mental health providers to increase services to students. It requires the Board of Higher Education to create a Technical Assistance Center to develop standards regarding mental health services at colleges and universities.

**Public Act 101-0463.** Requires the Department of Insurance and the Department of Healthcare and Family Services to create a common electronic prior authorization form to be used for the approval of drugs by managed care and health insurance companies. This law is intended to reduce administrative costs for healthcare providers.

**Public Act 101-0461.** Creates the Children and Young Adult Mental Health Crisis Act. The Act requires health insurance companies and government

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## Editor's Note

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Finally, this issue includes an article discussing the effects of COVID-19 on the residents of a New Jersey facility housing individuals who have been indefinitely committed under that state's Sexually Violent Predator statute. New Jersey and Illinois are two of 20 states that have civil commitment laws that apply to sex offenders who have completed their criminal sentences. The Illinois Sexually Violent Persons Commitment Act is found at 725 ILCS 207/1 et seq. While the New Jersey statute differs somewhat from the Illinois statute, the Temporary Detention Facility in Rushville houses some 500 residents in a former prison now run by the Illinois Department of Human Services. The residents have been committed indefinitely or have pending commitment petitions. As in New Jersey, the Illinois program delivers cognitive behavioral therapy by mental health experts in a "congregate living facility." Also, as in New Jersey, many of the residents of the Illinois program live at Rushville for decades. As of June 10, 2020, the Illinois Department of Public Health reports that 312 residents of Schuyler County, where Rushville is located, had been tested for COVID-19. There were 13 confirmed cases with no deaths reported.■

## Recent and Proposed Changes in Illinois Mental Health Laws

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entities to cover a wide range of mental health services for children and young adults.

**Public Act 101-0331.** Requires the Department of Public Health to create an annual plan to improve suicide prevention activities.

**Public Act 101-0587.** Allows a psychiatrist to perform the examination needed to certify someone for involuntary commitment to a mental health facility using telepsychiatry. Also allows advance practice psychiatric nurses to perform certifications for commitment and authorization of restraint and seclusion. This law recognizes the changing nature of inpatient psychiatric care in Illinois—specifically, the move from state hospitals to private hospitals. The latter are less likely to have a psychiatrist available around the clock to perform certifications.

**Public Act 101-0349.** Allows pharmacists to administer long-acting, injectable psychotropic medication.

**Public Act 101-0351.** Requires the Department of Corrections to screen all persons prior to release from prison to determine if they are eligible for Medicaid and, if so, to assist them in applying for Medicaid. This law recognizes the large number of people leaving prisons with ongoing medical needs, particularly mental health needs, and the necessity of insuring that those needs are met following discharge.

**Public Act 101-0574**. This Act requires both Medicaid and private insurance to reimburse care provided under a collaborative care model between psychiatrists and primary care physicians.

Important Pending Mental Health Legislation

Due to the COVID-19 pandemic, the Illinois legislature has suspended its session and appears unlikely to pass any legislation other than the state budget and bills deemed to be "emergency legislation." What follows is a list of some of the pending mental health legislation that is likely to be considered in the fall, or whenever the legislature resumes regular sessions.

**House Bill 2883.** This is part of a national effort to permit persons to relinquish, voluntarily and temporarily, their right to a Firearm Owners Identification Card. While the law does not require

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someone to provide any reason for doing so, it is intended to be used by persons in a mental health crisis to reduce the likelihood of harm to self or others. Washington and Virginia have passed similar legislation.

**House Bill 3975/Senate Bill 2315**. Prohibits the use of seclusion in schools.

**House Bills 4252 & 4636/Senate Bill 2490**. Permits persons in state hospitals to request a transfer to a less-secure facility and to obtain an administrative hearing to review that request. These bills would restore a statutory right that existed previously, but was repealed many years ago.

**House Bill 4626.** Amends the Power of Attorney for Healthcare Act to allow persons to elect to create a power of attorney whose revocation will not take effect for 30 days. Ordinarily a power of attorney may be revoked at any time. This provision would allow the agent to provide treatment over the objection of the principal during the 30-day period.

**House Bills 4841 & 5113/Senate Bill 3760.** These bills are intended to respond to the reduction in the number of state-operated inpatient psychiatric beds from 33,000 to 1,150 over the past decades and the need to insure that the remaining beds are used for those most at risk. It would require the Department of Mental Health to create policies to reduce the number of non-dangerous forensic patients in order to create capacity for non-forensic patients regularly denied admission to inpatient care despite serious, untreated illnesses.

**House Bill 5405/SB3853**. These bills would create a "Housing is Recovery Pilot Program" to increase supported housing for persons with mental illnesses.

**House Bill 5471/Senate Bill 3860.** These bills are part of a national effort by Mental Health America to create a peer-support specialist credential that would be recognized by private health insurance companies and transferable across state lines.

**Senate Bill 1188.** Creates a diversion program for persons charged with misdemeanors for whom a reasonable doubt exists as to their fitness to stand trial. If determined by the court to be appropriate, these individuals would be provided inpatient or outpatient mental health services and the charges would be dismissed.

**House Bill 5009/Senate Bill 3449.** These bills would require local governments to create alternatives to law enforcement to respond to mental health crises and, when needed, transport persons to mental health treatment.

**Senate Bill 3812.** Amends the Confidentiality Act to eliminate the requirement that a recipient of mental health services be notified if a mental health provider shares information with the provider's attorney.■

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# Appellate Update

BY PAT GRAHAM

## *In re Craig H.*, 2020 IL App (4th) 190061 (Opinion filed April 7, 2020)

**A power of attorney does not preclude an involuntary treatment petition.**

Craig H., Respondent-Appellant, "appeal[ed] from the trial court's order finding him subject to involuntary administration of psychotropic medication pursuant to section 2-107.1 of the Mental Health and Developmental Disabilities Code (Mental Health Code) (405 ILCS 5/2-107.1 (West 2018))." ¶ 1. The appellate court affirmed the trial court's judgment ¶ 2.

### Background

In 2018, a petition for administration of psychotropic medication was filed on the basis of the Respondent's deterioration of ability to function. ¶ 4. At the petition's filing, Craig H.'s mother was his agent through a health care power of attorney. ¶ 16. However, the psychiatrist's and the agent's preferred treatment options diverged. ¶ 19. The psychiatrist testified that the 82-year-old mother, who had been previously attacked, planned to take Respondent home and lock him in his room. ¶ 19. She did not have "experience watching [R]espondent take medications because she repeatedly stopped his medications." ¶ 16. The psychiatrist further testified that they believed the agent "did not have [R]espondent's best interest at heart." ¶ 16.

At the beginning of the hearing, Respondent's attorney moved to dismiss the petition, on the basis of Respondent having a valid health care power of attorney, and that the decision of the agent under the power of attorney must be honored. ¶ 6 The trial court denied Respondent's motion to dismiss and subsequently granted the petition. ¶ 7, 20.

Respondent argued three issues upon appeal: (1) the case fell under an exception to the mootness doctrine; (2) the trial court erred by denying his motion to dismiss; and (3) the court's order stripped him of his right to self-determination under the Powers of Attorney Law (755 ILCS 45/4-1 *et seq.* (West 2018)), in violation of both the Mental Health Code and the Powers of Attorney Law. ¶ 23.

### 1. Mootness

The court considered Respondent's case under two recognized exceptions to the mootness doctrine, capable-of-repetition-yet-evading-review and the public interest exception. ¶ 25. It met the "capable of repetition" exception in part because Craig T.'s history of mental health issues and his having a power of attorney. This appeal challenged the interpretation of both the Code and the Powers of Attorney Law; therefore, the resolution of this matter will likely affect future cases involving the Respondent. ¶ 28. This appeal also satisfied

the "public interest" exception to mootness in partly because Respondent's claim raised an issue of first impression. ¶ 30

**2. Motion to dismiss**

The appellate court affirmed the denial of Respondent's motion to dismiss when it affirmed the trial court's rulings with regards to the Mental Health Code and Powers of Attorneys Laws. *See* ¶ 34, 48. Because this matter is one of statutory interpretation, the court review these issues *de novo.* ¶ 35.

**3. Mental Health Code**

"Based upon the plain language of the provisions in the Mental Health Code, the existence of a power of attorney does not preclude the State from filing a petition for the involuntary administration of psychotropic medication." ¶ 38.

Specifically, the court found relevant section § 2-102(a-5)'s language that "pursuant to the provisions of Section 2-107 or 2-107.1 or [] pursuant to a power of attorney for health care under the Powers of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act." ¶ 38. (citing § 2-102(a-5)). Noting the "use of the disjunctive 'or'[,]" the court concluded that the decision of a power of attorney does not preclude the filing of a petition under 2-107.1. *Id.*

The court also noted that the Mental Health Code is silent as to the filing of the treatment petition when the agent objects to the involuntary medication, thus section 2-107.1 controls in this situation. ¶ 39.

Second, the court looked to the plain language of § 2-107.1 (a-5). ¶ 40. Specifically, the court found relevant this section's requirement that, in anticipation of filing a petition for involuntary administration of psychotropic medication, the petitioner "make a good faith effort to determine whether a power of attorney exists and to attach a copy of the instrument . . . to the petition." *Id.* The court stated that in circumstances where a petitioner identifies a power of attorney, rather than provide for the preclusion of a petition, the statute provides procedural requirements under which a petition may proceed. *Id.* Therefore the statute contemplates the filing of an involuntary medication petition even with the existence of a power of attorney. ¶ 41.

**4. Powers of Attorney Laws**

Despite the "broad language" employed in particular clauses of the Powers of Attorney Law (¶¶ 44, 45), the court concludes this does not preclude the State from filing a petition under § 2-107.1. ¶ 45.

The court acknowledges that "the plain language of the Powers of Attorney Law suggests that an agent has the unlimited power to make health care decisions for a person." ¶ 44. First, the court highlights the language of an included "purpose" provision. ¶ 43 (internal quotations omitted; internal formatting omitted). This includes the General Assembly's intent to recognize an individual's right "to control all aspects of his or her personal care and medical treatment . . . " ¶ 42. Included as well is a health care provider's duty upon belief a patient lacks capacity to "consult with any available health care agent . . . who then has the power to act for the patient . . . " *Id.* Second, the court recognizes a "supremacy clause" included in the Powers of Attorney Law. ¶ 43. This clause directs that the law "supersedes all other Illinois Acts or parts thereof . . . to the extent such other Acts are inconsistent with the terms and operation of this Article . . . " *Id.* However, noting that only two cases reference this provision and neither addresses its relation to the Mental Health Code, the court proceeds to evaluate whether it precludes the State from filing a petition pursuant to § 2-107.1. ¶ 45.

As the Powers of Attorney Law relates to the Mental Health Code, it is the Mental Health Code that prevails given the State's significant interests in providing for those suffering from mental illness and judicial preference for allowing more particular provisions to prevail over conflicting general provisions. ¶ 45, 46. First, the court recognizes that the State "has both a *parens patriae* interest in providing for those suffering from mental illness . . . and a penological interest in restoring Respondent to fitness to stand trial." ¶ 45 (citing *In re C.E.*, 161 Ill. 2d 200 (1994), *Sell v. United States*, 539 U.S. 166 (2003). Second, the Mental Health Code anticipates the filing of a petition pursuant to § 2-107.1 even where a respondent has a power of attorney and does not require that health care agent "to acquiesce to treatment before the court can order it." ¶ 46. The court notes "where there are two statutory provisions, one of which is general and designed to apply to cases generally, and the other is particular and relates to only one subject, the particular provision *must* prevail." ¶ 46 (citing *Village of Chatham v. County of Sangamon*, 216 Ill. 2d 402 (2005); emphasis added). Thus, the particular language of the Mental Health Code, which specifically addressed involuntary medication petitions permitted the filing of the petition here, irrespective of language in the Powers of Attorney Law ostensibly to the contrary. *Id.*

## *In re Robert M.*, 2020 Ill. App. (5th) 170015 (Opinion filed Feb. 28, 2020)

**Involuntary medication order affirmed refines the suffering criteria for involuntary medication.**

Robert M. appealed an involuntary medication order raising two issues: 1) the State provided insufficient evidence to establish that he was suffering as a result of his mental illness, and 2) that less restrictive treatments were explored and found to be inappropriate. ¶ 1. The appellate court affirmed the trial court order. ¶ 65.

**Background**

Respondent, diagnosed with schizoaffective disorder, bipolar type, was admitted to a mental health facility "after being found unfit to stand trial." ¶ 4-5. Additionally, "[at] the time of his admission . . . [Respondent] was experiencing pain from several infected teeth." *Id.* Respondent indicated to the psychiatrist that he was willing to take an antianxiety medication, but not antipsychotic medication. ¶ 10. Shortly following admission, a petition for the involuntary administration of psychotropic medication was filed pursuant to 405 ILCS 5/2-107.1, claiming that Robert M.'s behavior exhibited all three criteria for involuntary medication (deterioration in his ability to function, exhibiting threatening behavior, and suffering.) ¶¶ 4, 7-9, 36.

At trial, the psychiatrist testified that the Respondent "reported to his treatment team that he was 'in duress with anxiety.'"

(quotation in original); ¶ 8. He also stated that Respondent's participation in classes and therapy sessions were alone inadequate to treat his symptoms. ¶ 12. Respondent testified that he was willing to take an antianxiety medication to resolve his irritability (which stemmed from his dental pain), at least until his dental treatment was completed. ¶ 16.

The court then granted the involuntary medication petition, specifically finding that only the suffering criteria had been sufficiently proven and rejecting the other criteria for medication. ¶¶ 18, 22.

Although Respondent filed a motion to reconsider, it did not come to hearing before the order had expired. ¶ 23. Thus, the trial court found the motion to reconsider was moot and dismissed the motion. ¶ 27.

*Analysis*

On appeal, Respondent argued that (1) "there was insufficient evidence to support the court's finding that he was suffering (¶ 39), and (2) "there [was] no evidence that the less restrictive alternative of allowing him to voluntarily take [an antianxiety medication] was explored and found to be inappropriate." ¶ 52.

**1. Mootness**

The court noted that as the trial court's order had expired, the appeal was technically moot. ¶ 30. However, it found that the public interest exception to the mootness doctrine applied, thus permitting consideration of the appeal. ¶ 33. In particular, the court determined that Respondent's claim regarding suffering "turn[ed] on what type of evidence will support a finding that a respondent is exhibiting suffering." ¶ 33. "Similarly, [Respondent's] [claim regarding less restrictive services] turn[ed] on the question of whether, and under what circumstances, a respondent's willingness to voluntarily take some of the proposed medications constitutes a less restrictive form of treatment." *Id.* Thus, both claims presented questions of sufficient public concern. *Id.* After determining there was a need for an authoritative determination and likelihood of recurrence, the court considered both of Respondent's claims under the public interest exception. *Id.*

**2. Suffering**

Respondent argued that, *inter alia*, the trial court's finding that his symptomology in and of itself constituted suffering conflicted with established precedent. ¶ 39. Relying on *Debra B.*, Respondent argued such a holding was untenable as it was "tantamount to holding that any patient with a serious mental illness is subject to involuntary administration of medication." *Id.*; *see Debra B.*, 2016 Ill. App. (5th) 130573 at ¶ 45; (internal quotations omitted). However, the court found *Debra B.* was distinguishable from the present appeal. ¶ 40.

Here, however, the court found the psychiatrist's testimony of Respondent's symptoms supported a finding of suffering. ¶ 47. Robert M. himself admitted that he was experiencing anxiety ¶ 40. Among the symptoms testified to by the psychiatrist were Respondent's belief that "his fever was cooking his brain and that his dental infection was spreading throughout his bloodstream" (¶ 47; (internal quotations omitted)), paranoia surrounding facility staff and antibiotic medications which may have alleviated his tooth pain, angry behavior, and self-reported anxiety. *Id.* The court noted that "if there is a clear nexus between the symptoms themselves and a respondent's suffering, the symptoms themselves may be enough to support a finding of suffering." ¶ 45; citing *Debra B.*, 2016 Ill. App. (5th). It also reasoned that "it was easy to understand why such beliefs would cause fear and anxiety" (¶ 47), and further stated the psychiatrist's testimony was "precisely the type of evidence [the court] said the State could present to support a finding of suffering in *Debra B.*" ¶ 48.

**3. Less restrictive services**

In finding that Respondent's willingness to take an antianxiety medication did not constitute a less restrictive alternative to the medications being sought to be administered involuntarily, the court distinguished the present appeal from *In re Torry G.*, the only other Illinois case to squarely address the precise question presented. ¶ 53; *see In re Torry G.*, 2014 Ill. App. (1st) 130709.

In *Torry G.*, a psychiatrist sought to involuntarily administer "two primary medications and seven alternate medications to [respondent]." ¶ 59; citing *Torry G.*, 2014 Ill. App. (1st). While there was evidence Respondent refused to take two of the proposed medications, there was no evidence regarding his willingness to take any of the others or their appropriateness as substitutions. *Id.*; citing *Torry G.*, 2014 Ill. App. (1st). Referencing the established preference for voluntary over involuntary treatment in the context of admission proceedings, the court "found the same principle to be applicable in the case of proceedings for involuntary medication . . . " ¶ 58; citing *Torry G.*, 2014 Ill. App. (1st). As "there was no testimony establishing that the medications [Respondent] was willing to take could not effectively treat his mental illness . . ." the State had not met its burden to demonstrate that this less restrictive alternative had been explored and found to be inappropriate. ¶ 61; citing *Torry G.*, 2014 Ill. App. (1st); (internal quotations omitted).

In short though Robert M. was willing to take one medication, the court found that it would not be a sufficient substitute for all of the petitioned for medications. ¶ 63. Here, "the record . . . establishes that it was not appropriate to administer only an antianxiety medication without also administering antipsychotic medication to treat [Respondent's] other symptoms." ¶ 63. The court stated that "the question is not simply whether voluntarily taking those medications is appropriate for the patient at all, but whether taking those medications in lieu of the medications requested in the petition is appropriate." ¶ 62. Thus, the court concluded "the instant case [stood] in stark contrast to *Torry G.*" *Id. See also, In re Israel*, 278 Ill. App. 3d 24 (1996). As such, here, the evidence was sufficient to "prove that less restrictive services were explored and found to be inappropriate." ¶ 63.

Trial court order affirmed.■

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# Obscure New Jersey 'Treatment' Facility Has a Higher COVID-19 Death Rate Than Any Prison in the Country

BY JORDAN MICHAEL SMITH

*The following article was written by Jordan Michael Smith, The Appeal. It was published June 4, 2020 at https://theappeal.org/obscure-new-jersey-treatment-facility-has-a-higher-covid-19-death-rate-than-any-prison-in-the-country/, and is republished here with permission.*

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This story was produced in collaboration with Type Investigations.

With its innocuous name, the Special Treatment Unit (STU) sounds like a hospital. It's a building in Avenel, New Jersey, housing 441 "residents," as it calls them. It has what state officials have described as a "comprehensive treatment program" with cognitive behavioral therapy delivered by mental health experts.

But the STU is actually a prison in all but name—it's run by the state's Department of Corrections and located on the grounds of the East Jersey State Prison. So-called residents live there involuntarily, often for decades on end, their lives controlled and regimented. That's because the detainees in the STU were all convicted of sex offenses and deemed too dangerous to release, despite research showing that such assessments are often flawed.

Inside this small, harmless-sounding complex, at least eight individuals died of COVID-19 by the end of May. Two others have died since mid-March, but the causes haven't been released. As of May 28, state officials confirmed 55 STU prisoners had tested positive, but prisoner Roy Marcum said on June 2 that he believes the number is about 70.

With at least eight deaths per 441 prisoners, the STU has a higher death rate—by far—than any prison in America. Its death count is equal to that of all the prison complexes combined in California. Or all those in Arizona, Pennsylvania, or more than 14 other states, according to Bureau of Prison data. New Jersey ranks fourth in prison deaths due to the coronavirus (43 as of Wednesday).

Unlike in jails and prisons around the country, every individual in the STU has completed his criminal sentence. Some completed their sentences long ago and have been held in the STU since it opened in 1999. At least one of the eight people who died committed his crime more than 30 years ago, in the 1980s. Experts say America's way of dealing with individuals convicted of sex crimes has long been cruel, unjust, and counterproductive. In the pandemic era, it's become fatal.

Some prisoners have resigned themselves to their fate. Joshua Denisiuk, 26, was convicted for sex crimes he committed when he was just 15 and has been in the STU since 2013. He knows there is little he can do to avoid the coronavirus besides wash his hands frequently. "If I get it, I get it," he said.

For centuries, the ideas behind a process called "civil commitment" have allowed authorities to involuntarily institutionalize individuals whom psychiatric experts believe to be incapable of caring for themselves. Beginning in the 1960s, civil commitment became used primarily to hospitalize people who were considered an imminent danger to themselves or others, for short periods.

But in 1999, New Jersey followed other states in enacting a Sexually Violent Predator Act. The law effectively permits state officials to indefinitely lock up people convicted of sex offenses who "are likely to engage in repeat acts of predatory sexual offenses." When people around New Jersey convicted of sex offenses approach the end of their criminal sentences, the state's attorney general can petition to hold them under the law. Once they're in, they sometimes remain held there for the rest of their lives.

The American Psychiatric Association and many other health experts oppose civil commitment for individuals who have committed sex crimes, saying it lacks a scientific basis and violates core civil liberties. "Contemporary civil commitment measures grew out of interwoven panics concerning 'stranger danger,' satanic ritual abuse, and violent crime," said the historian Paul Renfro, author of "Stranger Danger: Family Values, Childhood and the American Carceral State." Renfro points to research showing that civil commitment does little to address sexual violence and that recidivism for sex crimes is actually lower than for other crimes.

But the Supreme Court has upheld the practice, and 20 states now have civil commitment laws for people classified by the state as sexually violent predators (SVPs), as does the federal government and the Bureau of Prisons. Approximately 5,400 individuals around the country—almost all men—are held under these laws.

As its name suggests, civil commitment is a civil procedure, not a criminal one. People held under these laws do not have the same legal rights as others in the justice system. They are held indefinitely, without potential release dates, living in limbo for years—sometimes for their entire lives. "Once you're there, nobody wants to take a chance and release someone who's been civilly committed," said Russell, who requested that his last name not be used to avoid being harassed by his neighbors. He spent nine years at the STU before being released nearly a decade ago.

The underlying basis for civil commitment is the assumption that an individual who commits a sexual offense at

some point in his life is an eternal risk to his community. Experts disagree.

"Nobody is a risk all the time," said Maia Christopher, executive director of the Association for the Treatment of Sexual Abusers. Determining the risk level of individuals is critical, she added, but SVP laws are broad and severe. Once individuals are caught in the system, it's difficult for them to get out. "There are very few ways for people to get acknowledged for positive behavior," Christopher said.

In New Jersey, as elsewhere, so-called SVPs are kept in separate facilities from prison detainees. "They don't consider you prisoners, but they treat you like prisoners," said William Moore, who was in the STU for 15 years before being released in 2014 at age 65. The state does not have to prove beyond a reasonable doubt that an individual will commit a sex crime in the future—authorities just need to present "clear and convincing evidence" to a judge.

Some of the detainees, like Denisiuk, were convicted of crimes as children. He doesn't participate in the treatment that is offered. He said his lawyer advised him against it, warning him that anything an individual said to a therapist or staff member in the facility can be used against him in a hearing. Rather than incriminate himself by saying the wrong thing, he hopes his case is resolved in court, and that he is eventually freed, since he already completed the sentence for the sexual assault he committed as a teenager more than 10 years ago.

People in civil commitment are at heightened risk of contracting the coronavirus because of age and poor health conditions. "We know that the death rate from COVID is higher among older individuals, and civil commitment disproportionately affects older individuals," said Mike Mangels, a public defender who represents the STU residents. Since people in civil commitment have already served their sentences—sometimes lengthy—they are older on average than other incarcerated people. Since the pandemic started, they are afraid for their lives. "They have to watch as some of the people they have known for 10 years or more, in some cases, are carted out, never to be seen again," he said.

Marcum, a 56-year-old who has been in the STU since 2000, told The Appeal and Type Investigations that as of last Saturday, 29 detainees were in isolation because they had tested positive for COVID-19. Detainees are now locked in their cells for more than 23 hours per day, he said, but for weeks state officials prohibited them from even wearing masks. Hand sanitizer was considered contraband until recently, according to detainees and news reports, and testing was slow and haphazard. "For a week I was getting a call just about every day that another person had died," said Mangels, the public defender.

Liz Velez, a spokesperson at New Jersey's Department of Corrections, said residents are not locked down and leave their cells for showers, phone calls and "passive recreation" such as playing board games and reading. "The STU [is] located in the northern region of the state—the region hardest hit by the pandemic." Velez said. "Across all our facilities we've implemented various virus mitigation strategies from enhancing sanitization, ensuring access to sanitation products like soap and hand sanitizer, along with CDC education on proper hygiene and we also distributed masks to all inmates, residents and employees."

The STU follows social distancing guidelines and anyone testing positive for the virus is placed in medical isolation with a well-trained team, she said, noting that the department was also providing on-site testing to residents and state DOC employees.

But concerns about the STU long predate the coronavirus. In 2016, detainees there filed a class-action lawsuit against authorities, alleging that conditions at the facility were "punitive." Detainees "are entitled to considerate treatment" but were instead treated like "criminals whose conditions of confinement are designed to punish," the suit noted, citing examples such as infrequent family visits and little or no educational, vocational or recreational activities." Detainees, it added, "are being denied meaningful mental health care treatment that gives them a realistic opportunity for their conditions materially to improve."

In response to COVID-19, group treatment programs in the STU, and around the country, have been canceled or scaled back. New Jersey's Department of Human Services, which runs the mental health treatment at the STU, did not respond to a request for comment by publication time. But according to detainees, the most common form of treatment in the facility, group therapy, has been canceled since mid-March, which means individuals in civil commitment cannot even work to be among the few deemed worthy of release.

As of 2016, only 15 percent of prisoners at the STU were ever released. The rest exist in purgatory, made worse by the threat of coronavirus. "People are scared," Marcum said. He is still hopeful that one day he'll be released. "Less so as the years go by."

Residents of the STU are eligible for furloughs in the community, but Velez said "no such trips have been scheduled during the pandemic to minimize exposure in the community."

"It would be one thing to lose the few freedoms we have if what they did was effective—but what they did was clearly pretty ineffective," Marcum said.

Unlike those incarcerated in prison or jail, the identities of people in civil commitment are unavailable to the public. The names of the eight people at the STU whose deaths were confirmed to be related to COVID-19 have not been released. They existed there anonymously, some for decades, and they died just as anonymously.

"We called it the 'Pine Box Release Program'—because the only way you were leaving it was in a box, dead," said Russell, the former prisoner released in 2011. He still has friends there, men who have been there for decades. He's hoping they'll one day be released, alive. But in the age of the coronavirus, he isn't counting on it.■

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*The Appeal is a non-profit media organization that produces original journalism about criminal justice that is focused on the most significant drivers of mass incarceration, which occur at the state and local level. For more information, contact The Appeal at https://theappeal.org/.*