13-4255, 13-4405

IN THE

United States Court of Appeals

FOR THE THIRD CIRCUIT

DISABILITY RIGHTS NEW JERSEY, INC.,
A New Jersey Non Profit Corporation,

Plaintiff-Appellant,

—v.—

COMMISSIONER, NEW JERSEY DEPARTMENT OF HUMAN SERVICES;
COMMISSIONER, NEW JERSEY DEPARTMENT OF HEALTH AND
SENIOR SERVICES; STATE OF NEW JERSEY,

Defendants-Cross-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

REPLY BRIEF FOR PLAINTIFF-APPELLANT

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STATEMENT OF THE ISSUE FOR THE CROSS-APPEAL

Whether the district court properly held that Administrative Bulletin (AB) 5:04B violates the Americans with Disabilities Act (ADA), Rehabilitation Act, and Due Process Clause of the Fourteenth Amendment and enjoined its application with respect to persons in a status of Conditional Extension Pending Placement (CEPP)—those persons in state hospitals whom a court has determined are no longer dangerous, as required for involuntary commitment to New Jersey state psychiatric facilities, but who remain in these facilities until appropriate placement is arranged.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

If Administrative Bulletin 5:04B were upheld, an administrative panel in a state psychiatric hospital could authorize non-emergency, forcible medication of a person for "dangerousness" a day after a judge determined that the person is no longer dangerous, as required to justify continued involuntary commitment, and that the person is ready for release. The district court readily recognized that the state's treatment of CEPP-status persons "cannot be justified" and violates the substantive and procedural components of the Due Process Clause, as well as those persons' rights under the ADA and RA.

The State asserts that it must be allowed to involuntarily medicate these individuals in case they become dangerous while in state hospitals under CEPP-

status. But, as the district court recognized, there is a separate policy in place to deal with involuntary medication in emergency situations, and the State fails to show why this emergency policy is insufficient to address any danger until the State can seek a court order for re-commitment and non-emergency involuntary medication. In addition, even under its own remarkable view, the State fails to show that it has a compelling government interest in forcibly medicating those who, as determined by a court, are not dangerous: the State admits that "A.B. 5:04B was very rarely applied to CEPP patients prior to the issuance of the injunction by the District Court." State Br. 69 n.14. The district court was correct in concluding that the State has "no interest in continuing to forcibly medicate" CEPP-status persons who have been determined by a court to no longer constitute a danger. JA43.

The district court's error—and the subject of DRNJ's appeal—was simply in failing to recognize that the Policy, which is so evidently unconstitutional and discriminatory when applied to CEPP-status persons, is also unconstitutional and discriminatory for all involuntarily committed persons with mental illness. Forcible medication is an extraordinary intrusion on a person's liberty interest, and due process demands that this intrusion not occur unless a judge determines by clear and convincing evidence that facts exist to justify the intrusion. The district court relied on, and the State defends its Policy as being the same as, the

procedures for forced medication upheld in *Washington v. Harper*. But *Harper* was fundamentally a case about the rights of dangerous *prisoners* to refuse medication. The individuals subject to the Policy are not prisoners—who actually have *fewer* rights but are provided significantly *greater* access to the courts through counsel or law libraries than persons subject to the State's Policy. *Harper* simply never addressed the rights of civilly committed persons to refuse treatment. We have long passed the era in which involuntarily committed persons with mental illness may be treated as criminals.

The State's Policy is not only unconstitutional for failing to comply with due process, it is also unlawfully discriminatory in violation of the Americans with Disabilities Act and Rehabilitation Act. The Policy targets persons with mental illness and takes away their right to refuse unwanted treatment—a right protected under New Jersey law for every other person.

None of the State's arguments excuse its discriminatory treatment of persons with mental illness. The State uses its challenged Policy to create a novel qualification on the right to refuse treatment that does not exist under New Jersey law and that does not apply to any other person or any other illness. The State also asserts that it is not discriminating against persons with mental illness because of their disability, but rather because they "present a danger of serious harm if untreated with medication." State Br. 23. The Policy, however, only applies to

persons with mental illness. In fact, the State highlights that it singles out persons with mental illness, contending that "[d]angerous psychiatric patients fall into a unique category." State Br. 29 n.2. But a person with other types of illnesses, such as tuberculosis, may present a danger of serious harm if untreated with medication, and yet their right to refuse unwanted medical treatment is protected. The ADA does not allow the State to target only those with mental illness and take away *their* right to refuse treatment.

ARGUMENT

I. AB 5:04B VIOLATES THE AMERICANS WITH DISABILITIES ACT AND THE REHABILITATION ACT.

The mandate of the ADA is clear: "[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.[1] The right to refuse medical treatment under New Jersey law is exactly the type of "services, programs, or activities," for which the ADA prohibits discrimination. The State effectively concedes as much. *See* State Br. 22.

[1] The State agrees with DRNJ that the legal requirements for the ADA and RA are, in all relevant respects, virtually the same. *See* State Br. 22; Opening Br. 21 n.2. Accordingly, except as otherwise noted, this brief uses "ADA" to refer to both the ADA and RA claims.

But in New Jersey state psychiatric hospitals, the State's Policy of non-emergency involuntary medication, AB 5:04B, denies involuntarily committed persons with mental illness their right to refuse treatment. The State argues that it can deny persons with mental illness a right enjoyed by every other person in New Jersey because (1) they are not *qualified* individuals with disabilities who are entitled to participate in the right to refuse treatment, and (2) AB 5:04B purportedly does not discriminate on the basis of a disability. Neither of these arguments have merit, nor has the State met its burden of satisfying any defense to its discrimination. AB 5:04B is a facially discriminatory policy that violates the ADA.

A. Involuntarily Committed Persons In New Jersey Psychiatric Hospitals Are "Qualified Individuals With A Disability."

The State briefly argues that individuals who are found dangerous under the state policy if untreated by medication are not "qualified" to refuse treatment by reason of their dangerousness. State Br. 30-31. But this "qualification" for the right to refuse treatment exists nowhere in the ADA or in New Jersey law on the right to refuse medical treatment. At bottom, the State has used AB 5:04B—the very discriminatory policy at issue—to create a novel qualification on the right to refuse treatment that does not otherwise exist. This is circular reasoning that has no support in the ADA and, if accepted, would insulate any blatantly discriminatory policy against scrutiny under the ADA.

The term "qualified individual with a disability" in the ADA broadly encompasses any "individual with a disability who, with or without reasonable modifications to rules, policies, or practices, … meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." 42 U.S.C. § 12131(2); *see, e.g.*, *Pa. Dep't of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998) (holding that "qualified individual with a disability" includes prisoners). The program or activity at issue here is the right under New Jersey law of any individual to refuse unwanted medical treatment.

"New Jersey has been in the forefront of recognizing an individual's right to refuse medical treatment." *State v. Pelham*, 824 A.2d 1082, 1087 (N.J. 2003). New Jersey courts consistently have held that legally competent adults have the right to refuse unwanted medical treatment, except in rare instances of an overriding court order. *See e.g.*, *In re Conroy*, 486 A.2d 1209, 1222 (N.J. 1985); *In re Farrell*, 529 A.2d 404, 410 (N.J. 1987) ("[W]e start by reaffirming the well-recognized common-law right of self-determination that [e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." (internal quotation marks omitted)). "[T]he right to self-determination ordinarily outweighs any countervailing state interests," and competent individuals can refuse even life-sustaining treatments, if they so choose. *Conroy*, 486 A.2d at

1225; *In re J.M.*, 3 A.3d 651, 657 (N.J. Super. Ct. Ch. Div. 2010) (observing that a competent person has the right to refuse treatment "for any reason"). Indeed, a person "has the right to refuse treatment even if this is medically unwise," such as when a person has a contagious disease like tuberculosis. *City of Newark v. J.S.*, 652 A.2d 265, 278-79 (N.J. Super. Ct. L. Div. 1993). The right to refuse unwanted medical treatment is also codified in New Jersey statutes and regulations. *See* N.J. Admin. Code 8:43G-4.1(a)(8) ("Every New Jersey hospital patient shall have" the right "[t]o refuse medication and treatment to the extent permitted by law"); N.J. Admin. Code 8:43-14.2(a)(3) (residential health care facilities); N.J. Admin. Code 8:39-4.1(a)(4) (long-term care facilities); N.J. Admin. Code 8:42C-5.1(b)(11) (hospice patients); N.J. Admin. Code 8:43F-4.2(a)(4) (adult day health services facility patients); N.J. Admin. Code 10:37-6.54(i) (state funded community mental health programs). Contrary to the State's argument, none of these New Jersey cases or laws conditions the right to refuse psychotropic medication "on an individual's ability to function non-dangerously in a hospital setting without medication." State Br. 30. A person with mental illness subject to AB 5:04B is a qualified individual with a disability.

B. AB 5:04B Discriminates On The Basis Of Mental Illness.

On its face, AB 5:04B discriminates on the basis of mental illness because it imposes on a person with mental illness a restriction on the right to refuse

medication that is imposed on no other person. AB 5:04B only applies when "an involuntarily committed [person] has been diagnosed with a *mental illness*, and, as a result of *mental illness*, poses a likelihood of serious harm to self, others, or property if *psychotropic* medication is not administered." JA430 (emphasis added). This Policy allows a state hospital panel to override the right to refuse treatment only for a person with mental illness, and only to specifically treat that person's mental illness with psychotropic medications. This is the type of discrimination against persons with mental illness that Congress meant to be checked by the ADA.

Nonetheless, the State claims that it is not discriminating against persons with mental illness because of a disability, but rather because the state hospital panel has determined that those persons would be dangerous if not medicated. State Br. 23, 28. The State claims, without providing any basis, that it can do so because "*[d]angerous psychiatric patients fall into a unique category* – unless they are administered psychotropic medication to treat their mental illness, they will pose a danger to self or others." State Br. 29 n.2 (emphasis added). But this argument was rejected by the Supreme Court in *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987). There, the school board asserted that it had dismissed a teacher not because of her disability (tuberculosis), "but because of the threat that her relapses of tuberculosis posed to the health of others." *Id.* at 281. The

Supreme Court rejected that argument, explaining that "[i]t would be unfair to allow an employer to seize upon the distinction between the effects of a disease on others and the effects of a disease on a patient and use that distinction to justify discriminatory treatment." *Id.* at 282.

AB 5:04B discriminates on the basis of disability because it allows the state to medicate for purported "dangerousness," without a judicial hearing, *only* persons with mental illness and *only* with psychotropic medications. All persons in state hospitals are presumed competent to make medical decisions, regardless of whether the patient is involuntarily committed for mental illness. N.J. Stat. Ann. 30:4-24.2.c ("No patient may be presumed to be incapacitated because of an examination or treatment for mental illness, regardless of whether the evaluation or treatment was voluntarily or involuntarily received."); *see also* N.J. Stat. Ann. 30:4:27.11c. The State cannot, for instance, forcibly medicate without a judicial hearing a person who is dangerous because he has a contagious disease, such as tuberculosis. *See, e.g., J.S.*, 652 A.2d at 279. In fact, absent a court order, the State could not even forcibly medicate patients involuntarily committed in state psychiatric facilities for contagious diseases that make them dangerous to others or to treat serious physical ailments that present a danger to the patient. The State's witnesses conceded as much. *See* JA687 (cannot forcibly administer antibiotics); JA816 (cannot forcible administer heart medication). Yet, the State treats mental

illness differently, and persons with mental illness are subjected to a policy in which a state hospital panel, rather than a court, can override their right to refuse medication for their mental illness. The ADA does not permit the State to discriminate against disabilities in this way.

This is the same type of discrimination addressed in *Hargrave v. Vermont*, 340 F.3d 27 (2d Cir. 2003). Although the State tries to distinguish and limit *Hargrave* as concerning whether a "previous determination of dangerousness justifying civil commitment allowed involuntary medication in opposition to a power of attorney," *see* State Br. 29 (quoting *Hargrave*, 340 F.3d at 36), that was only part of *Hargrave*—and the State notably omits the relevant discussion a few paragraphs later. There, the Second Circuit rejected Vermont's argument that its policy was not discriminating on the basis of disability because the policy only applied to certain persons with mental illness who were dangerous, in state custody, and incompetent to make decisions, explaining that "it is immaterial to the discrimination analysis that [the challenged law] applies only to a subset of the mentally ill rather than to every mentally ill individual in Vermont" and "[a] program may discriminate on the basis of mental illness if it treats a mentally ill individual in a particular set of circumstances differently than it treats non-mentally ill individuals in the same circumstances." 340 F.3d at 36-37. The Vermont law, like AB 5:04B, only applied to patients with mental illness, and

accordingly, it facially "discriminate[d] on the basis of mental illness." *Id.* at 31, 37. Such facially discriminatory policies are per se violations of the ADA. *See New Directions Treatment Servs v. City of Reading*, 490 F.3d 293, 303 (3d Cir. 2007).

The State contends that AB 5:04B practices a "benign" form of discrimination, in which a doctor necessarily considers a patient's medical condition as a factor in treatment, and is "not irrationally discriminating against the patient under the ADA or Rehabilitation Act." State Br. 28. But this argument misses the mark. The problem with AB 5:04B is not that the doctor considers a person's mental illness in reaching a medical opinion on whether a person is dangerous or on an appropriate treatment for the illness; rather, the unlawful discrimination comes from the fact that AB 5:04B subjects *only persons with mental illness* to a policy where a hospital panel can take away their right to refuse treatment.

None of the cases on which the State relies support this discrimination. *See* State Br. 23-28. In *McGugan v. Aldana-Bernier*, 752 F.3d 224 (2d Cir. 2014), the Second Circuit examined whether McGugan "was subject to 'discrimination' by reason of her disability" when, in following the state law governing civil commitment, a hospital made a medically erroneous determination that she had a mental illness likely to result in serious harm to herself or others. *Id*. at 231-32. In

other words, McGugan was attacking the hospital's medical diagnosis as being discriminatory because it was based on stereotyping persons who suffer from mental illness. *Id.* The court rejected this argument, explaining that "while she may have alleged medical malpractice, she has not alleged discrimination as required to state a claim under § 504 [of the RA]." *Id.* at 232-33.

Nor do the three district court opinions relied on by the State support its claim of "benign" discrimination. As the State admits, these cases dealt with "challenges to civil commitment, itself, rather than decisions to involuntarily medicate." State Br. 25. *Greist v. Norristown State Hosp.*, No. 96-cv-8495, 1997 WL 661097 (E.D. Pa. Oct. 22, 1997), involved a person acquitted of murder by reason of insanity who alleged that he was discriminated against in violation of the ADA because he was recommitted for involuntary treatment and denied outpatient treatment. *Id.* at *1, *3. The district court rejected his claim because he failed to show that he was wrongfully discriminated against by reason of his mental illness. *Id*. at *4. The "plaintiff's dangerousness belies his assertion that he is qualified for participation in an outpatient treatment program." *Id*. at *5

In *Estate of Awkward v. Willingboro Police Department*, No. 07-5083(NLH)(JS), 2010 WL 3906785 (D.N.J. Sept. 30, 2010), the issue was whether police officers violated the ADA in restraining Awkward in order to transport him to a treatment facility after he had been certified for involuntary commitment—the

decision to involuntary commit Awkward to a treatment facility was not at issue. *Id*. at *13. The district court concluded that the officers did not discriminate against Awkward based on his disability because once Awkward had been certified for involuntary commitment "the officers were then obligated to facilitate his transport." *Id*.

In *Bryant v. Steele*, No. 13-cv-5234(ADS)(GRB), 2014 WL 2475608 (E.D.N.Y. June 3, 2014), the plaintiff alleged that his involuntary commitment was based on stereotypes. Relying on *McGugan*, the district court rejected the plaintiff's arguments because, while he may have alleged negligent medical treatment, he had "not plausibly alleged that [the defendants] forcibly hospitalized him on the basis of considerations that were 'unrelated to' or 'improper to consideration of' the likelihood that he posed a danger to himself or others." *Id*. at *8.

These cases are inapposite. DRNJ is not arguing that mental illness cannot be considered in conjunction with determining whether a person should be involuntarily committed, nor is DRNJ challenging any medical opinion. The issue here is whether the State can subject involuntarily committed persons with mental illness to special non-judicial procedures, taking away on "dangerousness" grounds their right to refuse treatment for mental illness when no other person and no other type of illness (even if it is a dangerous illness) is subjected to this type of

restriction. It is irrational discrimination based on disability for the State to impose a policy enabling it to forcibly medicate a patient for mental illness purportedly because that illness makes them dangerous when the State could not, absent a court order, forcibly medicate that same patient for a contagious disease that may make the patient even more dangerous to staff or other patients.

Rejecting the unlawful discrimination of the State's Policy allowing non-emergency forcible medication of persons with mental illness based on the order of a hospital administrative panel does not, as the State contends, threaten the State's civil commitment regime. *See* State Br. 25 n.1. The State has long been able to detain individuals who are mentally ill and dangerous, *see Foucha v. Louisiana*, 504 U.S. 71, 80 (1992), and involuntary civil commitment is permitted if a *court* determines by clear and convincing evidence that the person has mental illness and is dangerous to self, others, or property. N.J. Stat. Ann. 30:4-27-2m. While "undue institutionalization qualifies as discrimination 'by reason of … disability'" under the ADA, *see Olmstead v. L.C.*, 527 U.S. 581, 597-98 (1999), the Supreme Court explained that "[t]he ADA is not reasonably read to impel States to phase out institutions." *Id.* at 604.

C. The State Fails To Meet Its Burden Of Establishing Defenses Under The ADA For The Discrimination Of AB 5:04B.

The State's Policy facially discriminates against persons with mental illness and is a violation of the ADA unless the State can invoke a defense to this

discrimination. The State asserts three defenses, and it is the State's burden to prove each of them. *See Frederick L. v. Dep't of Pub. Welfare of Com. of Pa.*, 364 F.3d 487, 492 n.4 (3d Cir. 2004); *see also Hargrave v.Vermont*, 340 F.3d 27, 36 (2d Cir. 2003); *Dadian v. Vill. of Wilmette*, 269 F.3d 831, 841 (7th Cir. 2001) ("[A] public entity that asserts the reason it failed to accommodate a disabled individual was because she posed a direct threat to safety bears the burden of proof on that defense at trial."). The State has failed to meet its burden on each of them.

1. AB 5:04B Does Not Meet The Direct Threat Exception.

The State's discrimination against persons with mental illness under AB 5:04B is not allowed under the direct threat exception to the ADA. This exception is not applicable unless there is (1) a "*direct threat*" (2) "to the health or safety *of others*." 28 C.F.R. § 35.139. A "direct threat" does not exist unless there is a "significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services." *Doe v. Cnty. of Ctr., Pa.*, 242 F.3d 437, 447 (3d Cir. 2001). Although the State characterizes the "direct threat" analysis as "flexible," State Br. 33, it actually "requires a rigorous objective inquiry," and "[t]he purported risk must be substantial, not speculative or remote." *New Directions Treatment Servs. v. City of Reading*, 490 F.3d 293, 305-06 (3d Cir. 2007). AB 5:04B does not fall

within the exception because it is (1) unnecessary to meet any direct threat, (2) overbroad, and (3) fails to include the required assessment of risk.

Non-emergency forced medication under AB 5:04B is unnecessary to meet any direct threat, because the State has a policy providing for involuntary medication for 72 hours in an emergency. A1423. The State argues that ADA Title II's direct threat exception is not limited to imminent threats and that "requiring a finding of imminent harm before any administration of involuntary medication is unworkable given the imprecise nature of predictions of harm that individuals with mental illness pose." State Br. 32, 34. But these "imprecise … predictions of harm" only go to show that the State has not met its burden of establishing that all persons subject to AB 5:04B present a significant risk. *Bragdon v. Abbott*, 524 U.S. 624, 649 (1998) ("Because few, if any, activities in life are risk free, *Arline* and the ADA do not ask whether a risk exists, but whether it is significant."). And the imminence of a threat is necessarily part of the "rigorous objective inquiry" of determining whether the purported risk that is being asserted as justifying the discrimination is "significant" and "not speculative or remote," or whether there are other ways of eliminating the risk. *See New Direction Treatment Servs.*, 490 F.3d at 305-06; *see also Hargrave*, 340 F.3d at 36 (considering imminence of a threat in applying the direct threat exception under Title II). Here, the State already has a tool for addressing imminent harm—AB

5:04A, the procedures for emergency medication—and the State has never asserted that this policy is unworkable for addressing imminent harm. And while the State complains of "no guidance" as to what the State should do after the 72 hours, State Br. 34, the guidance is simple and straightforward: seek a court order for involuntary medication. In fact, this is consistent with the process for involuntary commitment. *See* N.J. Stat. Ann. 30:4-27.9.c (requiring a court order to involuntarily detain a person in a psychiatric facility for more than 72 hours).

AB 5:04B is *overbroad* because the direct threat exception applies only to threats to *others* whereas AB 5:04B allows forced medication when a person poses a threat only to *self* or *property*. Notably, the State does not dispute that AB 5:04B exceeds the plain language of the direct threat exception. State Br. 34. That makes the direct threat exception inapplicable here. *See Hargrave*, 340 F.3d at 35. But, citing to the canon of construction that statutes should be construed to avoid absurd results, the State asserts that "[r]eading an inclusion of threats to self and property into the direct threat exception is plainly reasonable." State Br. 35. In essence, the State argues that because its proposed expansion of the exception to include threats to self or property is reasonable, then limiting the exception to threats to others, as stated in the text, is absurd. That is not how the absurdity canon works. Rather, that canon applies only in "rare cases" in which applying the literal language of the statute has a result "so bizarre that Congress 'could not have intended' it."

Demarest v. Manspeaker, 498 U.S. 184, 190-91 (1991). That is not the case here. Regardless of whether the State's preferred expansion of the direct threat exception to include threats to self or property is reasonable, the actual language of the direct threat exception limiting it to threats to others is not at all absurd—let alone so absurd that this Court should ignore the plain meaning. *See Lamie v. U.S. Trustee*, 540 U.S 526, 538 (2004).

Nor do EEOC regulations under Title I of the ADA support the State's position. Curiously, the State takes contradictory positions on whether these regulations are even relevant to Title II's direct threat exception. Compare State Br. 35 (arguing that EEOC regulations support an expanded direct threat exception) with State Br. 32-33 (arguing that "imminence" of the harm, which is expressly listed in EEOC regulations, is not a factor under Title II regulations). Nonetheless, it is an entirely reasonable policy choice for the EEOC to conclude that threats to self should be included within the direct threat exception of Title I's employment discrimination provisions that apply to private employers, *see Chevron U.S.A. Inc. v. Echazabal*, 536 U.S. 73, 86 (2002) (involving whether oil refinery was required to hire a person with Hepatitis C when exposure to toxins at the refinery would aggravate his illness), and for the Attorney General to conclude that a public entity should not be allowed to use "threats to self" to exclude a person from participating in that entity's "services, programs, or activities." *See* 56

Fed. Reg. 35694-01 (the "direct threat" exception responds to the "need to balance the interests of people with disabilities against legitimate concerns for *public safety*") (emphasis added). And in any event, even if Title II's direct threat exception was expanded to include threats to self, as in the EEOC regulation, AB 5:04B would still exceed the scope of the direct threat exception because it allows involuntary medication if the state hospital panel concludes that the person "poses a likelihood of serious harm … to *property*."[2] JA430. The EEOC's regulation does not extend so far as to allow exclusion of persons with disabilities because of threats to property. 29 C.F.R. § 1630.2(r). The State has failed to meet its burden of showing that every person subject to AB 5:04B poses a direct threat within the meaning of the regulation sufficient to exclude that person from the protections of the ADA. *Hargrave*, 340 F.3d at 36.

The direct threat exception also requires an individual assessment of risk in excluding qualified individuals from participating in the State's program of the right to refuse medication. Although the State claims that AB 5:04B "satisfies the

[2] AB 5:04B also does not meet the EEOC's direct threat exception because it is discriminatory by applying only to persons with mental illness. In promulgating the employment direct threat regulation relied on by the State, the EEOC explained that although "[a]n employer may require, as a qualification standard, that an individual not pose a direct threat to the health or safety of himself/herself or others[,] [l]ike any other qualification standard, such a standard must apply to all applicants or employees and not just to individuals with disabilities." 56 Fed. Reg. 35726, 35745.

direct threat exception because it involves an individualized assessment," State Br. 32, that "assessment" is done for persons with mental illness by a hospital panel, whereas all other individuals in New Jersey—including those with an infectious disease who may be dangerous without treatment—are entitled to a judicial hearing. In other words, the problem is that AB 5:04B discriminates on its face against persons with mental illness, by subjecting only *them* to this process and only for involuntarily treating mental illness with psychotropic medication. The State has created a separate burden on the right of a person with mental illness to refuse treatment with mind-altering drugs. Whereas persons without mental illness are entitled to a judicial hearing before their right to refuse treatment can be overridden, *see City of Newark v. J.S.*, 652 A.2d 265, 278-79 (N.J. Super. Ct. L. Div. 1993), the State subjects involuntary committed persons with mental illness to having their right to refuse treatment vetoed by a state hospital panel. The State has not met its burden, *see Frederick L. v. Dep't of Pub. Welfare of Com. of Pa.*, 364 F.3d 487, 492 (3d Cir. 2004), of showing that all persons with mental illness pose a direct threat that justifies subjecting their right to refuse medication to AB 5:04B. *See Sch. Bd. of Nassau Cnty. v. Arline*, 480 U.S. 273, 285 (1987) ("The fact that *some* persons who have contagious diseases may pose a serious health threat to others under circumstances does not justify excluding from the coverage of the Act *all* persons with actual or perceived contagious diseases."); *New*

Direction Treatment Servs., 490 F.3d at 299, 305-07 (holding that a zoning statute that subjected all methadone clinics to special restrictions requiring their location be approved by municipal bodies did not fall within direct threat exception because there was no evidence that methadone clinics as a class posed significant risks).

The State also asserts that "the Policy requires that the treating prescriber consider less restrictive interventions before initiating the involuntary medication procedures." State Br. 32. But AB 5:04B only requires "considering" less restrictive alternatives—it does not require the State to use less restrictive alternatives in the first instance to remove or reduce the threat. Looking at how the State has implemented AB 5:04B shows that requiring the psychiatrist to "consider" less restrictive alternatives is toothless. The "Involuntary Medication Administration Reports" (IMARs) completed when forcible medication is being pursued frequently have a section for notating the "less restrictive treatments or interventions considered or attempted," and often the only less restrictive alternatives listed as being considered were "counseling" the patient about the need for medication. *See e.g.*, JA931 ("[Patient] was counseled multiple times"); JA980 ("Have attempted to counsel the patient regarding medications and clozapine trial"); JA1007 ("redirection, counseling, chaplains counseling); JA1072 (blank); JA1496 ("Psychoeducation re: importance of adherence to medication regimen provided - presented by psychiatrist. Information about patient's mental illness

provided"); JA2262 ("verbal de[-]escalation[;] offered medication"). And nothing indicates that the panel approving forced medication required less restrictive treatments be tried before authorizing forcible medication of a patient. *See*, *e.g.*, JA 963, 1017, 1050, 1063, 1076, 1099, 1484, 1500, 1542, 1684, 1698, 1730, 1772, 1867, 1912. The State cannot meet the direct threat exception for AB 5:04B because it has not shown that reasonable modifications to its hospital's care of involuntarily committed persons—whether through alternative housing or treatments other than forced medication—could not reduce the risk of dangerousness to an insignificant level. 42 U.S.C. § 12182(b)(3); *Doe*, 242 F.3d at 447.

2. AB 5:04B Is Not A Legitimate Safety Requirement.

The State contends that AB 5:04B is permissible as a "legitimate safety requirement" pursuant to 28 C.F.R. § 35.130(h). State Br. 36. But the State does not—and cannot—dispute that this regulation was meant to cover facially neutral requirements like being able to swim before taking a SCUBA class or setting safety restrictions for operation of powered mobility devices. *ADA Title II Technical Assistance Manual* at II-3.520075; 75 Fed. Reg. 56164-01, 56200 (explaining that § 35.130(h) "provides public entities the appropriate framework with which to assess whether legitimate safety requirements that may preclude the use of certain other power-driven mobility devices are necessary for the safe

operation of the public entities"); *cf. Baughman v. Walt Disney World Co.*, 685 F.3d 1131, 1136-37 (9th Cir. 2012) (observing that a parallel regulation under Title III of the ADA allowed Walt Disney World to establish legitimate safety requirements in its accommodation of a patron's use of a Segway). Even though DRNJ's opening brief explained in detail the legal background and purpose of § 35.130(h) and why the exception cannot apply here, *see* Opening Br. 38-41, the State does not respond to any of it. AB 5:04B facially discriminates against persons with mental illness, and therefore cannot be a legitimate safety requirement. The State has failed to meet its burden of showing that AB 5:04B qualifies as a legitimate safety requirement.

3. The Fundamental Alteration Defense Does Not Apply.

The State also fails to meet its burden of showing that the fundamental alteration defense applies. The State incorrectly argues that DRNJ must explain "how the State's clinical model is somehow unequal or inferior to a judicial model, and therefore discriminatory under the ADA." State Br. 38. The discrimination is evident from the face of AB 5:04B, because it only takes away the right of persons with mental illness to refuse medical treatment, while all other persons—regardless of their disease—retain the right to refuse treatment absent a court order requiring otherwise. No other showing of discrimination is required under the ADA.

The State asserts that "the modifications DRNJ seeks would fundamentally alter [the State's] involuntary medication procedures" because the State has made a policy choice that providing judicial review would interfere with the process the State has chosen to implement. State Br. 38. But state policy will necessarily change anytime discrimination is eliminated—the ADA would be toothless if it *did not* force changes in discriminatory state policies. "Public entities could evade the ADA by claiming it would fundamentally alter their program to eliminate a facially discriminatory provision of a challenged program, and Congress' intent in enacting the ADA would be defeated." *Lovell v. Chandler*, 303 F.3d 1039, 1054 (9th Cir. 2002). That is why this Court and others have recognized that the fundamental alteration defense cannot be invoked to save a facially discriminatory policy like AB 5:04B. *See New Direction Treatment Servs.*, 490 F.3d at 305 ("[I]t is inappropriate to apply the 'reasonable modification' test to facially discriminatory laws. The only way to modify a facially discriminatory statute is to remove the discriminatory language."); *see also Lovell*, 303 F.3d at 1054; *MX Group v. City of Covington*, 293 F.3d 326, 344-45 (6th Cir. 2002); *Bay Area Addiction Research and Treatment, Inc. v. City of Antioch*, 179 F.3d 725, 734-35 (9th Cir. 1999). The State does not attempt to reconcile its argument with this Court's decision in *New Direction Treatment Services*—and in fact fails to cite this case at all.

Finally, the State also asserts, in a single sentence that merely quotes *Harper*, that requiring judicial hearings and counsel would impose a burden on the State. State Br. 39. This Court, however, has repeatedly instructed that "states cannot sustain a fundamental alteration defense based solely upon the conclusory invocation of vaguely-defined fiscal constraints." *See Frederick L. v. Dep't of Pub. Welfare of Com. of Pa.*, 364 F.3d 487, 496 (3d Cir. 2004); *see also Pa. Prot. and Advocacy, Inc. v. Pa. Dep't of Pub. Welfare*, 402 F.3d 374, 380 (3d Cir. 2005) ("Though clearly relevant, budgetary constraints alone are insufficient to establish a fundamental alteration defense."). The State identifies nothing in the record of this case to show that providing judicial hearings and counsel would impose an undue burden. Accordingly, this bald assertion cannot meet the State's burden to show that the fundamental alteration defense applies.[3]

II. AB 5:04B IS UNCONSTITUTIONAL FOR FAILING TO PROVIDE BASIC DUE PROCESS.

The State does not—and cannot—dispute that civilly committed patients subject to AB 5:04B have greater liberty interests than convicted prisoners and retain rights during commitment that prisoners do not have. *Youngberg v. Romeo*,

[3] The State's argument that AB 5:04B does not violate the ADA is further undermined by the State's failure to discuss—let alone distinguish—several of this Court's key ADA Title II cases, relied on in DRNJ's opening brief, including *Doe*, 242 F.3d 437; *New Directions Treatment Servs. v. City of Reading*, 490 F.3d 293 (3d Cir. 2007); *Pa. Prot. and Advocacy, Inc. v. Pa. Dep't of Pub. Welfare*, 402 F.3d 374 (3d Cir. 2007).

457 U.S. 307, 321-22 (1982); N.J. Stat. Ann. 30:4-24.2.a. Yet the State asserts that its Policy for forcible administration of mind-altering drugs to involuntarily committed persons is constitutional solely because that policy mimics procedures that the Supreme Court held were sufficient for the involuntary medication of *prisoners*. State Br. 40 (citing *Washington v. Harper*, 494 U.S. 210 (1990)). Persons involuntarily committed for mental illness are not prisoners, and they cannot and should not be treated like prisoners. *Harper* did not address the due process required by the constitution before forcibly medicating someone who has not committed—or even been charged with—a crime.

In defending the constitutionality of this Policy, the State relies on inapplicable precedent and conflates the dangers in a prison environment with those in a psychiatric facility. It also downplays the procedure already in place that allows for the forcible administration of psychotropic drugs in situations where an imminent threat of danger exists in New Jersey psychiatric facilities. Due process is a flexible analysis that "calls for such procedural protections as the particular situation demands." *Mathews v. Eldridge*, 424 U.S. 319, 334 (1976). Here, while the *Harper* procedure may be sufficient due process for prisoners, due process demands that the rights of involuntarily committed patients in state hospitals, who have neither committed nor been charged with a crime, be protected by a judicial

determination by clear and convincing evidence before allowing the massive curtailment of rights by the State's non-emergency, forced medication.

A. Competent Involuntarily Committed Persons In New Jersey State Psychiatric Hospitals Are Entitled To Greater Due Process Than Prisoners.

There is no question that "[t]he forcible injection of medication into a nonconsenting person's body … represents a substantial interference with that person's liberty," *Riggins v. Nevada*, 504 U.S. 127, 134 (1992), and the State does not dispute that this interest is not "modif[ied] or var[ied]" by a patient's involuntary commitment to a state facility. N.J. Stat. Ann. 30:4-27.11c; *see also* N.J. Stat. Ann. 30:4-24.2.c. Nevertheless, the State attempts to expand the holding in *Harper*—which involved only "convicted criminals"—to the competent patients at issue here, asserting that "*Harper* has been applied to other individuals in institutional settings who present a danger to themselves, others or property if they are not medicated against their will." State Br. 40, 44. The State's analysis is flawed.

The State first contends that, because the *Harper* procedure has been applied to pretrial detainees, it must apply here as well. State Br. 44-45 (citing *United States v. Hardy*, 724 F.3d 280 (2d Cir. 2013) (detainee charged with drug trafficking, racketeering and murder); *United States. v. Loughner*, 672 F.3d 731 (9th Cir. 2012) (detainee charged with the attempted assassination of a

Congresswoman, murder of federal judge, and murder and attempted murder of other federal employees); *Riggins*, 504 U.S. 127 (detainee charged with murder and robbery); *Gooden v. Ricci*, No. 08-cv-5321(JAP), 2011 U.S. Dist. LEXIS 16608 (D.N.J. Feb. 17, 2011) (detainee charged with aggravated assault)).[4] But like convicted criminals, the rights of pretrial detainees are diminished because a judge has determined that probable cause exists that they committed a crime. *Boring v. Kozakiewicz*, 833 F.2d 468, 472 (3d Cir. 1987) (pre-trial detainees are detained pursuant to "a finding of probable cause that they committed crimes, a circumstance which permits an extended restraint of their liberty"). No such determination has been made with respect to involuntarily committed patients, N.J. Stat. Ann. 30:4-27.11c, and thus those patients are not subject to the same curtailment of rights as imprisoned pretrial detainees. *See White v. Napoleon*, 897 F.2d 103, 112 (3d Cir. 1990) ("Prisoners may well suffer a greater loss of liberty than persons involuntarily committed to mental institutions.").

Not only do prisoners and pre-trial detainees have fewer rights, but the government has greater leeway in imposing policies in prison to maintain security. *See, e.g.*, *Bistrian v. Levi*, 696 F.3d 352, 373 (3d Cir. 2012) ("[C]onditions that are

[4] The only other case cited by the State, *Aruanno v. Glazmin*, is entirely inapposite because it involved an evaluation of the rights of a *convicted* inmate, rather than a pretrial detainee. No. 03-cv-3696(GEB), 2007 WL 1221113 (D.N.J. Apr. 20, 2007) *aff'd sub nom.*, 316 F. App'x 194 (3d Cir. 2009).

reasonably related to a penal institution's interest in maintaining jail security typically pass constitutional muster."); *Bell v. Wolfish*, 441 U.S. 520, 546 (1979) ("[M]aintaining institutional security and preserving internal order and discipline are essential goals that may require limitation or retraction of retained constitutional rights of both convicted prisoners and pretrial detainees."). Although the State argues that the Supreme Court "has counseled against courts involving themselves in the day-to-day operations of State facilities," every case the State cites in support of its arguments involved jails or prisons. *See* State Br. 60 (citing *Washington v. Harper*, 494 U.S. 210, 224 (1990) (prisons); *Bell v. Wolfish*, 441 U.S. 520 (1979) (federal correctional center); *Sandin v. Conner*, 515 U.S. 472 (1995) (state prison); *Florence v. Bd. of Chosen Freeholders of Burlington*, 132 S. Ct. 1510 (2012) (county jail)). "There are few cases in which the State's interest in combating the danger posed by a person to both himself and others is greater than in a prison environment, which, 'by definition,' is made up of persons with 'a demonstrated proclivity for antisocial criminal, and often violent, conduct.'" *Harper*, 494 U.S. at 225 (*citing Hudson v. Palmer*, 468 U.S. 517, 526 (1984)). Thus, a prison regulation impinging on a prisoner's constitutional rights "is valid if it is reasonably related to legitimate penological interests." *Turner v. Safley*, 482 U.S. 78, 89 (1987).

But New Jersey psychiatric hospitals *are not prisons* and their patients *are not prisoners*. While patients may have been committed on the basis of posing a danger to self, others, or property, N.J. Stat. Ann. 30:4-27-2, unlike prison inmates they have not "necessarily shown a lapse in ability to control and conform their behavior to the legitimate standards of society by the normal impulses of self-restraint [or] shown an inability to regulate their conduct in a way that reflects either a respect for law or an appreciation of the rights of others." *Hudson v. Palmer*, 468 U.S. at 526. In fact, although patients have been civilly committed to a restricted environment, they are presumed competent and retain all other legal and civil rights, including the right to vote, contract, and hold licenses. N.J. Stat. Ann 30:4-24.2 ("Rights of patients"). And the state's hospitals include patients there voluntarily (who have the right to refuse unwanted medication), which further shows that a psychiatric hospital cannot be equated with a prison environment. Thus, there can be little doubt that the danger present in a prison exceeds that in a psychiatric hospital, weighing in favor of greater constitutional protections before a patient's rights should be infringed. *Mathews*, 424 U.S. at 333-34 (due process is "flexible and calls for such procedural protections as the particular situation demands").

In addition, the functional need to protect psychiatric hospital workers is already appropriately addressed by the procedure in AB 5:04A, which explicitly

allows for the immediate, forcible medication of a patient where an imminent risk of danger exists. JA1121; JA1423. This too calls for greater constitutional protections for psychiatric patients than the prisoners in *Harper*. The due process that the Supreme Court found sufficient for prisoners in *Harper* does not satisfy the due process of civilly committed persons. *See Riggins*, 504 U.S. at 134-35 (describing *Harper* as "[t]aking account of the unique circumstances of penal confinement").

The State's assertion that "the standard set forth in *Harper* has been applied repeatedly in the context of civil commitment," *see* State Br. 45, is not supported by the two cases on which the State heavily relies. For example, in *Morgan v. Rabun*, the court held that emergency forcible medication of a previously convicted murderer did not violate substantive due process where the plaintiff threatened psychiatrists with "homicidal ideas" and brandished a weapon-like object. 128 F.3d 694, 698 (8th Cir. 1997). But here there is no challenge to the state's authority to medicate in an emergency, and this holding has no application to the constitutional challenge to *non*-emergency forcible medication under AB 5:04B. JA1121; JA1423 (AB 5:04A authorizes the involuntarily administration of psychotropic medication in emergencies where patients "present[] a risk of imminent or reasonably impending harm or danger to self or others"). Other than this narrow holding on the constitutionality of emergency medication procedures,

the Eighth Circuit otherwise declined to rule on the plaintiff's procedural due process challenge to the long-term, oral administration of psychotropic medication. *Id.* at 699 ("We need not perform the *Mathews* balancing test, however, because Morgan's evidence fails to create a fact issue as to whether he took these oral medications voluntarily.").

Jurasek v. Utah State Hosp. is also inapplicable, as that case involved only the forcible medication of an *incompetent* patient. 158 F.3d 506 (10th Cir. 1998). The Tenth Circuit explained that "the Due Process Clause allows a state hospital to forcibly medicate a mentally ill patient *who has been found incompetent* to make medical decisions if the patient is dangerous to himself or others and the treatment is in the patient's medical interests." *Id.* at 511 (emphasis added). *Jurasek* did not, however, make any finding as to what protections must apply before a *competent* patient may be forcibly medicated, the question at issue here. Unlike *Jurasek*, patients subject to AB 5:04B are presumed competent. N.J. Stat. Ann. 30:4-24.2.c. In short, the holdings in *Morgan* and *Jurasek* do not apply to the circumstances at hand, and the State has failed to identify any other case upholding a procedure for the long-term, forcible medication of competent psychiatric patients without an immediate risk of danger present.[5]

[5] Like *Morgan* and *Jurasek*, the remaining cases cited by the State do not endorse the *non*-emergency, long-term medication of patients in psychiatric care, but rather deal with issues factually distinct from those present here. *See Noble v.*

B. Before Civilly Committed Patients Can Be Forcibly Medicated, Due Process Requires A Judicial Hearing And Proving The Basis For Involuntary Medication By Clear And Convincing Evidence.

AB 5:04B allows the State to forcibly medicate a person with mind-altering drugs solely based on the decision of a hospital administrative panel, and in the absence of a court order or determination by clear and convincing evidence that the medication is warranted. The State justifies this process as constitutionally sufficient based on *Harper*.[6] *See* State Br. 51-52 (asserting that the request for a

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Schmitt, 87 F.3d 157, 162 (6th Cir. 1996) (denying the state's motion to dismiss constitutional claims on qualified immunity grounds because the plaintiff alleged that "an emergency situation did not exist so as to justify a generic intervention with involuntary medication"); *Howell v. Springfield Hosp. Ctr.*, No. JFM-13-cv-811, 2014 WL 1388262, at *3-4 (D. Md. Apr. 7, 2014) (addressing whether physician exercised professional judgment in determining that patient was dangerous such that involuntary medication was warranted, but not commenting on constitutionality of the applicable procedure for involuntary medication); *Sims v. Ahlin*, No. 12-cv-00019-SKO PC, 2012 U.S. Dist. LEXIS 157723 at * 5 (E.D. Cal. Oct. 31, 2012) (recognizing that an involuntarily medicated patient "must be provided with procedural protections to ensure that the decision to medicate him involuntarily is not arbitrary or erroneous," but dismissing complaint because the "[p]laintiff's very brief complaint leaves unclear the circumstances surrounding the administration of medication"); *Coleman v. State Supreme Court*, 697 F. Supp. 2d 493, 509 (S.D.N.Y. 2010) (evaluating a statute that, unlike AB 5:04B, "does *not* allow [] patients to be forcibly injected with medications against their will," and is thus "considerably less invasive that those considered in *Harper*, *Riggins*, and *Sell*." (emphasis added)).

[6] The State repeatedly claims that its policy "exceeds" the procedures of *Harper*. *See* State Br. 4, 54, 56, 70. Yet, the only two differences identified are (1) that the State uses "well-educated and experienced nurses as [Client Services Advocates]," and (2) "[t]he hearing in a State Hospital is chaired by an independent psychiatrist" who "is not employed in a State Hospital." State Br. 55-56. First, the State identifies no basis to conclude that its Client Services

judicial hearing "should be rejected because it conflicts with *Harper* and all other relevant cases that have addressed the issue"); *id.* at 62 (stating that "the Supreme Court in *Harper* directly rejected the notion that due process requires a clear and convincing standard of proof in the dangerousness context"). But the minimum procedural protections that satisfy due process for prisoners do not provide required due process for competent, civilly committed persons who have not committed a crime. For civilly committed individuals, the State cannot forcibly medicate, absent an emergency, without a judicial hearing in which the State proves by clear and convincing evidence that medication is warranted.

1. Due Process Requires a Judicial Hearing.

Few intrusions into a person's liberty are as great as the forcible medication by the government with mind-altering drugs. *See Riggins v. Nevada*, 504 U.S. at 134. For many, this intrusion may be even greater than physical detention through

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Advocates are better educated or experienced than the representative in *Harper*. Second, nothing in AB 5:04B prohibits the State from using its own psychiatrist as chair of the panel. In fact the State has contemplated such an arrangement. JA1370 (admitting the "potential" of independent psychiatrists being state employees and that the State had "envisioned this").

In June 2012, the State stated that the two physicians retained to serve as independent psychiatrist were Dr. Lily Arora and Dr. David Rissmiller. JA427. Dr. Arora was affiliated with Robert Wood Johnson - University Behavioral Health Care at Rutgers. JA427; JA2454. Dr. Rissmiller was affiliated with UMDNJ-School of Osteopathic Medication. JA427; JA1370 ("So we initially looked at an affiliation with the university, as I mentioned, UMDNJ, which if they were members—if they were employees of the UMDNJ in that essence would be State employees.").

involuntary commitment; while a person who is involuntarily committed loses control over their freedom of movement, a person who is involuntarily medicated with psychotropic medication loses control over their mind. *Id.*; *see also id.* at 141-44 (Kennedy, J., concurring). "[W]hen the purpose or effect of forced drugging is to alter the will and the mind of the subject, it constitutes a deprivation of liberty in the most literal and fundamental sense." *United States v. Cruz*, No. 13-4378, 2014 WL 3360689, at *15 n.4 (3d Cir. July 10, 2014). This is an incredible power for the State to have, and one that is ripe for abuse as state hospitals dealing with patients having complex and challenging mental illnesses may find it tempting to substitute their judgment for the patient's, thereby creating a more compliant and manageable population of patients. While no one doubts that state hospitals and doctors have the best medical intentions in recommending forced medication, it would be blinking reality to ignore that they also have an institutional interest in possessing substantial leeway in the decision to forcibly medicate. The State argues that it wants the authority to forcibly medicate outside of emergencies to "proactively treat[] patients" and employ a "long term solution" for the "root cause" of dangerousness. State Br. 59-60. But the Due Process Clause protects the rights of a competent individual to choose for himself whether to treat an illness. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990). The State cannot, for example, confine persons with mental illness "merely to

ensure them a living standard superior to that they enjoy in the private community." *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975); *see also id.* ("[T]he mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution."). So too, the State cannot forcibly medicate a person merely because it believes, pursuant to its "clinically-driven model," that the medication is in a person's best interests. A judicial hearing is a necessary and important safeguard.

The State asserts that "[d]angerousness of the patient, not competency, drives" hospitals' administrative hearings on forced medication. State Br. 55. Yet, it is precisely because *dangerousness* is the purported basis for forced medication that a court must be involved, because this is not an issue simply of a medical diagnosis. That makes this inquiry different than that in *Parham v. J.R.*, in which the Supreme Court concluded that the due process required in determining whether a minor child meets the medical standard for voluntary commitment by his parents for mental health treatment was satisfied by having a staff physician evaluate the child. 442 U.S. 584, 606-07 (1979). In *Parham*, it was only an issue of medical diagnosis. *Id*. at 607. And *Harper*'s holding that a judicial hearing was not required before *prisoners* could be forcibly medicated for dangerous necessarily turned on "the unique circumstances of penal confinement." *Riggins*, 504 U.S. at 134-35. Patients in state hospitals are not in penal confinement, and they have

greater liberty interests and are therefore entitled to greater protection of those interests than prisoners or pretrial detainees.[7] *Youngberg v. Romeo*, 457 U.S. at 321-22. As the New Jersey Supreme Court explained in the context of civil commitment, "[t]he final determination of dangerousness lies with the courts, not the expertise of psychiatrists and psychologists. Courts must balance society's interest in protection from harmful conduct against the individual's interest in personal liberty and autonomy. The ultimate decision on dangerousness is, therefore, a legal one, not a medical one, even though it is guided by medical expert testimony." *In re D.C.*, 679 A.2d 634, 648 (N.J. 1996); *see also State v. Putnoki*, 510 A.2d 1329, 1334 (Conn. 1986) ("[T]he ultimate determination of mental illness and dangerousness is a legal decision"); *DeVeau v. United States*, 483 A.2d 307, 312 (D.C. 1984). When the State seeks to forcibly medicate a civilly committed patient for dangerousness in the absence of an emergency, a judicial hearing is required to balance the individual's interest against the risk of harmful conduct.

Finally, throughout its brief, the State describes the process of AB 5:04B with terms suggesting medical authority. *See* State Br. 10 ("clinically-driven

[7] The State's reliance on *Loughner* is similarly misplaced, as that too addressed the issue of whether a pretrial detainee accused of murdering six people could be involuntarily medicated by a prison facility for dangerousness without a judicial hearing. *United States v. Loughner*, 672 F.3d 731, 754 (9th Cir. 2012).

model"); *id.* at 11 ("clinical model"); *id.* at 38 ("clinical model"); *id.* at 58 ("patient-centric administrative hearing"); *id.* at 60 ("clinically driven administrative model"); *id.* at 61 ("clinical, so that it is patient-centric"); *id.* at 62 ("therapeutic alliance"). Such an inference is not warranted. The State's model is really about making it easier to forcibly medicate. Lisa Ciaston, a legal liaison for the Division of Mental Health, described AB 5:04B as being a "clinical model" that is "patient centric" because it "provides the *efficient decision-making* by very qualified individuals who understand medication." JA791, JA800-01 (emphasis added). Yet, when asked if any patient was consulted in the drafting of AB 5:04B, she conceded that she was not aware of any patients that were consulted in the development of this so-called "patient-centric" policy. JA2587. AB 5:04B does not require a doctor to meet with the patient before initiating the forcible medication process. JA434-35; JA517-18. "Efficient decision-making," when dealing with the process by which the State can forcibly medicate a person in a *non*-emergency, is not necessarily a good thing and does not protect the rights of those who are being forcibly medicated. "[T]he Constitution recognizes higher values than speed and efficiency," and the Due Process Clause was designed "to protect the fragile values of a vulnerable citizenry from the overbearing concern for efficiency and efficacy that may characterize praiseworthy government officials no less, and perhaps more, than mediocre ones." *Stanley v. Illinois*, 405 U.S. 645,

656 (1972); *cf. Addington v. Texas*, 441 U.S. 418, 425 (1979) ("[W]e must be mindful that the function of legal process is to minimize the risk of erroneous decisions."). And although the State argues that providing a judicial hearing "could subvert the 'therapeutic alliance'" between a physician and the individual who is being forcibly administered psychotropic medication against her will, State Br. 61-62, in fact the opposite is true: putting the decision in the hands of the court helps to protect the relationship between the patient and physician. JA784; JA1209; *see, e.g. City of Newark v. J.S.*, 652 A.2d 265, 279 and n.14 (N.J. Super. Ct. L. Div. 1993) (noting that after the court denied the government's request to forcibly medicate to treat an involuntarily committed person with tuberculosis, the person began cooperating and agreed to a consent order in which his release from commitment was conditioned on taking medication). A "therapeutic alliance" between a physician and a patient is strengthened where the patient knows that a court will hear his objections to treatment and that the court, not the doctor, will make the decision on whether the State can override the patient's refusal.

Last, the State argues that judicial hearings would "impose significant financial and other costs," State Br. 60, yet it fails to address the fact that New Jersey state judges already hold thousands of civil commitment hearings at the very hospitals where the patients at issue reside, JA1141-42, or that adding forcible medication hearings would constitute less than a 5% increase in the judicial

hearings already taking place. JA57; JA360; JA13. Indeed, the State's claim that judicial hearings would be a burden is inconsistent with its later argument that a patient has meaningful access to courts because "his commitment status is reviewed by a judge several times each year." State Br. 66. The State has no good argument for why *non*-emergency forced medication decisions could not also be decided by a judge at these frequent hearings. While the State argues that judicial hearings will "require the 'utilization of the time of psychiatrists, psychologists, and other behavioral specialists in preparing for and participating in hearings," State Br. 60, presumably—if the administrative hearings under AB 5:04B truly were proceeding as required—the time specialists spend on judicial hearings should be no more than that spent on the administrative hearings already taking place. And if the State's argument is that additional time would be necessary for these specialists to be prepared to justify the basis for forced medication to an independent court—one that regularly deals with mental health legal issues—then that only further confirms that the State's current Policy fails to provide appropriate safeguards of a person's right to refuse treatment.

In short, the State's unsubstantiated claims of the "significant" burdens associated with judicial hearings cannot overcome the severe risk of prejudice to involuntarily committed patients from being subjected to unwarranted forcible medication.

2. Due Process Requires a Clear and Convincing Standard of Proof.

The State does not dispute that a clear and convincing standard of proof is typically required when fundamental rights are at stake. *See Addington*, 441 U.S. at 425, 427 (clear and convincing evidence required before civilly committing an individual); *In re Commitment of J.R.*, 916 A.2d 463, 469 (N.J. Super. Ct. App. Div. 2007) (same); *Santosky v. Kramer*, 455 U.S. 745, 747-48 (1982) (clear and convincing evidence required before terminating parental rights); *E.B. v. Verniero*, 119 F.3d 1077, 1111 (3d Cir. 1997) (clear and convincing evidence required to prove future dangerousness of certain sex offenders to mandate registration). But relying once again on *Harper*, the State argues that due process does not "require[] a clear and convincing standard of proof in the dangerousness context." State Br. 62. Yet again, the State ignores the fundamental differences in the protections required for prisoners, as in *Harper*, and the civilly committed. A standard of proof "instruct[s] the factfinder concerning the degree of confidence . . . he should have in the correctness of factual conclusions." *Addington*, 441 U.S. at 423. Although it may be appropriate to allocate the risk of error of improper forced medication equally in the prison environment in light of "unique circumstances of penal confinement," *Riggins*, 504 U.S. at 134, it is not appropriate in the context of civil commitment.

The fact that "dangerousness" is the criteria for forced medication calls for a clear and convincing standard of proof. Involuntarily commitment itself requires the state to prove dangerousness by clear and convincing evidence. *See Addington*, 441 U.S. at 427; *J.R.*, 916 A.2d at 467. "The burden should not be placed on the civilly committed patient to justify his right to liberty." *State v. Fields*, 390 A.2d 574 (N.J. 1978).

The reasons that a clear and convincing standard is required for involuntary commitment hold true for non-emergency forced medication. To start, the State concedes that it does not rely on the original commitment decision to justify forced medication. State Br. 54 n.10. As a result, the state court's decision to authorize involuntary commitment does not authorize their forced medication. Forced medication requires a separate determination that should apply the same evidentiary standard as for involuntary commitment. As the Supreme Court explained, "[a]t one time or another every person exhibits some abnormal behavior which might be perceived by some as symptomatic of a mental or emotional disorder, but which is in fact within a range of conduct that is generally acceptable. Obviously, such behavior is no basis for compelled treatment and surely none for confinement." *Addington*, 441 U.S. at 426-27. A clear and convincing evidentiary standard is necessary because "there is the possible risk that a factfinder might decide to commit an individual based solely on a few isolated instances of unusual

conduct. Loss of liberty calls for a showing that the individual suffers from something more serious than is demonstrated by idiosyncratic behavior." *Id.*

The State does not dispute that the "likelihood of serious harm [or danger]" standard imposes no specific time limitation on the conduct doctors may rely upon in supporting medication determinations (other than the undefined phrase within the "reasonably foreseeable future"), nor does it dispute that this lack of a time limitation allows physicians to rely on evidence from months or years before a hearing. JA1125-26; JA2659, JA2661. And the State cannot deny that past medication determinations have been supported by conclusory recitations of the "likelihood" standard in the absence of a more appropriately defined standard of proof. JA 1558; JA1575; JA1621; JA1637; JA1651; JA1658; JA1684; JA1698; JA1712; JA1730. While the State asserts that these examples consist of "few decisions from the dozens of medication review hearings," State Br. 64, any case of unjustified forced medication is an extraordinary violation of due process, and absent a more appropriately defined standard there is a serious risk that similar decisions will be made in the future. The procedures of AB 5:04B do not reflect the significance of the decision to forcibly medicate and put the risk of error on patients. That is improper. *Addington*, 441 U.S. at 423. Given the interest at stake, due process requires the imposition of a clear and convincing standard of

proof that will significantly reduce the risk of an erroneous deprivation of patient rights.

III. THE STATE'S FAILURE TO PROVIDE COUNSEL TO PERSONS SUBJECT TO FORCIBLE MEDICATION UNDER AB 5:04B DENIES THEM ACCESS TO COURTS.

Any support the State draws from *Harper* is further eroded in light of the *additional* protections that prisoners—like those in *Harper*—are provided, including law libraries or assistance from persons trained in law to help them vindicate their rights. *Bounds v. Smith*, 430 U.S. 817, 828 (1977); *see Peterkin v. Jeffes*, 855 F.2d 1021, 1041 (3d Cir. 1988) ("Legal assistance … whether in the form of an accessible and adequate law library, court-appointed or other attorneys or para-professionals, or some combination of legal resources—is central, not peripheral, to the right of access to the courts that *Bounds* protects."); *cf. Vitek v. Jones*, 445 U.S. 480, 496-97 (1980) (requiring that a state provide counsel to indigent prisoners whom the state seeks to treat as mentally ill). With a law library or legal resources, a prisoner who has a mental illness has the means to research challenges to a decision to medicate him pursuant to *Harper* procedures. But patients in the state's psychiatric facilities do not have these same resources to bring a challenge to the decision to forcibly medicate. Despite having *greater* liberty interests, these patients have *fewer* resources and *fewer* protections than a prisoner.

The State argues that forcibly medicated patients are able to seek appellate review of the medication determinations under AB 5:04B and that "there are lists of available attorneys" to assist them. State Br. 66. Whether these "lists" actually provide meaningful and adequate access to counsel is disputed. JA2469. And more importantly, any appellate review takes place only *after* a patient has already been forcibly administered mind-altering drugs, drugs which "can hamper the attorney-client relation" and "prevent[] effective communication" with counsel. *Riggins*, 504 U.S. at 144 (Kennedy, J. concurring). Thus, allowing forcibly medication before the patient's first opportunity to meaningfully challenge the dangerousness determination renders the after-the-fact right to an appeal inadequate to protect the patient's constitutional rights.

Finally, citing *Lewis v. Casey*, 518 U.S. 343 (1996), the State argues that there cannot be a right of access to courts claim because there has been no claim of "'actual injury' by hindering … efforts to pursue such a claim or defense." State Br. 67. But the "actual injury" that *Casey* requires is "a nonfrivolous legal claim [that] had been frustrated or was being impeded"—or that may be imminently impeded—by the State's failure to provide access to courts. *Casey*, 518 U.S. at 349-53. "In other words, prison law libraries and legal assistance programs are not ends in themselves, but only the means for ensuring 'a reasonably adequate opportunity to present claimed violations of fundamental constitutional rights to

the courts.'" *Casey*, 518 U.S. at 351 (quoting *Bounds*, 430 U.S. at 825). DRNJ's constituents are being forcibly medicated and have nonfrivolous legal claims—the right to be free from that forced medication—that are being impeded by the State's failure to provide them adequate access to courts to protect that right *before* the State violates it, or to vindicate it afterwards. JA1475 (describing patient JK who was hindered in pursuing an appeal by the lack of legal assistance or law libraries).

IV. THE DISTRICT COURT CORRECTLY ENJOINED THE STATE'S APPLICATION OF AB 5:04B TO CEPP-STATUS PERSONS, WHO A COURT HAS DETERMINED SHOULD NO LONGER BE INVOLUNTARILY COMMITTED [STATE'S CROSS-APPEAL].

While the district court upheld the application of AB 5:04B to patients in the status of involuntary commitment, the district court also ruled that applying AB 5:04B to persons under CEPP-status—who have been judicially determined *to no longer* pose a danger to self or others—violated the ADA and substantive and procedural due process. JA36, JA43, JA57-59. Tellingly, the State devotes fewer than five pages of its brief to its cross-appeal challenging this aspect of the district court's order, asserting only that "the State's justification for involuntarily medicating CEPP patients is precisely the same as for medicating non-CEPP patients – they have been found to be dangerous by an independent panel of medical professionals." State Br. 70. This glosses over the legal significance of CEPP-status.

As the district court explained, "New Jersey psychiatric patients on Conditional Extension Pending Placement ('CEPP') status … were initially involuntarily committed to inpatient [state] hospitals, but have since been determined by the New Jersey Superior Court to no longer constitute a danger to themselves or others and therefore are entitled to discharge. The sole reason for CEPP patients' continued commitment is temporary unavailability of an appropriate placement." JA36.

Involuntary civil commitment is limited to the period during which an individual is "both mentally ill and dangerous," and as soon as the State lacks "clear and convincing evidence that the individual is mentally ill and dangerous," it must release him. *Foucha*, 504 U.S. at 80. The New Jersey Supreme Court recognized these limitations on civil commitment in a case predating *Foucha*, holding that "[w]hen a court determines at a commitment review hearing … that an individual is no longer dangerous to self, others or property by reason of mental illness, the individual shall be entitled to leave the mental hospital and re-enter the community." *In re Commitment of S.L.*, 462 A.2d 1252, 1258 (N.J. 1983). But the court was concerned about the effect of its ruling, because some of the individuals in *S.L.* had been institutionalized for over 30 years and, "[a]lthough legally entitled to leave the mental hospital, they are incapable of completely exercising that right due, in part, to the effects that prolonged confinement has had on their own

personal capacity to survive in the outside world and on their relationships with friends and family who might provide support and assistance." *Id.* at 1258. The court did not want to "pull the rug from under these people" by immediately discharging them from the hospital and "cast them adrift into the community when the individuals are incapable of surviving on their own," so the court went on to hold that "[i]f the court determines that the individual is not able to survive in the community independently or with the help of family or friends, the court shall direct that the individual remain in the institution, but immediately schedule a placement review hearing to occur within 60 days." *Id.* If the court determines at this review hearing that "immediate placement is not possible, the court shall continue the individual's confinement, require that the individual be placed in the environment least restrictive of his or her liberty within the institution, and schedule a subsequent placement review hearing to occur within six months." *Id.* The order to continue confinement of a person entitled to discharge pending an appropriate placement is called "Conditional Extension Pending Placement [CEPP]." N.J. Ct. R. 4:74-7(h)(2).

CEPP is a "narrow exception" to the rule that the State must discharge a person who does not meet the standards for involuntary commitment. *In re Commitment of M.C.*, 896 A.2d 495, 500 (N.J. Super. Ct. App. Div. 2006). CEPP allows the State to continue to hold a person who cannot survive on her own until

she can be placed in a facility that will provide the needed support and assistance. *In re Commitment of G.G.*, 640 A.2d 1156, 1160 (N.J Super. Ct. App. Div. 1994). But New Jersey courts have been clear that the State cannot use CEPP as a means for keeping a person in the state mental hospital so that the State can ensure compliance with a medication plan. *See In re Commitment of M.C.*, 896 A.2d at 503 ("[C]ommitment in order to ensure compliance with a medication schedule to which the patient agrees is not a basis for continuing the commitment of a person who is not mentally ill and dangerous."); *In re Commitment of T.J.*, 949 A.2d 286, 294 (N.J. Super. Ct. App. Div. 2008) ("[T]he trial court's fear of T.J.'s potential relapse without specific aftercare placements designed by the SSPRC, however well-intentioned, is legally insufficient to continue his hospitalization."). Indeed, courts have made clear that "extending an involuntary commitment simply because the hospital has not yet arranged for the periodic follow-up care of a patient not found to be a danger to self, others or property" is an "erroneous approach" that "devalue[s] [a patient's] constitutional right to liberty." *In re Commitment of G.G.*, 640 A.2d at 1161.

To be clear, the State's application of AB 5:04B to CEPP-status persons violates the ADA and Due Process Clause for all the same reasons as those discussed above and in DNRJ's opening brief that apply to involuntarily committed person in state hospitals. But there are additional, legally significant

reasons that applying AB 5:04B to CEPP-status persons violates the ADA and due process.

A. Applying AB 5:04B To CEPP-Status Persons Violates The ADA.

"Dangerousness" is the State's sole justification for why it can apply the procedures of AB 5:04B to restrict the right of persons with mental illness to refuse unwanted psychotropic medication when no other person in New Jersey has his right to refuse treatment subject to similar restrictions. State Br. 29 n.2 ("Dangerous psychiatric patients fall into a unique category."). This is discrimination on the basis of mental illness, as a patient in state facilities who wants to refuse medication for any other illness is competent to exercise that right and cannot be forcibly treated, absent a court order. N.J. Stat. Ann. 30:4-24.2.c. The State impermissibly treats mental illnesses differently and treats persons with mental illness as if they are incompetent to give or withhold consent.

But the State's justification for AB 5:04B is even more baseless for CEPP-status persons because they have been *judicially determined* to no longer be dangerous: A person is placed on CEPP only after a judge determines that the person is "no longer dangerous … by reason of mental illness." *S.L.*, 462 A.2d at 1258. Even under the State's erroneous grafting of a "dangerousness" qualification on the right to refuse treatment, CEPP-status persons meet the State's

definition of qualified individuals with a disability because they have been determined by a court not to be dangerous.

The State justifies applying AB 5:04B to CEPP-status persons because "a CEPP finding … does [not] ensure that a patient will not *in the future* become dangerous if he refuses medication while in state custody." State Br. 69 (emphasis added). But there is no legal basis to apply a policy to a group of people who are not dangerous simply because the State fears they could be dangerous later. And the State cannot justify its discrimination against CEPP-status persons on the grounds that they were once involuntarily committed for having a mental illness and posing a danger; this is purely unlawful discrimination on the basis of mental illness. *Cf. Foucha*, 504 U.S. at 85 (plurality) (concluding that a state violates the Equal Protection Clause by treating insanity acquittees who are no longer mentally ill differently than other classes of persons).

Finally, the State makes no argument in its brief that its application of AB 5:04B to CEPP-status persons is justified by defenses under the ADA. *See* State Br. 71. It is the State's burden to prove a defense under the ADA. *See Frederick L. v. Dep't of Pub. Welfare of Com. of Pa.*, 364 F.3d 487, 492 n.4 (3d Cir. 2004). By failing to brief the application of any defense, the State has waived any argument that such a defense would apply. *Ethypharm S.A. France v. Abbott Labs.*, 707 F.3d 223, 231 n.13 (3d Cir. 2013).

B. Applying AB 5:04B To CEPP-Status Persons Violates Substantive And Procedural Due Process.

The upshot of the State's argument that it can apply AB 5:04B to CEPP-status persons is that a state court could decide that an involuntarily committed person is no longer dangerous to self, others, or property and entitled to be released as soon as appropriate placement can be arranged and then the very next day a hospital panel can order that this same person be subject to *non*-emergency forced medicated because that panel concludes, contrary to the court, that he is dangerous to self, others, or property. Not surprisingly, the district court quickly recognized that this procedure "falls within the paradigm of state action which is arbitrary, conscience-shocking and oppressive in a constitutional sense" and fails to provide requisite procedural protection for involuntarily committed persons' liberty interests. JA36, JA43.

"[T]he touchstone of due process is the protection of the individual against arbitrary action of government, whether the fault lies in a denial of fundamental procedural fairness, or in the exercise of power without any reasonable justification in the service of a legitimate governmental objective." *Cnty. of Sacramento v. Lewis*, 523 U.S. 833, 845 (1998) (citations omitted); *see also Foucha*, 504 U.S. at 80 ("[T]he Due Process Clause contains a substantive component that bars certain arbitrary, wrongful government actions 'regardless of the fairness of the procedures used to implement them.'"). "Freedom from bodily restraint has

always been at the core of the liberty protected by the Due Process Clause from arbitrary governmental action." *Id.* (citing *Youngberg v. Romeo*, 457 U.S. 307, 316 (1982)).

Here, persons on CEPP-status have been judicially determined to no longer be dangerous and therefore entitled to release from civil commitment, and yet the State is claiming the power to forcibly medicate them if a state hospital panel disagrees with the court's conclusion. Whatever else it may encompass, at a minimum due process requires state officials to respect the judgments of state courts. The forcible medication of a person because a state hospital panel thinks they are dangerous when a *state court* has held the exact opposite is exactly the type of abuse of power that is arbitrary and "shocks the conscience." *Lewis*, 523 U.S. at 846.

The only legal authority the State identifies to support involuntarily medicating CEPP-status persons is, unsurprisingly, *Harper*. State Br. 70. The State reasons that because "the policy at issue [in *Harper*] applied to prisoners … who had not been civilly committed" and AB 5:04B mirrors the policy in *Harper*, "the application of A.B. 5:04B to CEPP patients is plainly constitutional." State Br. 70. But *Harper* involved convicted prisoners, who have diminished liberty interests relative to civilly committed individuals, especially those who a court has determined *no longer need to be committed* because they no longer pose a risk of

danger to society. *See Youngberg*, 457 U.S. at 321-22 ("Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.").

The State argues that its motivation for applying AB 5:04B to CEPP-status persons is not "nefarious or discriminatory" but rather is "to alleviate the symptoms of their mental illness and to facilitate their discharge." State Br. 71. But purportedly laudable motivations certainly do not suffice to allow the State to deprive individuals of their constitutionally protected freedoms. *O'Connor*, 422 U.S. at 575; *see also id.* ("[T]he mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution."). So too, the State cannot use CEPP status as a means for medicating a person against her will merely because the State believes it will "alleviate the symptoms" of her mental illness. State Br. 71; *In re Commitment of G.G.*, 640 A.2d at 1160.

Applying AB 5:04B to CEPP-status persons also violates their procedural due process rights. These are individuals who are entitled to be released because a judge has determined that they *no longer* meet the requirements for involuntary commitment. The liberty interest that may have been diminished by civil commitment has thus been restored, as CEPP-status individuals cannot be involuntarily re-committed unless the State proves to a court the basis for re-

commitment by clear and convincing evidence. *See In re Commitment of B.L.*, 787 A.2d 928, 935-36 (N.J. Super. Ct. App. Div. 2002) (holding that involuntary recommitment of a person discharged on conditional release requires a court hearing in which basis for recommitment is established by clear and convincing evidence); *In re A.R.*, No. 894-09, 2012 WL 1697061 (N.J. Super. A.D. May 16, 2012) (reversing the recommitment of a CEPP-status person because the State did not provide legally competent evidence to justify involuntary civil commitment); *see also McNeil v. Dir., Patuxent Inst.*, 407 U.S. 245, 249-50 (1972) (after the expiration of a prison sentence, state must follow procedures for civil commitment to continue treating a prisoner); *Humphrey v. Cady*, 405 U.S. 504, 511 (1972); *Baxstrom v Herold*, 383 U.S. 107, 110 (1966); *In re Perruso*, 896 A.2d 255, 259 (D.C. 2006) ("A trial court's revocation of outpatient commitment status resulting in inpatient hospitalization must be based on clear and convincing evidence … .").

This restored liberty interest demands greater procedural protection than that provided by AB 5:04B. *See Morrisey v. Brewer*, 408 U.S. 471, 481 (1972). The State's interest in applying its non-emergency forced medication Policy to CEPP-status persons is minimal. The State already has procedures for involuntary medication in an emergency. And if a person continues to be dangerous past the 72 hours allowed for emergency involuntary medication, then that person is likely subject to re-commitment, which would require a hearing before a judge. At these

hearings, the State can request that a judge determine that the constitutional standard for involuntary medication is met or that the person is incompetent and the State can make medical treatment decisions for the person. The State concedes that, before the district court's order, AB 5:04B "was very rarely applied to CEPP patients." State Br. 69 n.14. The district court's injunction against applying AB 5:04B to CEPP-status persons, who have been judicially determined to not be dangerous, simply took away a power the State does not need, and should not have.

CONCLUSION

For the foregoing reasons, this Court should reverse the district court's grant of summary judgment to the State with respect to the patients in New Jersey psychiatric hospitals who are not CEPP status, should grant judgment to DRNJ that AB 5:04B violates the ADA, RA, Due Process Clause, and right of access to courts for all persons in the State's psychiatric hospitals, and should enjoin AB 5:04B.

This Court should affirm the district court's grant of summary judgment to DRNJ that AB 5:04B violates the ADA, RA, and Due Process Clause with respect to CEPP-status persons.

August 27, 2014

Respectfully submitted,

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This brief complies with Federal Rule of Appellate Procedure 32(a)(7) because it is proportionately spaced, has a typeface of 14 points or more, and contains 13,669 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

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August 27, 2014

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Pursuant to Local Appellate Rule 46.1(e), the undersigned certifies that at least one of the attorneys whose name appears on the brief is a member of the bar of the United States Court of Appeals for the Third Circuit.

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13-4255, 13-4405

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