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Mental Health Matters

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

Letter from the chair

BY SANDY BLAKE

In this issue of *Mental Health Matters*, we continue our work and the conversation about mental health issues. We report on the efforts of Dentons and Mayer Brown, joined by Equip for Equality and Uptown People's Law Center in securing a permanent injunction in federal court in a lawsuit against the Illinois Department of Corrections.

We also examine the limited circumstances under which treatment providers may administer involuntary medication to a patient without prior consent from a court.

Let's keep the conversation going. ■

Sandy Blake is an assistant public defender in Kane County. Her practice currently focuses on defense of involuntary admission and treatment petitions, defense of sexually violent persons petitions, and post-conviction matters.

Recognizing and respecting the limitations of emergency medications

BY SARAH BERKOWITZ AND MATTHEW R. DAVISON

An adult recipient of mental health services in Illinois has the right to refuse medication. A refusal must be honored, except in two circumstances.

In the first circumstance, upon a written petition, a circuit court finds by "clear and convincing" evidence that the recipient meets certain statutory criteria. This first scenario typically occurs in a "nonemergency" setting and is subject to a variety of safeguards (including expert testimony and cross-examination of the same).

In the second circumstance, which is the subject of this article, administration of medication is due to a perceived "emergency", something that is oftentimes subjective, and therefore, can potentially violate an individual's rights. Unlike the first-described situation, where judicial involvement is mandated (along with a burden of proof), this second circumstance involves administering medications without prior consent from a court. Given this, clarity and consistency in the administration of such medications in an emergency setting is imperative. Illinois law provides a statutory framework for such situations, but concern and confusion continue to dominate the landscape statewide over when psychotropic medications may be administered in an "emergency" despite a recipient's refusal.

To understand how a valid application of emergency medications works in practice, one should begin with the premise that a refusal of medication is a right. If services are refused, then "[treatment] shall not be given unless such services are necessary to prevent the recipient from causing serious and

Continued on next page

Recognizing and respecting the limitations of emergency medications

CONTINUED FROM PAGE 1

imminent physical harm to the recipient or others and no less restrictive alternative is available." This "exception of necessity" is commonly referred to as "emergency treatment". As set forth below, a facility's deployment of such treatment must follow strict statutory framework and heed its limitations.

Given that the statute contemplates emergency treatment as necessary to prevent "serious and imminent physical harm" to themselves or others, one may initially conclude that such events are momentary and likely only arise during a scenario lasting mere minutes. Accordingly, the application of forced medication should correlate with said limited timeframe. In practice, however, some treatment centers and practitioners may employ a far-too-generous application of the statute's contemplation of when treatment is necessary to prevent imminent harm and how long such treatment is needed to assuage any immediate concerns.

Any extended administration of such refused medications (or blatant overuse) must square with the Mental Health and Development Disabilities Code (the "Code"), which warns "[p]sychotropic medication or electroconvulsive therapy may be administered under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient›s record." In other words, the rationale for all treatment, as described above, must be clearly documented. Failure to clearly document the treatment given and why the treatment was given can only invite future scrutiny and potential litigation.

The administration of emergency medications can be traumatizing, particularly when this treatment is given involuntarily. However, at times, such drastic treatment measures must be taken in order to immediately protect the well-being of the patient and those around them as stated in 405 ILCS 5/2- 107(a). When administering these types of emergency and short-lasting treatments, health care professionals must carefully re-evaluate and document the need for the treatment every 24 hours and remain mindful of a hard "cap" 72-hour limitation window of time in which such medications may be consistently administered (even if every 24 hours the need for treatment is re-justified).

These articulated limitations sometimes give rise to confusion among practitioners. The most common source of disagreement or uncertainty stems from 405 ILCS 5/2-107(d) which states in part that: "[n]either psychotropic medication nor electroconvulsive therapy may be administered under this section for a period in excess of 72 hours…unless a petition is filed…and treatment continues to be deemed necessary, by a health care provider."

Some psychiatrists and staff assume this to mean that an individual may be medicated for 72 hours by "emergency" without much additional thought or documentation. However, and to reiterate, even if such a period of medication is deemed "necessary", the facts and supporting record for such a prolonged treatment without court oversight must still be redetermined (and recorded) at least every 24 hours during that 72-hour window and must be "based upon a personal examination of the recipient by a physician or a nurse under the supervision of a physician". This daily redetermination serves as a stopgap to ensure treatment teams are not initially adjudicating an emergency and then going on to administer prolonged, forced medications without any documented reassessment of the facts constituting the emergency. Given the drastic implications of forced medications, this 24-hour written reassessment is a small "ask" of the facility and treaters should be mindful of its requirements.

By contrast, consider the provider's options if the treatment team concurrently filed a petition pursuant to 405 ILCS 5/2–107.1(a–5)(4). If a petition was pending, and the necessary factors were present to

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constitute an emergency, then the 72-hour cap would not apply. What's more, consider an unsettling application of the statute if "emergency" medications were administered consistently from Tuesday all the way up through a Sunday without a break. If an advocate for the patient contends that such emergency medication was an abuse, what is the response by the treatment team if the Thursday of that week also happened to be on a holiday?

An additional (and significant) limitation that some staff altogether disregard (or aren't aware of) is that long-acting psychotropic medications (commonly referred to long acting injectable antipsychotics or LAIs) should never be administered as "emergency" medication. Unlike the administration of emergency medications, the use of an LAI such as haloperidol decanoate, which is given *via* intramuscular injection, has effects which can last up to 30 days. Such treatment, by definition, lasts much longer than medications typically used in a psychiatric emergency (such as short-acting haloperidol or Thorazine or Zyprexa). LAIs are prohibited from being administered involuntarily without a petition being filed (and granted) which specifically states that a patient needs to receive the long-acting antipsychotic medication. The policy and logic behind this distinction should be apparent but some treatment teams, unfortunately, must be reminded why such a potent and long-acting medication must not be given without a full hearing on the various factors set forth by Illinois law. Absent a court order, paternalism must yield to autonomy.

It is understandable that some treatment teams may feel frustrated or impatient with the law's limitations regarding forced emergency medication. An alternate angle to consider is that emergencies are fact-based events. The facts that motivate one psychiatrist to invoke medication to "prevent serious and imminent harm" may not be the same for another psychiatrist. Further, such decisions are not judicially reviewed or scrutinized by authorities *prior* to treatment. Because of this, limitations are important. Similarly, some experts even contend that recognizing a patient's right to refuse (and making that refusal easier and respected) can actually lead to more and more patients consenting to medication.

Simply stated, emergency medications are for emergencies. Time and again, there is an ever-growing suspicion that some facilities overutilize the emergency treatment statute in lieu of filing a court proceeding that would require time, attention and scrutiny. This is fundamentally improper and emergency medications are ***not*** a substitute for substantive, dedicated treatment. Hospital teams should routinely be asking themselves whether their aim is to "get someone out" of a facility by quick-acting medications or "keep someone out" by engaging in collaborative care plans and long-view discharge planning. Such introspection may not only save the hospital time, money and repeated admissions, but ultimately it could accomplish what motivated care from the very beginning: a person with better health, insight and comprehensive care. ■

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1. Of course, there are exceptions to the exceptions that exist outside the scope of this article such as designations and directions made pursuant to an advance directive. For example, as recently as August 3, 2018, Public Act 100-0710 provides that "psychotropic medication or electroconvulsive therapy may be administered 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 **over the objection of the recipient** if the recipient has not revoked the power of attorney or declaration for mental health treatment as provided in the relevant statute." http://www.ilga.gov/legislation/publicacts/100/PDF/100-0710.pdf (emphasis added). The wisdom and practicality of such an Act may be questioned and debated in a subsequent and separate commentary.
2. See 405 ILCS 5/2–107.1(a–5)(4).
3. See, *e.g.*, Ben Hattem, *NYC Hospital Uses Forced Medication to Compel Blood Work* (Dec. 8, 2015), https://citylimits.org/2015/12/08/nyc-hospital-uses-forced-medication-to-compel-blood-work/ (this article highlights several different instances including where "a patient asked to speak with an attorney and was given an injection 'to complete a medical evaluation.' In another, a patient given an injection under emergency circumstances was also given a second sedative dose 'because he refused blood work.' In another, an injection was ordered because a patient "continued to refuse" blood work, and was discontinued when the patient said he was ready to have blood drawn. None of the records included in the complaint mention violence or present dangerousness…").
4. 405 ILCS 5/2-107(a).
5. *Id*.
6. 405 ILCS 5/2-107(b).
7. See, *e.g.*, *Hirschfeld v. New York City Health and Hospitals Corporation, et al.*, 07-cv-1819, available at: http://psychrights.org/states/NewYork/KingsCtyHosC-complaint.pdf. This case was brought by New York's Mental Hygiene Legal Service and sought an injunction against Kings County Hospital Center from unlawfully administering forced medications.
8. See Hattem, *supra* note 3 (detailing how one expert posits that individuals in emergency rooms may arrive calm but, after hours of waiting and delays, grow frustrated and the situation escalates to eventually result in forced medications. The author goes on to note that recipients of mental health care with a history of trauma grow hesitant to secure treatment at facilities where they've previously experienced forced medication).
9. See, *e.g.*, Human Rights Authority - Chicago Region Report 08-030-9004, https://www2.illinois.gov/sites/gac/HRA/Reports/2008/08-030-9004.pdf, (in this matter, the HRA examined two instances of forced emergency medications involving throwing a telephone and pushing staff and found that both incidents were sufficiently documented to justify the facility's decision to administer medication).
10. 405 ILCS 5/2-107(c) and (d).
11. *Id*.
12. *Id*.
13. See, *e.g.*, Human Rights Authority - Chicago Region Report 14-030-9025, https://www2.illinois.gov/sites/gac/HRA/Reports/2014/14-030-9025.pdf (The Illinois Human Rights Authority substantiated a complaint that Chicago Read Mental Health Center did not follow the Mental Health Code when it administered emergency medications to an individual. Specifically, the investigation found that the facts involved (slamming doors and attempting to make phone calls) did not amount to the required threat level to be deemed an "emergency". Further, the investigation revealed that the emergency medication order was initiated as a prospective 3-day order and was additionally in violation of the redetermination requirements set forth in 405 ILS 5/2-107.
14. *See* 405 ILCS 5/2-107 (d) which excludes consideration of Saturday and Sunday from the 72-hour window of limitations as well as any "holidays". Notwithstanding the example, one must always remember that an emergency must be present, and the facts must be supportive of the application of such treatment and a daily reassessment must be documented.
15. 405 ILCS 5/2-107(g).
16. See Elyn Saks, *The Consent Dilemma* (Aug. 8, 2017), https://www.politico.com/agenda/story/2017/08/09/drug-treatment-mental-illness-000491.

Mentally ill inmates continue to suffer 10 years after filing class action lawsuit

A federal court has found that the state of Illinois continues to violate the constitutional rights of more than 12,000 prisoners with mental illness.

The finding comes even after the case had reached a settlement agreement in 2016, but the plaintiffs had to return to court when the Illinois Department of Corrections (IDOC) failed to live up to its agreement and constitutional violations continued, according to the plaintiffs' lead counsel, Harold Hirshman, senior counsel for Dentons.

The court issued a 50-page decision finding that the IDOC has been deliberately indifferent to prisoners' mental health, in violation of the Eighth Amendment.

"It is clear mentally ill inmates continue to suffer as they wait for the IDOC to do what it said it was going to do," Judge Michael M. Mihm said. The court described the changes needed to IDOC's mental health care as "monumental." (Order pg. 40)

The court-appointed monitor and doctors for IDOC testified the mental health care in Illinois' prisons is "dangerous" and an "emergency." The court expressed concern "with the overall lack of a sense of urgency" in response to the harms being done to prisoners with mental illness.

The court order finds that prisoners in acute mental health crisis—those with worsening psychosis, or who are actively suicidal—are not provided with the mental health treatment needed to stabilize. Instead, they are locked in seclusion cells 24 hours a day with nothing to do, with only 15-minute treatment sessions each day. Hundreds of Illinois prisoners are placed on these "crisis watches" each month. In one recent month, 121 such prisoners remained locked in those isolation cells for over 10 days.

The order also addresses solitary confinement, which is known to exacerbate mental illness. IDOC staff testified to the negative impact of solitary confinement on those with mental illness, yet more than 80 percent of Illinois prisoners in solitary are classified as mentally ill. The court-appointed monitor, Dr. Pablo Stewart, testified that this issue was as serious as any he has seen in his career, and that Illinois prisoners with mental illness in solitary are "suffering immensely."

The permanent injunction found that the violations are largely caused by "systemic and gross deficiencies in staffing." Reports showed that Wexford Health Sources, Inc.—the private company that IDOC pays to provide mental health care in all its prisons—failed to provide more than 10,000 hours of clinical staff time required by its contract to deliver mental health treatment to Illinois prisoners. As a result, many prisoners' psychiatric medication is not managed, and people often just stop taking their medications. Thousands of prisoners are in danger because of the lack of needed medication management.

In a 2016 settlement agreement, IDOC agreed to provide at least eight hours of structured out-of-cell time each week to those in solitary confinement, but evidence at trial showed that the prisoners received only two to four hours per week, mostly provided through weekly movies. The court found that this is insufficient: "It is generally accepted that out-of-cell time for mentally ill inmates in segregation is necessary to avoid a rapid decline in mental health."

"Thousands of people with mental illness throughout Illinois prisons are suffering needlessly from mental illness that could be treated. Their conditions are getting worse during their incarcerations, when our state needs to provide the care needed to make them better so that they can go home to their families and communities." said Amanda Antholt, senior attorney at Equip for Equality and one of the attorneys representing the plaintiffs. "It should not take years of litigation, and multiple court orders, to get the state to provide even the most minimal care to people who are desperately in need."

Equip for Equality is a private, not-for-profit legal advocacy organization and is the federally mandated Protection & Advocacy System designated to safeguard the rights of people with physical and mental disabilities.

"Prisoners in Illinois with mental illness have been tortured for far too long. We are thrilled that the court sees this injustice and that there will be federal oversight of the care provided to this vulnerable population," said Alan Mills, executive director of Uptown People's Law Center (UPLC) and one of the attorneys representing the plaintiffs.

UPLC is a nonprofit legal services organization specializing in prisoners' rights, Social Security disability, and tenants' rights and eviction defense. UPLC currently has seven pending class action lawsuits regarding jail and prison conditions.

"We are gratified that Judge Mihm viewed the evidence at both the preliminary and permanent injunction hearings as supporting the claim that the IDOC was failing to provide adequate mental health care to the thousands of inmates who so badly need it. We remain frustrated that despite the IDOC's promises, such legal action was necessary. The IDOC knew what the Constitution required and simply ignored its obligations to these sick prisoners who have nowhere to go for care. A civilized society cares for the helpless. The IDOC has shirked this responsibility year after year. They should be ashamed," noted lead counsel Hirshman.

The court's order follows a June 8, 2018, report by the independent court-appointed monitor, Dr. Stewart, that IDOC has failed to comply with 18 of the 25 terms that it previously agreed to with a settlement agreement. The order gives the IDOC two weeks to submit a proposal to address the constitutional deficiencies. The plaintiffs will then have one week to respond to that proposal.

Case No. 1:07-cv-01298-MMM (Central District of Illinois)

A copy of the judge's order can be found at https://www.uplcchicago.org/what-we-do/prison/rasho-v-baldwin.html

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