ILLINOIS STATE BAR ASSOCIATION

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Mental Health Matters

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

Editor's Note

BY SANDRA M. BLAKE

Now is a truly exciting time to be a mental health law practitioner.

Mental Health Matters reported on the six sessions of the Illinois Mental Health Summit series, *Improving the Court and Community Response to Persons with Mental Illness and Co-Occurring Disorders through Compassion and Hope,* held virtually from September-December 2020. As a final product of the summit series, the National Center for State Courts drafted and issued a 2020 Illinois Mental Health Summit Report, available at https://www.illinoiscourts.gov/courts/additional-resources/mental-health-task-force/

On December 7, the Illinois Supreme Court and National Center for State Courts hosted a **Report Release Web Event: A Call to Action** to present an overview of national initiatives, report findings, and Illinois Mental Health Task Force next steps.

In announcing the event, the court noted, "Ultimately, the results of the Regional Mapping Workshops will inform

Continued on next page

You Are Not Alone

BY YASMINE A. OWAYNAT & E. KENNETH WRIGHT

The discourse surrounding mental illness is overwhelmed with stigmas and stereotypes that impede people from seeking or fully participating in mental health services. "Mental illnesses are associated with weakness; to appear weak is the last thing an athlete wants,"[1] says Victoria Garrick, a professional volleyball player from the University of Southern California. "The culture we live in as athletes does not make it easy to honor [taking a break], if you think about it, the culture of athletics preaches: 'where there is a will there is a way,' and 'the best don't rest, unless you puke, faint or die, keep going,'"[2] she explains.

"During water breaks I would run to the bathroom and sob, because for five seconds I just wanted my day to stop!... I told myself I was weak for wanting a break,"[3] explains Garrick. "I can remember a few times that I was biking, and I was thinking if this car would accidently hit me, that would stop my week, that would give me the break that I so badly need,"[4] she says. This is the reality among most athletes, because the stigma surrounding mental health issues makes it difficult for them to come forward.

During competition, one mistake can cause devastating consequences. For that reason, athletes often suffer from anxiety, depression, and other mental health challenges that go unnoticed. This stigma

Continued on page 3

Editor's Note

CONTINUED FROM PAGE 1

a statewide vision of what a behavioral health continuum of care with multiple diversion pathways should look like in Illinois and lead to development of a plan and pilot projects to improve court and community responses to mental health and co-occurring disorders." After completion of the Resource Mapping Workshops, it is hoped that each community and region will sustain efforts through ongoing Councils or leveraging efforts through collaboration with established coordinating councils, task forces, and coalitions.

"The release of the Summit Report and the recent hire of a Statewide Behavioral Health Administrator to facilitate the Task Force equips the Supreme Court with a road map and resource to continue leading the change at the intersection of behavioral health and justice. My Supreme Court colleagues and I thank everyone involved in the summit series and heeding this call to action," said Hon. Chief Justice Anne M. Burke.

For further information regarding the Illinois Mental Health Task Force, visit https://www.illinoiscourts.gov/courts/additional-resources/mental-health-task-force/ or contact Scott Block, Statewide Behavioral Health Administrator, Administrative Office of the Illinois Courts, at sblock@illinoiscourts.gov or (312) 793-1876.

Also, watch future issues of *Mental Health Matters* for reports on statewide projects as the momentum moves us forward. ■

You Are Not Alone

CONTINUED FROM PAGE 1

has created a culture for athletes where social acceptance takes precedence over mental health. As a result, athletes suffer from the fear of the consequences that may result from seeking help. They fear that seeking help may affect their career, or be reported to management. Thus, they choose to suffer alone with the pressure and constant scrutiny. Due to this stigma, athletes lack knowledge of mental illnesses, programs, and other forms of assistance, nor do they have the time to seek and receive treatment.[5]

The Struggles of a Professional Baseball Player

A professional baseball player, who asked to remain anonymous, explained in an interview the effects playing at the professional level has on an athlete's self-esteem. He explained, "Prior to being drafted, I was the man, best on every team, looked up to everywhere I went. Making it to the professional level tested how mentally strong I am."

"It is difficult to cope when others are constantly competing to steal your place, and it is tough when you have toconstantly prove your worth," he said. "Sometimes I would doubt whether I am valuable, worth it, or even good enough. I would have to remind myself that I am," he said. "You can be dropped just like that and nobody will question the decision. The team chemistry is different than it was in high school," he explained.

When asked how he coped, he said: "I learned that baseball is a game of failure; you mustcontinuously develop and learn to accept it. Practice is key. Practicing mentally is just as important as practicing physically, if not more important." He explained: "I sometimes imagine myself in a different setting, off the field, in a happy place." His teammates use other methods including yoga, meditation, phone applications, and talking to field coaches. "2021 is the first year that the MLB has a mental coach, and it has changed many lives. The players now have an outlet to go to, someone to talk to, confidentially, without the fear of being exposed," he added.

Mental Health Matters

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Mindfulness Is Training Not Meditation

There must be a new approach towards mental health in the athletic world. It is insufficient to merely suggest an ending to this stigma. We must go further towards reeducating athletes, coaches, and other such contributors on the imperatives of incorporating mindfulness into athletic training. In revealing the complementary nature of mindfulness and training, coaches may adopt practices that benefit athletes and their teams as a whole. The National Football League (NFL), Major League Baseball (MLB), and other organizations are now mandating that every team has a psychologist on staff. This is a huge step forward for mental health, and for athletic performances.

In addition, however, athletes at all levels should be consistently evaluated, and receivemedicine and therapy through their schools and organizations. Coaches must include mental health practice in daily or at least weekly practices to educate athletes about mental health in order for them to overcome any struggles that they may be facing alone.

Attorneys' Struggle

The feeling of failure is not foreign to lawyers, especially young ones. The constant worrying about being prepared, forgetting due dates or a trial date, or forgetting to admit a piece of evidence that may have cost the entire case, the list goes on. Attorneys, just like athletes, fear making a mistake, because even a little mistake is tremendously costly.

How Do We Cope When Mistakes Are Costly?

Practicing mindfulness should not be seen as a weakness, but rather it should be incorporated in athletes' practices. In an interview, Dr. Stephanie Hernandez[6] defined mindfulness as "the practice of being present." The goal is to be aware of what is going on around you rather than live in the past, she explained. "Practicing mindfulness can change the structure of your brain and neural chemistry,"[7] says Dr. Michael Gervais,[8] a high performance psychologist who works in high-stakes environments with some of the best in the world.[9] It is important to practice mindfulness in order to cope with the never-ending distractions in life, including your own negative thoughts.

Dr. Gervais's method includes creating a personal philosophy that will guide you in times of stress. He emphasizes the importance of understanding yourself by identifying the guiding principal that sits beneath your thoughts, words, and actions. Write down 25 words or less to explain what it is you stand for, and that will allow you to avoid the loud noises that pull you away, says Dr. Gervais.[10]

Dr. Gervais also emphasizes the importance of having a conviction of those principals; he adds, "Train your mind to be calm, confident, and optimistic in any environment…just like training your body to be strong and flexible."[11] Optimism is the fundamental belief that everything will work out, "so train your mind to stay in it, even when it's hard," he says. At the end of your day, Dr. Gervais recommends writing down three things that are amazing in your life. A study from the University of Pennsylvania found that doing this will train your mind to become more optimistic, explained Dr. Gervais.[12] Also, observe your own thoughts and emotions by doing single-point focus exercises like focusing on a candle or your breath, and when your mind wanders, refocus it, "just simply saying hello and goodbye to the distraction and then coming right back to the one thing," says Dr. Gervais, will sharpen your mind.[13]

"In times of stress, take a deep breath, think of a peaceful situation like being on the beach, and let go of all the bad thoughts and judgment," Dr. Hernandez adds. "Imagine stress being on something moving and watch it as it pushes away." These techniques will cause real changes in stress responses like reduced blood pressure, increased blood circulation, reduced anxiety, reduced stress, regulated sleep, regulated mood, decreased fatigue, improved memory recall, and improved attention. There is a whole list of benefits from practicing mindfulness.

"Practice coping and mindful techniques like you would practice for a game [or a trial]," emphasizes Dr. Hernandez. "Mental health isn't only for people with impairment, it is for everyone. It is important to treat your mind just as you treat your body," she adds.

Conclusion

When mistakes could cost limbs or lives and the consequences are immense, mental illnesses are inevitable. We must learn to cope in high-stakes environments by taking control of our mind when times get stressful. We must learn what mental perseverance looks and feels like, and understand that mental health struggles are universal. In turn, that will pave the way towards normalizing seeking help. We also must learn to cope on an individual level. To cope, we must have a philosophy to fall back on; we must be in control of our mind, and in order to do that we must train our mind by practicing mindfulness. We cannot be afraid to seek help. It does not make us weak or different. We all suffer, but only some of us are strong enough to do something about it.■

Yasmine A. Owaynat is a Judicial Law Clerk, and E. Kenneth Wright is the presiding judge,First Municipal District, Circuit Court of Cook County.

1. Tedx Talks (2017, June 2). *Athletes and Mental Health: The Hidden Opponent* [Video]. YouTube. https://www.youtube.com/watch?v=Sdk7pLpbIls.
2. *Id.*
3. *Id.*
4. *Id.*
5. *Id.*
6. Dr. Stephanie Hernandez is a psychiatrist at the Baylor College of Medicine in Houston, Texas.
7. GQ. (2019, November 19). *How the Seahawks Sports Psychologist Trains the Team* [Video]. YouTube. https://www.gq.com/video/watch/the-assist-how-the-seahawks-sports-psychologist-trains-the team#:~:text=Meet%20Mike%20Gervais%2C%20 the%20sports%20psychologist%20for%20 the,game%20is%20im portant.%20for%20the%20 past%20eight%20years.
8. Dr. Michael Gervais has a master's degree in sports science and a PhD in psychology, and currently works with the NFL's Seattle Seahawks.
9. Finding Mastery. (2020). *About Dr. Michael Gervais*. https://findingmastery.net/about-michael-gervais/
10. GQ. (2019, November 19). *How the Seahawks Sports Psychologist Trains the Team* [Video]. YouTube. https://www.gq.com/video/watch/the-assist-how-the-seahawks-sports-psychologist-trains-the team#:~:text=Meet%20Mike%20Gervais%2C%20 the%20sports%20psychologist%20for%20 the,game%20is%20im portant.%20for%20the%20 past%20eight%20years.
11. *Id.*
12. *Id.*
13. *Id.*

Appellate Summary

BY ANDREAS LIEWALD

In re Hans T., 2021 IL App (2d) 180387 (August 4, 2021)

The Second District appellate court reversed an order subjecting respondent, Hans T., to involuntary admission on an outpatient basis, under which he was required to reside in a locked unit of a nursing home for 180 days. ¶1. The appellate court agreed with the respondent that the order was essentially an order for involuntary admission on an inpatient basis, without the statutory procedures and findings necessary to impose such an order, and for twice the time permitted for an initial involuntary inpatient admission. ¶1.

Background

Central DuPage Hospital filed documents seeking the involuntary outpatient admission of respondent, alleging that he was a person with a mental illness that, if left untreated, was reasonably expected to result in increase in symptoms to the point that he would meet the criteria for commitment and whose illness had more than once caused him to refuse needed and appropriate mental health services in the community. ¶3. The hospital alleged that respondent had been admitted to inpatient treatment several times and that he returned because he was unable to function in his home, in that he was noncompliant with his medications and aggressive with his mother. ¶3. The State then filed a motion for the care and custody of respondent for community placement, seeking to place respondent in a residential facility upon discharge from the hospital, have his mother named as his custodian, and for him to take all prescribed medication, which it listed. ¶4.

At the involuntary admission hearing, respondent's mother, respondent's social worker, and psychiatrist recommended and requested that respondent be placed at Aperion Care Center (Aperion), an intermediate care facility – nursing home, where patients were not allowed to leave freely, for the maximum of 180 days. ¶5-7. Respondent's attorney moved for a directed finding, arguing that, although the petition was for 180 days of outpatient treatment, the State and hospital were requesting to place respondent in a secure facility on an inpatient basis for 180 days, which the trial court denied. ¶8. Respondent then testified on his own behalf. ¶9. In closing, respondent's attorney argued, inter alia, that the statute governing outpatient admission allowed someone to be admitted for up to 180 days, because outpatient treatment was a less restrictive setting than inpatient treatment, which the statute governing inpatient admission limited to 90 days. ¶10. The attorney argued that the State was improperly trying to combine the provisions of both statutes. ¶10.

The trial court stated that it was taking judicial notice that respondent was found unfit to stand trial in 2010. ¶11. It stated that the testimony at the hearing was essentially unrebutted and that respondent had made many statements that were divorced from reality and underscored the need for continued treatment. ¶11. The trial court granted the petition. ¶11.

Respondent filed a motion to reconsider, arguing that no reasonable definition of outpatient treatment entailed a person being physically confined to a hospital against his will. ¶12. The trial court stated that it would grant the motion to reconsider to correct certain scrivener's errors, such as a box being checked next to the statement that the period of "hospitalization" shall not exceed 180 days. ¶12. It stated that the order's intent was not that respondent be hospitalized but rather that respondent's mother would be his custodian and that the least restrictive environment for him would be custody by and through his mother at Aperion. ¶12. The trial court did not consider Aperion the same as inpatient hospitalization. ¶12.

Respondent filed a notice of appeal, arguing that (1) his due process rights were violated when the trial court involuntarily committed him to inpatient treatment in a nursing home under the section of the Mental Health and Developmental Disabilities Code (Mental Health Code) (405 ILCS 5/1-100 et seq (West 2018)) governing outpatient treatment (section 3-818), which has less stringent standards and is up to 180 days, twice as long as permitted for inpatient commitment; (2) the involuntary admission order was void for lack of statutory authority, because it required him to take medications, including psychotropic medications; (3) he was denied a fair trial when the trial court sua sponte took judicial notice of a matter outside the record after the close of evidence and relied on the information and its findings; and (4) this appeal fell within exceptions to the mootness doctrine. ¶13.

The state thereafter filed a confession of error, agreeing that the trial court's order should be reversed because the Mental Health Code requires separate hearings for involuntary admission and for involuntary treatment with medications, and also because respondent should not have been committed to an inpatient facility for 180 days after an outpatient commitment proceeding. ¶14. The appellate court initially issued a minute order that accepted the State's confession of error, reversed the trial court's order, and served as the mandate. ¶14. Respondent then filed a motion with the appellate court to recall the mandate and issue an opinion. ¶15. Respondent argued that the appellate court should issue an opinion because there was no case law providing guidance about the difference between an order for involuntary inpatient admission and an order for involuntary outpatient admission, nor was there case law addressing the authorization of involuntary medication in an involuntary outpatient order. ¶15.

The appellate court granted respondent's request to recall the mandate. ¶16. It vacated the minute order and ordered that his request for the new decision to be an opinion would be taken. ¶16.

Analysis

Mootness

The appellate court found that the public interest exception to the mootness doctrine applied to the issue of involuntary inpatient admission versus outpatient admission. ¶21. First, the issue was of public nature, involving construing portions of the Mental Health Code, as opposed to being a case-specific concern. ¶20, 21. Second, there was a need for an authoritative determination to guide public officers, because as the trial court pointed out, there was no case law on this subject. ¶20, 21. Last, a future recurrence of the question was likely because mental health patients often face involuntary commitment to nursing home settings. ¶20, 21.

However, the appellate court did not find the public interest exception to the issue of whether the trial court lacked authority to order medication as part of its involuntary admission order because the appellate case law is clear that the trial court must hold separate hearings on petitions to involuntary administer psychotropic medication and for involuntary admission. Citing 405 ILCS 5/2-107.1; In re David M., 2013 IL App (4th) 121004, ¶¶35-38; In re E.F., 2014 IL App (3d) 130814, ¶48; and In re Sharon H., 2016 IL App (3d) 140980, ¶31. ¶22. An involuntary admission hearing can be for admission on either an inpatient basis or an outpatient basis. Citing 405 ILCS 5/119 and 119.1 (West). ¶22. The appellate court also did not find the capable of repetition yet avoiding review exception to be applicable to this issue because the State had already conceded error on this issue as it pertains to respondent, so it was very unlikely that the issue would recur with him. ¶23.

Finally, the appellate court held that because respondent did not argue the issue that the trial court erred in sua sponte taking judicial notice of respondent previously being found unfit to stand trial in his motion to recall the mandate, it would not address the issue. ¶24.

Involuntary Inpatient Admission Versus Involuntary Outpatient Admission

The appellate court agreed with respondent that the nursing home to which respondent was ordered was a licensed private hospital under the Mental Health Code, the statutes defining "mental health facility" and "licensed private hospital", and consistent with Muellner v. Blessing. ¶31, 35. Citing 405 ILCS 5/1-112, 113, and 114 (West 2018); and Muellner v. Blessing Hosp., 335 Ill. App. 3d 1079, 1083 (4th Dist. 2002). The appellate court held that the order for care and custody thus could not give respondent's mother the authority to require respondent to stay at a nursing home facility under the terms set forth by the court, which effectively ordered respondent's "hospitalization." ¶35.

The appellate court found that the trial court ordered the respondent be involuntarily admitted on an inpatient basis to Aperion, a nursing home, even though Central DuPage Hospital filed a petition for involuntary outpatient admission. ¶33. As respondent highlighted, the statute governing involuntary inpatient admission contains stricter criteria than that for involuntary outpatient admission, in that it requires a showing that respondents would otherwise be reasonably expected to place themselves or others in physical harm, are incapable of independently caring for their basic physical needs so as to prevent serious harm to themselves, or do not understand the need for and refuses treatment such that they are reasonably expected to suffer mental or emotional deterioration to the extent that they meet one of the first two criteria. Citing 405 ILCS 5/1-119 (West 2018). ¶33. Because involuntary inpatient admission severely curtails a person's liberty, initial commitment orders are limited to 90 days. Citing In re Barbara H., 183 Ill. 2d 482, 496 (1998) and 405 ILCS 5/3-813(a)(West 2018).

The appellate court found, in contrast, involuntary admission on an outpatient basis requires a showing that either (1) a person would meet the criteria for inpatient admission without treatment on an outpatient basis and for whom such treatment can be reasonably ensured only through court order, or (2) a person has a mental illness that, without treatment, is reasonably expected to progress to the point that the person would meet the criteria for involuntary inpatient admission, and whose mental illness has previously caused the person to refuse necessary mental health services. Citing 405 ILCS 5/1-119.1 and 5/3-813. ¶34. "As outpatient treatment does not involve overnight hospitalization, it is not as severe an impairment to a person's liberty as inpatient treatment, and thus an initial order of commitment on an outpatient basis may be for a longer period of time, specifically up to 180 days. ¶34. The appellate court accordingly found that the trial court erred by granting the petition for involuntary outpatient admission where the treatment ordered fell within the category of involuntary inpatient admission." ¶34.

The appellate court agreed with the respondent that the fact that the trial court entered an order placing respondent in the care and custody of his mother did not affect the above analysis. ¶35. Section 3-812(a) of the Mental Health Code states

"If a respondent is found subject to involuntary admission on an outpatient basis, the court may issue an order: (i) placing the respondent in the care and custody of a relative or other person willing and able to properly care for him or her; or (ii) committing the respondent to alternative treatment at a community mental health provider." 405 ILCS 5/3-812(a). ¶35.

"First, the statute applies if the trial court finds that a respondent is subject to involuntary admission on an outpatient basis, whereas here the trial court effectively ordered respondent committed on an inpatient basis. Second the statute states that the trial court may order the respondent to either be placed in the care and custody of an individual willing to properly care for him or her or be committed to alternative treatment at a community mental health provider. Here respondent was placed in the care and custody of his mother, but she testified that she was not willing to care for him. The statute additionally states that the order may grant the custodian the authorization to hospitalize the respondent if he or she fails to comply with the order's conditions, but such hospitalization is limited to 24 hours, excluding weekends and holidays. Citing 405 ILCS 5/3-812(b). Indeed, the statutory definition of 'care and custody' expressly excludes the authority to require hospitalization of respondent." ¶35.

The appellate court also held that

the trial court's amended order stating that, in addition to being in the care and custody of his mother, respondent was ordered to reside at the nursing home as a community placement, unless otherwise decided by his mother, who could place him in another "intermediate care facility," violated the Mental Health Code because it required respondent's involuntary inpatient admission based on a petition and the criteria for involuntary outpatient admission. ¶36.■

Andreas Liewald is a staff attorney with the Illinois Guardianship and Advocacy Commission, West Suburban (Hines) Office.

Legal Mechanisms for Family Involvement in Caring for Persons with Serious Mental Illnesses

BY MARK J. HEYRMAN

Continuity of care for adults[1] with serious mental illnesses remains a problem in Illinois, particularly for persons who may, from time to time, be admitted to an inpatient psychiatric facility. For a variety of reasons, inpatient stays are usually quite brief. During these brief stays, hospitals are often unable to obtain information about the history of the treatment of the patients' illnesses, including what medications patients have received, whether those medications have been effective, and what side-effects the persons may have experienced. Hospitals may also lack information about what types of discharge plans have been found to be successful or unsuccessful in the past.

This lack of information has many causes. Persons who are so seriously ill that they need inpatient care are often unable or unwilling to provide the needed information and/or unable or unwilling to identify the places where they have previously been treated or to give informed consent to obtain written records of previous treatment.[2] Often, even with written consent, there just is not time for the hospital to obtain those records before the person must be discharged.

Finally, some patients may require involuntary commitment and/or court-ordered psychotropic medication or electro-convulsive therapy (ECT) under the Mental Health and Developmental Disabilities Code, (the Mental Health Code) 405 ILCS 5/1-100, *et seq*. Here too, the courts need information about the history of the person's illness and treatment. The involuntary commitment standard expressly requires consideration of the patient's "behavioral history" and "evidence of the person's repeated past patterns of specific behavior and actions related to the person's illness." 405 ILCS 5/1-119. The statute governing court-ordered medication and ECT also requires proof "[t]hat the illness... has existed for a period marked by the continuing presence of ...symptoms or the repeated episodic occurrence of these symptoms." 405 ILCS 5/2-107.1 (a-5)(4)(c). The evidence needed to help the court make these important determinations is often unavailable to the state's attorneys who are charge by statute (405 ILCS 5/3-101) with pursuing involuntary commitment and court-ordered medication or ECT.

Fortunately, many persons with serious mental illnesses have family members who are actively involved with caring for them. For example, it is not unusual for an adult with a serious mental illness to live with her or his parents or other relatives and/or be financially dependent on relatives. Family members often have substantial relevant information about the history of the person's illness and treatment and may even be in possession of the person's psychiatric records. Despite this, family members often find that various laws[3] prevent them from helping their loved one to get appropriate care and making sure that mental health providers and the courts have the information that they need to make good decisions. This article is intended to outline the legal mechanisms that family members may use to assist mental health providers and the courts in making decisions correctly and improving patient outcomes.

1. **Written consent to obtain records under the Mental Health and Developmental Disabilities Confidentiality Act**. 740 ILCS 110/1, *et seq*. A person who is or has received mental health services may give written consent to any other persons to access her or his mental health records or communications. 740 ILCS 110/5. Family members may ask their loved ones for consent to obtain mental health records.
2. **Guardianship of the Person**, 755 ILCS 5/11a-1, *et seq*. A family member may petition the court to be appointed guardian of the person of an adult who "because of ...disability...lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the care of his person." 755 ILCS 5/11a-3(a)

Advantages

- Access to all health care records including mental health records
- Control over most health care decisions
- Must be notified seven days in advance of a patient's discharge from an inpatient mental health facility. 405 ILCS 5/3-903(a)

Disadvantages

- Expensive and time consuming
- Not useful for most persons with mental illnesses who generally lack decisional capacity for only brief periods
- Cannot be used to obtain psychiatric hospitalization–must use commitment proceedings under the Mental Health Code. (See Section 4 below.)
- Cannot be used to consent to psychotropic medications over the ward's objections–must use involuntary treatment hearing provisions in the Mental Health Code. 405 ILCS 5/2-107.1(b). (See Section 5 below.)

3. **Advance directives**. Illinois has two laws which allow competent adults to designate someone to make decisions for them should they lose the ability to make decisions due to a serious mental illness (or other reason).

- Mental Health Treatment Preference Declaration Act. 755 ILCS 43/1, *et seq*.

Advantages

- Irrevocable once principal becomes disabled. 755 ILCS 43/50
- Allows access to records. 755 ILCS 43/30 (3).

Disadvantages

- Only applies to hospitalization, psychotropic medication and ECT. 755 ILCS 43/75.
- Only permits 17 days of hospitalization. 755 ILCS 43/75.

- Durable Power of Attorney for Healthcare. 755 ILCS 45/4-1, *et seq*.

Advantages

- Applies to all health care decisions.
- Allows access to records. 755 ILCS 45/4-10.

Disadvantages

- Revocable by ward even though s/he lacks decisional capacity. 755 ILCS 45/4-10.

- Durable power of Attorney for Health Care--with delayed revocation option. 755 ILCS 45/4-6(a-5) This provision gives persons the option to create an advance directive which remains in effect for 30 days after the person decides to revoke it.

Advantages

- Allows agent to consent to treatment for 30 days following a revocation by the patient.
- Allows access to mental health records during this period.

4. Involuntary commitment proceedings

- Family members may petition to have a loved one committed to a hospital if involuntary inpatient care is needed to prevent harm to the person or others. 405 ILCS 5/3-701.[4]
- As a petitioner, a family member may request to be notified if a commitment petition is dismissed in favor of an informal or voluntary admission and has the right to object to the dismissal. 405 ILCS 5/3-801(b).
- If the petition is dismissed the petitioner has right to be notified when the patient is being discharged. 405 ILCS 5/3-801(b) and 405 ILCS 5/3-902(d).
- Petitioner has the right to hire her/his own counsel and participate in a commitment hearing. 405 ILCS 5/3-101.
- Family participation may be helpful in obtaining the commitment of someone who needs it, but also in preventing the inappropriate commitment of someone who does not. The latter may occur because a person may not be committed if she or he will not come to harm if released to family or friends who are willing to help. 405 ILCS 5/1-119(2). The court may not be aware that such family members exist.
- Family members may also petition to have a loved one committed to outpatient care under 405 ILCS 5/3-751, *et seq*.[5]

5. **Court-ordered psychotropic medication and ECT**. Family members may petition the court to order psychotropic medication or ECT for a loved one whether or not the loved one is in a hospital. 405 ILCS 5/2-107.1.[6]

6. Special provisions concerning access to information about hospitalization

- Hospitals are required to ask a person at the time of admission if s/he wants anyone notified of the hospitalization and provide such notice if requested. 405 ILCS 5/2-113(a).
- Anyone may ask a mental health facility if a person is hospitalized in that facility and the facility must notify the recipient of the request. If the recipient consents, the hospital must advise the person how to contact the recipient. 405 ILCS 5/2- 113(b), (c) and (d).
- If a person lacks decisional capacity and the treating physician determines that disclosure would benefit her or him, disclosure of the fact that a person is in the hospital may be made to a relative involved in the person's treatment. 740 ILCS 110/5.5 effective 1-1-2022.

7. **Participation in treatment**

planning. At the beginning of treatment a mental health facility is required to create an individual treatment plan in consultation with the patient. A guardian, anyone designated under an advance directive (See Section 3 above) or anyone else designated by the patient must be permitted to participate in the creation of the treatment plan. 405 ILCS 5/2-102(a) Family members may ask their loved ones to designate them to participate in this important process.

8. **Notice of restriction of rights.** Upon admission, every patient must be notified of her or his right to designate someone to be notified if she or he is subjected to restraint, seclusion or the restriction of any other right in Chapter II of the Mental Health Code. 405 ILCS 5/2-200 and 201 Family members may ask their hospitalized loved ones to designate them under this provision.
9. **Access to discharge plan**. Allows relatives who are actively involved in the patient's treatment to receive notice that the patient will be discharged and a copy of the discharge plan if and only if the patient lacks decisional capacity and the disclosure is in the patient's best interest. 740 ILCS 110/5.5 effective 1-1-2022.
10. **Providing records and other information to the hospital.** Although this is not required by law, many hospitals will accept records and information about a patient from family members and friends in order to ensure appropriate care. This is important because hospitals are often unable to obtain records and information about past treatment in a timely manner, even with the patient's full cooperation. Depending on the circumstances, if the hospital refuses to accept records offered to them in person, it may be appropriate to send them by certified mail or some delivery services which will confirm to the sender that the hospital has received them.■

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1. This article refers only to the laws governing adults with mental illnesses. The laws governing family involvement in the care of minors are substantially different.
2. In *Zinermon v. Burch* 494 U.S. 113, 110 S. Ct. 975; 108 L. Ed. 2d 100 (1990), the United State Supreme Court explained that, while the law presumes that people are competent, that presumption cannot be relied upon when someone is being admitted to an inpatient psychiatric facility.
3. These laws exist for the important purpose of protecting patient privacy and autonomy.
4. The detailed standard for involuntary inpatient commitment is set forth in 405 ILCS 5/1-119.
5. The detailed standard for involuntary outpatient commitment is set forth in 405 ILCS 5/1-119.1.
6. The detailed standard for court-ordered medication and ECT is set forth in 405 ILCS 5/2-107.1(a-5)(4).