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Mental Health Matters

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

Illinois Supreme Court issues new rule regarding use of restraints in mental health and disability cases

BY MERYL CAMIN SOSA

The Illinois Supreme Court has issued Supreme Court Rule 296, which requires that trial courts not use restraints on individuals involved in Mental Health and Developmental Disabilities Code proceedings unless the court conducts a separate hearing on the record as to the necessity for restraints.

The **new rule** is effective immediately.

Proposed by the 24-member Special Supreme Court Advisory Committee for Justice and Mental Health Planning, Rule 296 was adopted to ensure that a dignified judicial process is maintained for the respectful treatment of persons in mental

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Appellate update

BY BARBARA GOEBEN

In re Christopher C., 2018 IL App (5th) 150301 (Rule 23, October 18, 2018, Motion to Publish granted, November 16, 2018)

This case was an appeal of an involuntary medication order. The fifth district reversed for two reasons: First, that the state failed to prove by clear and convincing evidence that the proposed testing was necessary for the safe and effective administration of treatment, and second, that the state failed to provide evidence of the designated treatment administrators (doctors). The court did not consider the other raised argument regarding ineffective assistance of counsel. Reversed.

Because the 90-day medication order expired, the court considered this appeal under the "capable of repetition, yet evading review" exception to mootness. This was "due to the short duration of involuntary treatment orders and the respondent's ongoing mental health issues and unwillingness to take medication." Though the respondent "raises sufficiency-of-the-evidence claims that may have no bearing on future proceedings" this appeal will still be considered because the respondent's "claims also involve issues of statutory compliance that could affect the outcome of a future case."

The court then considered whether the state proved by clear and convincing evidence that the tests and other procedures ordered were essential for the safe and effective administration of the medication. Since the testifying doctor offered no specific testimony regarding the procedure, or frequency of the requested blood draws or tests (or even specified the tests requested), the state failed to prove this element by clear and convincing evidence, thus warranting reversal.

The next issue was whether the treatment order's designation of the persons authorized to administer the

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health cases who are subjects of the court proceedings.

Input and feedback regarding the creation of Rule 296 was provided by numerous sources and stakeholders throughout the state of Illinois. The impetus for the creation of the new rule came from the case of *In re Benny M.*, 2017 IL 120133, where the supreme court held that the use of restraints on a respondent in an involuntary treatment proceeding should be used only upon a finding of manifest necessity.

The court's hearing for the necessity of restraints may include factors such as whether the respondent poses a risk of danger to himself, herself or others; whether there is a risk of elopement; the physical security of the courtroom or the room in which the proceeding is being held; and any risk assessment prepared by a trained professional.

The respondent and the respondent's attorney will have the opportunity to be present and to be heard at the hearing, and all counsel may present evidence or make proffers and arguments that are relevant to the court's consideration of the use of restraints.

If a decision is made to use restraints, the court shall state its findings of fact on the record as to the basis for the order entered and the court must allow the least restrictive restraints necessary. Under no circumstances should a respondent be restrained to another person, a wall, the floor or furniture while in the courtroom.■

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Appellate update

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treatment was supported by evidence presented at the hearing and whether this is reversible error. While noting this is a case of first impression, the fifth district—citing in part to the Code's requirement under 2-107.1(f) that annual trainings be provided for physicians and nurses in state-operated mental health facilities regarding the appropriate use of psychotropic medication—held that the order must be supported by evidence. This requirement helps to ensure that only a limited number of designated individuals will be able to administer the medications. Since the state presented no evidence--either through testimony or judicial notice--of who would administer the treatment (besides the testifying doctor), the circuit court should not have authorized those persons to administer the treatment.

There was one dissent in this opinion, Justice Cates, who noted that this appeal is moot and therefore should have been dismissed; she further stated that the state presented sufficient evidence to support the involuntary medication order.

In re Bonnie S., 2018 IL App (4th) 170227 (December 3, 2018, Petition for Rehearing denied)

This case was an appeal of an involuntary medication and an involuntary commitment order. The fourth district affirmed the orders finding that the state sufficiently complied with the Code's procedural and evidentiary requirements.

Concerning the threshold mootness question, the court considered this appeal under the "capable of repetition" exception to mootness.

With regards to the involuntary commitment order, the respondent raised two issues: 1) that the state failed to promptly file the second certificate as required by sections 3-610 and 3-611 of the Code; and 2) the state failed to disclose treatment timeframes in the treatment plan as required by section 3-810.

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Here, the examination for the second certificate occurred on February 28, 2017, however the second certificate was then filed on the day of the hearing, March 13, 2017. The issue then is whether this is considered a prompt filing as required by section 3-610 and 3-611. As for the "prompt" filing of the second certificate, the fourth district held that since the Code does not state the consequences of failing to promptly file the second certificate, it is a directory, rather than a mandatory requirement. Though the court did not condone or express approval of the long delay between the examination and the filing, which occurred here, it determined that because the delay was not unreasonable and because it did not prejudice the respondent, reversal is not warranted.

The second argument on the commitment case was whether section 3-810 of the Code was complied with because of the treatment plan's failure to provide a projected timeline for the treatment attainment. Though the state conceded that the predisposition report did not include a treatment timetable, it argued that the doctor's testimony (that the respondent, because of the severity of her illness, needs "long-term treatment" and the maximum period for commitment) constitutes substantial compliance with this requirement. The court agreed with the state's substantial compliance argument and affirmed the commitment order.

As for the involuntary treatment order, the respondent raised two issues that the Fourth District also rejected: 1) that the state failed to prove by clear and convincing evidence that the Respondent received the required written information about alternative forms of treatment; and 2) that the order for involuntary treatment was unsupported by evidence as to who would administer the treatment.

As to the written information regarding alternative treatment requirement prior to involuntary treatment as required by section 2-102(a-5) of the Code, the fourth district determined that this requirement is only necessary when there are reasonable, viable alternatives. Here, since the doctor testified that there were no alternative treatments other than medication, and because of the severity of the respondent's illness, the record "demonstrates any type of counseling or therapy was not reasonable without medication." The court therefore concluded that the state demonstrated it provided proper written notice of all reasonable alternative treatments to the respondent.

The final issue considered was the failure to provide evidence regarding the people authorized to administer the medication. Though noting that the treatment order must designate who is authorized to administer the treatment, the court held that the Code "does not indicate that specific evidence must be presented regarding who is authorized to administer treatment, and we decline to read such a requirement into it." It did note that sound practice would be to present this evidence and that the order specify the authorized treatment administrators. Judgment affirmed. ■

Barbara Goeben is a staff attorney with the Illinois Guardianship and Advocacy Commission, Metro East Regional Office in Alton.

1. *In re Christopher C.*, 2018 IL App (5th) 150301 at ¶¶ 19-20.
2. *Id.* at ¶ 11.
3. *Id.* at ¶ 12.
4. *Id.* at ¶ 14.
5. *Id.* (citations omitted).
6. *Id.*
7. *Id.* at ¶ 15.
8. *Id.* at ¶¶ 19-20; 405 ILCS 5/2-107.1 (a-5)(4)(G).
9. *Id.* at ¶ 21 (405 ILCS 5/2-107.1 (a-5)(6)).
10. *Id.* at ¶ 23.
11. *Id.* at ¶ 24.
12. *Id.*
13. *Id.* at ¶ 25.
14. *Id.* at ¶¶ 30-31.
15. *In re Bonnie S.*, 2018 IL App (4th) 170227 at ¶ 2.
16. *Id.* at ¶ 25.
17. *Id.* at ¶ 2; 405 ILCS 5/3-610, 5/3-611, 5/3-810.
18. *Id.* at ¶ 42.
19. *Id.* at ¶ 39.
20. *Id.* at ¶ 43.
21. *Id.* at ¶ 47; 405 ILCS 5/3-810.
22. *Id.* at ¶¶ 51-52.
23. *Id.* at ¶ 52.
24. *Id.* at ¶ 2
25. *Id.* at ¶¶ 54, 62; 405 ILCS 5/2-102(a-5).
26. *Id.* at ¶ 64.
27. *Id.*
28. *Id.* at ¶ 65.
29. *Id.* at ¶ 67; 405 ILCS 5/2-107.1(a-5)(6).
30. *Id.*
31. *Id.* at ¶ 70.

Legislative proposal would reduce gun violence, preserve owners' rights

BY ANGELLA W. MOLVIG

The Voluntary Do Not Sell Database Bill (HB 2883) proposes to amend Illinois gun laws to include the creation of a "Voluntary Do Not Sell Database," which the Department of State Police would be required to consult before authorizing a firearm sale. This bill aims to provide a low-cost method of reducing gun violence without restricting the rights of gun owners.

The Voluntary Do Not Sell Database bill would require the Department of State Police to create and maintain a database on which individuals can voluntarily place themselves. Under current Illinois law, the Department of State Police must run automated searches of several databases[1] before authorizing a firearms sale. This bill would simply add one more required database to consult, thereby alleviating concerns of undue burdens being placed on the Department. If the search yields an individual listed on the database, the sale must be denied.

An individual who wishes to add himself or herself to the database would be required to submit a notarized application to the Department of State Police. Upon receipt of the application, the Department is required to immediately update the database. If an individual desires to remove himself or herself from the database, a notarized withdrawal application must be submitted to the Department. The application would be automatically approved and the individual's name would be removed from the database seven days after receipt of the withdrawal application. The entire process is completely

voluntary; therefore, it does not restrict anyone's right to own a gun.

This bill recognizes that some mental illnesses are highly treatable but incurable diseases, meaning that many afflicted individuals will often relapse. Such a relapse can result in harm to self or others. In Illinois, nearly 16 percent of the population has a mental illness, which is approximately 1.5 million people. This bill would allow such an individual to prevent him or herself from purchasing a firearm during periods of relapse without fear of losing his or her right to have a gun when the illness is in remission and the risk of harm has passed.

Research shows that people battling mental illnesses would put a registry like the proposed one to use. A survey of both inpatient and outpatient individuals being treated for mental illness reported that nearly half of the respondents would be willing to utilize a registry to restrict themselves from purchasing firearms. This suggests that this low-cost mechanism has real potential to save lives.

There is growing support for "do not sell" registries of this sort. If Illinois passes this bill, it would make it the second state to do so. Washington State passed a similar version of this bill last year, which became effective on January 1, 2019. Versions of this bill are also being considered in at least six different states, and recently, the American Bar Association got on board with the proposal, voting in favor to adopt a similar resolution on January 28, 2019.■

Angella W. Molvig, is a J.D. candidate from The University of Chicago Law School, Class of 2019.

1. The Department of State Police is required to consult the following databases: its own criminal history record information files; criminal history record information files of the FBI, including the National Instant Criminal Background Check System; and the files of the Department of Human Services. 430 ILCS 65/3.1(b).
2. Mental Health America, *Mental Health in America—Adult Data*, http://www.mentalhealthamerica.net/issues/mental-health-america-adult-data (accessed February 1, 2019).
3. Frederick E. Vars et al., "Willingness of Mentally Ill Individuals to Sign Up for a Novel Proposal to Prevent Firearm Suicide" *The Official Journal of the American Association of Suicidology*, 2016, 5
4. Lorelei Laird, "ABA House opposes arming teachers and supports suicide-prevention measure," *ABA Journal*, http://www.abajournal.com/news/article/aba-passes-two-resolutions-on-gun-violence (accessed January 29, 2019).

Pandora's box: The predicament of incarcerating mentally ill defendants in the Illinois Department of Corrections

BY TIMOTHY JAMES TING

According to Greek mythology, when Pandora opened a jar (now commonly referred to as a box), multiple evils entered into the world of humankind while hope remained trapped within the vessel. The phrase "Pandora's Box" has now been commonly defined as a situation that creates multiple complicated and nuanced difficulties. There may be no current issue more analogous to that definition than the predicament of incarcerating mentally ill defendants in Illinois. The Illinois Department of Correction's Annual Report for the Fiscal Year of 2017 has an admirable prerogative regarding mentally ill defendants who are incarcerated within their facilities. Specifically, "the mission of the IDOC Office of Mental Health Management (OMHM) is to assist incarcerated individuals affected by Mental Illness and Serious Emotional Disturbance to decrease needless suffering, better manage their illness and achieve personal goals to reach and maintain their highest level of functioning." Nevertheless, for many inexperienced prosecutors and defense attorneys, there may not be much of an understanding of the services that are offered by the Illinois Department of Corrections for mentally ill defendants and the difficulties in rehabilitating mentally ill offenders upon their release.

The Cost of Incarcerating Mentally Ill Defendants

The number of incarcerated defendants in the Illinois Department of Corrections as of June 30, 2017 was 43,075. Unsurprisingly for experienced attorneys in the criminal field, the mental health caseload for the Illinois Department of Corrections constituted "approximately 28 percent of its current population." Even if that percentage were conservative, there would still be over 12,000 inmates who suffer from a mental illness to such an extent that mental health services were provided for those inmates. Given that the total expenditure for all facilities within the Illinois Department of Corrections was $1,151,909,931.67 as of June 30, 2017, such a large percentage of the prison population presents several issues pertaining to the treatment and cost of incarcerating mentally ill inmates.

The annual cost for incarcerating a single inmate in one year rose from $21,930.00 in 2016 to $26,365.00 in 2017 while the total inmate population decreased from 44,817 to 43,075 in those respective years. The Office of Mental Health Management (OMHM) employed "approximately 400 full-time positions, such as psychiatrists, psychologists, social workers, behavioral health technicians and psychiatric nurses and extensive physical plant enhancements at five facilities (Dixon, Logan and Pontiac correctional centers, Joliet Treatment Center and Elgin Treatment Center)" in 2017. The constant pressing need to hire skilled workers in the mental health field to address the mentally ill prisoner population appears

to be an inevitable trend. Even with a slight decline in the prison population from 2016 to 2017, it appears that the cost for incarcerating mentally ill defendants continues to increase.

The Correlation Between Recidivism and Mentally Ill Defendants

The questions for judges, prosecutors, and defense attorneys alike are (1) whether incarceration is necessary for mentally ill defendants and (2) whether incarceration can truly readjust mentally ill defendants to lawfully comply with the strictures of society at the time of their release. To begin the adjudication of the criminal process, a defendant must meet a minimum level of competency to be deemed fit to stand trial. The United States Supreme Court has long held that the due process clause of the Fourteenth Amendment of the United States Constitution prohibits the prosecution of a person who is unfit to stand trial. However, the required level of competency is a very low standard to satisfy. A defendant is presumed to be fit to stand trial and a defendant is only adjudicated as unfit if, "because of his mental or physical condition, he is unable to understand the nature and purpose of the proceedings against him or to assist in his defense." Accordingly, a majority of defendants are adjudicated as fit to stand trial even though they are still afflicted by a mental illness.

It is at this stage of the process—when a defendant is clearly mentally ill but still able to operate at a minimum level of fitness—that all practitioners of criminal law find themselves in a precarious position. Clearly, there are crimes that are simply too severe for an offender to be placed on a lesser punishment such as probation or conditional discharge. However, it is questionable whether incarceration would truly rehabilitate a mentally ill offender. While the Illinois Department of Corrections has not maintained specific data regarding the recidivism rates for mentally ill offenders, it has provided generalized data pertaining to recidivism. Again, the results are unsurprising for any experienced practitioner in criminal law: in 2015, 39.9 percent of offenders reoffended and were resentenced to the Illinois Department of Corrections within three years. In 2010, that number was as staggeringly high as 51.7 percent. While it is admirable that the recidivism rate substantially decreased by 11.8 percent from 2010 to 2015, nearly 40 percent of inmates reoffending is still far from the purpose elicited in the Illinois Constitution that "all penalties shall be determined both according to the seriousness of the offense and *with the objective of restoring the offender to useful citizenship*."

The results are perhaps more troubling when the correlation of mental illness and recidivism is examined. A total of 200,880 inmates from Florida prisons were studied from 2004 to 2011 by scholars from Florida State University's College of Criminology. The findings of the study clearly established "that a mental illness diagnosis [has] a positive effect upon post-release recidivism." Moreover, "individuals diagnosed with a serious mental illness, rather than just any mental health diagnosis, were more likely to recidivate, and recidivate sooner." Accordingly, the researchers opined that: "not only are mental health in-prison programs and services needed but these programs and services must be aligned and coordinated with community mental health services that provide inmates and prison releasees with a mental health 'continuum of care' based upon 'best practices' for successful reentry."

The Future for Mentally Ill Defendants

In 2008, the Illinois Legislature enacted the Mental Health Court Treatment Act. The Illinois Legislature noted:

There is a critical need for a criminal justice system program that will reduce the number of persons with mental illnesses and with co-occurring mental illness and substance abuse problems in the criminal justice system, reduce recidivism among persons with mental illness and with co-occurring mental illness and substance abuse problems, provide appropriate treatment to persons with mental illnesses and co-occurring mental illness and substance abuse problems and reduce the incidence of crimes committed as a result of mental illnesses or co-occurring mental illness and substance abuse problems. It is the intent of the General Assembly to create specialized mental health courts with the necessary flexibility to meet the problems of criminal defendants with mental illnesses and co-occurring mental illness and substance abuse problems in the State of Illinois.

Despite the admirable intentions of the Illinois Legislature, the reality is that economic disparity and geographical limitations impede the objective of Mental Health Courts in many rural counties. Some counties in Southern Illinois for example have just one presiding judge: Massac County, Johnson County, Pope County, Pulaski County, Perry County, and Washington County to name just a few. With the workload considerations that these judges may face, instituting a Mental Health Court could be extremely difficult – particularly in economically depressed regions where there are simply a lack of resources that would otherwise be available to defendants in more metropolitan areas. Accordingly, the harsh truth for practitioners is that there are no easy answers. Defendants with mental illnesses are more likely to recidivate and there are a lack of resources to assist previously incarcerated defendants to successfully reintegrate into society. The struggle is real… and for now, despite the best intentions of the Illinois Legislature and the Illinois Department of Corrections, a prison cell for many mentally ill defendants is simply Pandora's box. ■

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1. Dede Short, *Fiscal Year 2017 Annual Report,* The Illinois Department of Corrections Office of Constituent Services 18 (July 2018), https://www2.illinois.gov/idoc/reportsandstatistics/Documents/FY2017%20IDOC%20Annual%20Report%20FINAL.pdf.
2. *Id*. at 78.
3. *Id*. at 18.
4. *Id*. at 84.
5. Compare the Illinois Department of Corrections' Fiscal Year 2016 Annual Report, pages 74 and 80, to the Fiscal Year 2017 Annual Report, pages 78 and 84.
6. *Short, supra* note 1 at 18-19.
7. *Medina v. California*, 505 U.S. 437, 453 (1992).
8. 725 ILCS 5/104-10.
9. https://www2.illinois.gov/idoc/reportsandstatistics/Documents/Recidivism%20FY10_FY15_Trends.pdf.
10. *Id*.
11. Ill. Const. Art. I, § 11 (emphasis added).
12. William D. Bales, Melissa Nadel, Chemika Reed & Thomas G. Blomberg, 60 *Recidivism and Inmate Mental Illness*, International Journal of Criminology and Sociology 40 (2017).
13. *Id*. at 49.
14. *Id*. at 50.
15. *Id*.
16. 730 ILCS 168/1-105.
17. 730 ILCS 168/5.