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

Letter from the chair

BY SANDY BLAKE

As a relative newcomer to mental health law, I was astounded to learn that one in four people have some form of mental illness. Unless an individual lives as a hermit, it would be virtually impossible for any of us to be untouched by mental illness. That being the case, I am also astounded that we avoid the subject of mental illness in everyday conversation.

Members of the Mental Health Law Section Council are recognized leaders in all aspects of mental health law. We have renewed our commitment to review proposed and existing statutes, legislation, rules and court decisions affecting persons with mental illnesses and substance abuse disorders and make recommendations to the Board of Governors concerning these matters; to provide training and education to lawyers concerning the interaction between mental illness and the law and legal practice; to provide information to mental health professionals and the public concerning laws and rules affecting persons with mental illnesses; to collaborate with other professional and advocacy organizations to promote awareness of mental illnesses and mental health and to increase mental health services.

We begin our work and the conversation with this issue of *Mental Health Matters*. ■

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.

Appellate update

BY ANDREAS LIEWALD

Lakewood Nursing & Rehabilitation Center, LLC v Department of Public Health, 2018 IL App (3d) 170177 (Opinion filed August 16, 2018).

On October 28, 2013, Lakewood Nursing and Rehabilitation Center (Lakewood) sent a resident of its facility, Helen Sauvageau, a notice of involuntary transfer or discharge and opportunity for hearing, for failing to pay for her stay there. On November 1, 2013, Sauvageau filed a request for hearing which the parties agreed to stay, when Sauvageau applied for Medicaid. On January 13, 2014, her Medicaid application was denied. On January 15, 2014, Lakewood's attorney informed Illinois Department of Public Health (IDPH) of the denial and requested IDPH to set an intent to discharge hearing date.

On February 10, 2014, a pre-hearing was held. Lakewood filed a motion to dismiss its hearing request, arguing that the IDPH no longer had jurisdiction to hold a hearing because it would be doing so after the 10-day limitations period in section 3-411 of the Nursing Home Care Act (Act) (210 ILCS 45/3-411 (West 2014)). IDPH denied the motion to dismiss, determining that the language within the section was directory rather than mandatory.

On March 24, 2014, an evidentiary hearing was held. The administrative law judge (ALJ) recommended, based on Sauvageau's stipulation that she owed money to Lakewood, that the notice of involuntary transfer or discharge should be approved 30 days subsequent to the receipt

Appellate update

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of the final ruling in the matter. The chief ALJ adopted the recommendation in its final administrative order.

Lakewood filed a complaint in the circuit court, alleging that the hearing and final order were void because they violate the statutory time requirements. IDPH filed a motion to dismiss, arguing that Lakewood's claims were moot because Sauvageau no longer lived in the facility. It also argued that the trial court only has jurisdiction to review final administrative decisions and that Sauvageau did not challenge the decision but rather sought "declaratory relief regarding the timing of the Department's actions." The trial court granted the motion to dismiss.

Lakewood appealed, and the appellate court reversed and remanded the trial court's decision in *Lakewood Nursing & Rehabilitation Center, LLC v Department of Public Health,* 2015 IL App (3d) 140899. The court stated that the time requirement issues that Lakewood presented were too premature for its review and would be better addressed on remand.

On remand, the circuit court held that the time requirements of section 3-411 of the Act are directory. It determined that section 3-814 of the Act, which gave IDPH authority to prepare transfer or discharge plans to ensure the protections of residents, allowed IDPH the discretion to approve the notice 30 days after the final ruling. Lakewood appealed.

The appellate court reversed the circuit court's judgment.

Analysis

IDPH's ruling was void because it violated statutory time requirements under Sections 3-411 of the Act (210 ILCS 45/3-411 (West 2014)), which provides that IDPH hold a hearing at the resident's facility not later than 10 days after a request for hearing is filed, and render a decision within 14 days after the filing of the hearing request.

The appellate court found that the term "not later than 10 days" in section 3-411 constitutes negative language. "Illinois courts, including the court, have determined that language prohibiting a further action constitutes negative language and, therefore, a mandatory construction." The appellate court determined that Section 3-411 is mandatory. Because the appellate court found that IDPH lacked jurisdiction, it did not determine whether IDPH erred when it did not render its decision within 14 days.

IDPH erred under section 3-413 of the Act (210 ILCS 45/3-411 (West 2014)) when it required Lakewood to keep Sauvageau as a resident for an additional 30 days after its decision.

"Looking at the plain language of section 3-413, it does not give IDPH authority to approve the notice of transfer and discharge 30 days after the receipt of the final ruling." The section only required Lakewood to maintain Sauvageau as a resident for 34 days following the receipt of the notice or 10 days following the receipt of the final ruling. Therefore, the appellate court found that IDPH's ruling regarding the 30-day extension was void. ■

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

1. ***Lakewood Nursing & Rehabilitation Center, LLC v Department of Public Health***, 2018 IL App (3d) 170177, ¶ 1, 3-4.
2. *Id.* ¶¶1, 4.
3. *Id.*
4. *Id.* ¶ 4.
5. *Id.* ¶ 5.
6. *Id.*
7. *Id.*
8. *Id.* ¶ 6.
9. *Id.*
10. *Id.*
11. *Id.* ¶ 7.
12. *Id.*
13. *Id.*
14. *Id.*
15. *Lakewood Nursing & Rehabilitation Center, LLC v Department of Public Health*, 2015 IL App (3d) 140899.
16. *Id.* ¶ 11.
17. *Id.*
18. *Id.*
19. *Id.* ¶ 23.
20. *Id.* (citations omitted).
21. *Id.*
22. *Id.* ¶ 24.
23. *Id.* ¶ 26 (citations omitted).
24. *Id.* ¶ 27.
25. *Id.*, citing *Walsh v. Champaign County Sheriff's Merit Comm'n*, 404 Ill. App. 3d 933, 938 (4th Dist. 2010). ("any action beyond the administrative agency's statutory authority is void").

Mental Health Matters

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CLE program highlighted mental health issues and legal professionalism

BY DARA M. BASS

On May 16, 2018, the Illinois State Bar Association's Mental Health Law Section Council hosted a Continuing Legal Education event titled, "What's New in Mental Health Law: Mental Health Issues and Legal Professionalism." Four speakers shared their professional involvement with Mental Health law in Illinois from different perspectives.

Section Council Chairperson Robert J. Connor began the program. Connor is a deputy general counsel with the Illinois Department of Human Services, which he has represented for over 30 years. His rich experience includes work in areas such as mental health law, developmental disability and rehabilitation service laws. His expertise lies in the area of confidentiality of records. He has conducted legal review of the new databases that aggregate the private data of mental health consumers.

Connor thanked participants for attending the live presentation. He emphasized the importance of reviews and updates on mental health law. He then introduced the four speakers by highlighting their talents and extensive expertise.

Barbara Goeben spoke first. A graduate of Northwestern Law School, she has worked at Land of Lincoln Legal Assistance Foundation, Inc., with a specialty on consumer and housing issues. While there, she helped establish the consumer information desk at the Madison County Small Claims Court docket and a program to do direct legal outreach at homeless shelters. Since 2006, Goeben has worked at the Illinois Guardianship and Advocacy Commission Legal Advocacy Service, where she has represented clients at both the trial and appellate levels.

Goeben provided an update of 2016-2017 Mental Health Case Law decisions in the Illinois Appellate Court and Supreme Court levels. She reviewed cases and highlighted the most salient developments. The cases she covered revolved around themes such as: medication issues, commitment, the Mental Health Confidentiality Act, guardianship, criminal law, and DCFS involvement. This summary features Goeben's discussion of two Supreme Court cases and one case from each appellate district, though she covered more.

First, Goeben started with Illinois Supreme Court case *In re Linda B.,* 2017 IL 119392 (Opinion filed September 21, 2017) (Petition for Rehearing denied November 20, 2017). The respondent was admitted to a medical floor of a hospital, where she received both general medical and psychiatric treatment. She was subsequently transferred to the behavioral health unit of the same facility. At that point, the State filed their Petition for Commitment. The court affirmed both lower courts, which denied respondent's argument that the petition was filed too late. The court addressed two important issues: 1) what constitutes an admission to a mental health facility and 2) what constitutes a mental health facility, itself. An admission may be defined by the respondent's legal admission (rather than mere physical admission), specifically, when the respondent begins to *receive* mental health services. The court expanded the definition of a mental health facility to include any facility where the respondent has received mental health services, despite the title of the facility, which is irrelevant in making the determination.

Goeben has found that best practice is to file a petition earlier rather than later. As soon as the recipient is receiving mental health services (and wants to leave the facility), one should pursue filing a petition.

The other Illinois Supreme Court case on which Goeben reported is *In re Benny M.*, 2017 IL 120133 (Opinion filed November 30, 2017). It is a medication case involving the handcuffing (shackling) of the respondent at the hearing. The holding indicated that when a court is faced with a respondent who could be disruptive in court, the judge may not rely solely upon the word of the State's Attorney or the hospital to determine whether or not shackling is appropriate. Rather, the judge must make an independent determination, on the record, based on factors such as whether the respondent is a risk for flight, a threat to safety, or presents an issue with maintaining order in the courtroom. In addition, defense counsel bears the burden of advocating for the removal of the handcuffs from their client. Counsel must object to the handcuffs and request an opportunity to be heard. Ultimately, in *Benny M.*, the court reversed the appellate court's judgment and affirmed the circuit court's ruling, which had found that the respondent may be physically restrained during the hearing. The court found that the trial court did not rely merely upon the security officer's opinion but, rather, appropriately weighed the information provided through its own independent assessment.

Goeben spoke about some district court cases, including *In re Debra B.*, 2016 IL App (5th) 130573 (May 31, 2016). It discusses involuntary medication and the requirement of providing written information. *Debra B.* also addresses the sufficiency of evidence regarding suffering and deterioration of the ability to function for involuntary medication. The decision must be made based on a person's *current* mental state. Respondent must be provided with written information regarding alternatives to medication. Regarding proof of suffering, the State needed to show that the respondent was experiencing the type of suffering that can be alleviated by psychotropic medication. Regarding deterioration, the appellate court held that the State needed to show a deterioration in the respondent's

ability to function on a basic level. The appellate court ultimately reversed the trial court's decision and held that the trial court's findings (that the respondent was suffering and that her ability to function had deteriorated) were against the manifest weight of the evidence.

Next, Goeben spoke about *In re Clinton S.*, 2016 IL App (2d) 151138 (Dec. 2, 2016). This case involves involuntary treatment as it relates to hemodialysis, testing, and other procedures. The respondent could not take his medication because it would further harm his kidney disease, as there is a direct correlation between the medication and kidney disease. The doctor ordered hemodialysis. The *Clinton S.* court affirmed the trial court's decision to order hemodialysis as a procedure for the safe and effective administration of the psychotropic medication.

Goeben also spoke about *In re Tara S.*, 2017 IL App (3d) 160357 (August 3, 2017). This case found that the psychiatrist must personally examine the recipient; a mere review of the records is not sufficient for involuntary medication. The expert testimony must be that of a psychiatrist who personally examined the respondent. *Tara S.* also represents the fact that a respondent must receive sufficient written information about medications before being required to take the medication. In this case, the court held that the respondent could not be compelled to take the medication (lithium) "without receiving written notice of side effects, risks, benefits, and alternative treatments to lithium."

Additionally, Goeben gave background on *In re Jian L.*, 2018 IL App (4th) 170387 (Opinion filed January 29, 2018). In this case, the respondent filed a written request for discharge. The State proceeded with the hearing even though the respondent withdrew her request for discharge. The appellate court affirmed the trial court's decision to proceed on a petition despite the fact that the respondent withdrew the request for discharge from voluntary admission. Further, the *Jian L.* court held that any (technical) deficiencies in the certificates (which had not been executed under the penalty of perjury under the Mental Health and Developmental Disabilities Code) that were attached to the State's petition did not prevent the court from adjudicating the petition.

Finally, in *People v. Viramontes*, 2017 Il App (1st) 142085 (Opinion January 9, 2017), Goeben explained, a witness testified as to whether her mental health records were admissible. This case addresses the confidentiality of a witness's mental health records, as it implicates the Illinois Mental Health and Developmental Disabilities Confidentiality Act. The trial court determined that some of the witness's mental health records were admissible, whereas six years of them were not. The appellate court stated, "It is well-established under Illinois law 'evidence of a witness' mental condition is admissible to the extent it bears upon the credibility of the witness' testimony.'" The *Viramontes* appellate court affirmed the trial court, holding that "the vast majority of records concerned depression, anxiety, and an eating disorder, none of which would be relevant to testing" the witness's credibility.

The next speaker was Mark Heyrman, a Clinical Professor at the University of Chicago Law School. He teaches courses in Mental Health Advocacy and Mental Health Law. Heyrman is a board member and Past President of Mental Health America of Illinois and chairs its Public Policy Committee. He helped found and is the facilitator of the Mental Health Summit.

Heyrman spoke about mental health legislation that is either pending in or has passed out of the 100th General Assembly of 2017-2018. He categorized the legislation into eight different topics: criminal justice, guardianship and advance directives, gun violence, Medicaid, the Mental Health and Developmental Disabilities Code, miscellaneous bills, private insurance / mental health insurance parity, and workforce issues. This summary features some of the bills that Heyrman discussed within each topic.

First, Heyrman spoke about legislation in the area of criminal justice. He noted that our country confines more people in jails and prisons than any other country. Many of those people suffer mental illnesses. House Bill 375 (Public Act 100-0247) improves police training regarding persons with mental illnesses. This is where the CIT (Crisis Intervention Team) training comes into play.

Heyrman also spoke about Senate Bill 1276 (Public Act 100-0424), which requires a report about whether persons found unfit to stand trial for a *misdemeanor* will be fit before their sentence would expire (rather than within one year); it also changes the periodic treatment reports for insanity acquittees from 60 days to 90 days. This helps to resolve the problem that many people arrested on misdemeanors never truly stand trial.

On the topic of guardianship and advance directives, Heyrman referenced Senate Bill 1319 (Public Act 100-0427), which permits the use of videoconferencing in guardianship hearings. This will help to facilitate probate proceedings in a similar manner to videoconferencing in Mental Health cases.

Further, Heyrman discussed Senate Bill 2609, which clarifies that objecting to treatment does not revoke an advance directive. In Illinois, two types of advance directives are: a Power of Attorney for Healthcare and a Mental Health Treatment Preference Declaration. In terms of the first, more generic type, there are three listed ways to revoke a Power of Attorney for Healthcare: 1) tear it up, 2) deface it, or 3) declare one revokes it. This bill clarifies that the effect of refusing medication does not revoke the Power of Attorney for Healthcare. This bill was being voted upon, in Springfield, the day of this program's presentation.

In terms of the area of gun violence, Heyrman mentioned that House Bill 772 was still pending. It creates the Lethal Violence Order of Protection Act to permit the temporary removal of guns following a hearing. It is modeled on the domestic violence order of protection so you can obtain a temporary restraining order. A loss of weapons only occurs after a full court hearing. In terms of gun violence as it relates to mental illness, one-third of homicides and two-thirds of suicides are committed by firearm.

In the realm of Medicaid, Heyrman informed that a very large number of people with serious mental illness are now

covered under the Affordable Care Act. He also enlightened participants about a few different bills. One such bill is House Bill 2907 (Public Act 100-0385), which amends the Medicaid law that governs telepsychiatry to remove the requirement that the healthcare professional be in the room with the patient. This should help to expand the use of teleconferencing and alleviate the tax on the existing workforce shortages among psychiatrists and psychologists.

House Bill 4096, which requires DHFS to create a standard preferred drug list for Medicaid-managed care organizations that allows MCOs (Managed Care Organizations) to offer more but not fewer choices, is another bill Heyrman elaborated upon. Medicaid and insurance companies will pay for it.

Next, Heyrman talked about House Bill 4950 / Senate Bill 2951 (which was pending at the time of the presentation), which creates Medicaid pilot programs for early mental health treatment for youth and early engagement for persons with opioid addiction. Early intervention, he noted, is very effective.

Heyrman next spoke about the Mental Health and Developmental Disabilities Code. He highlighted House Bill 3703 (Public Act 100-0012), which creates a pilot program allowing interstate commitments with Iowa in the Rock Island area. Thus, commitments can occur across state lines.

Additionally, he focused on House Bill 3709 (Public Act 100-0196), which increases the amount of outpatient treatment which may be provided to a minor (mainly aged 12 and above) without parental consent. This is particularly relevant where harm would come to a patient if he or she asks a parent for permission.

Another, miscellaneous bill that Heyrman mentioned is House Bill 2477, which the ISBA's Mental Health Law Section Council developed. It allows long-term residents of the State hospitals to vote.

On the topic of private insurance and Mental Health Insurance parity, Mark Heyrman authored an op-ed in the *Chicago Sun-Times* in favor of House Bill 4146. The bill prohibits changes in the coverage of pharmaceuticals during the term of coverage. This is particularly relevant for people who manage chronic conditions.

Finally, in the sphere of workforce issues, Heyrman explained House Bill 5109, which creates a Community Behavioral Health Professional Loan Repayment Program. This is a mechanism to help fund professionals' training and address workforce shortages.

The next speaker was Christine Anderson, Esq. She is the Director of Probation and Lawyer Deferral Services and Senior Litigation Council at the Attorney Registration and Disciplinary Commission. She has been with the office for about 30 years. During her employment with the ARDC, Anderson has investigated and prosecuted hundreds of cases of attorney misconduct and has argued several disciplinary cases before the Supreme Court of Illinois. She currently monitors the attorneys placed on diversion, supervision status by the Inquiry Board and probation and conditional admission by the Supreme Court of Illinois.

Anderson spoke about Licensure and the Impaired Lawyer. She highlighted five areas: 1) facts and figures relating to the ARDC and impairments in the legal profession, 2) signs and symptoms of impairment issues and attorney regulation, 3) promoting wellness and LAP (Lawyers' Assistance Program), 4) colleagues and attorney wellness, and 5) rule amendments.

At least 25-30 percent of Illinois lawyers who face formal disciplinary charges before the ARDC are identified as suffering from addiction or mental illness. Fewer lawyers are being reported as suffering from these issues. But when complaints are filed, they are very serious. *Himmel* reports (filed by lawyers) show that almost 50 percent of formal ARDC complaints at hearing are generated by a lawyer's report. Three reasons to take action are: 1) the organization's success, 2) the well-being influences ethics and professionalism, and 3) humanitarian reasons, meaning that untreated mental health and substance use disorders can ruin lives and careers.

Some of the warning signs of an impaired lawyer are: attendance issues, personal problems, financial issues, performance problems, and health issues. From the perspective of the impaired lawyer, their duty is spelled out in Rule 1.16, which is titled, "Declining or Terminating Representation." It states that a lawyer shall not represent a client or…shall withdraw… if: the lawyer's physical or mental condition materially impairs the lawyer's ability to represent the client.

The ARDC refers cases to the Lawyers' Assistance Program (LAP), which prioritizes confidentiality, above all else. Supreme Court Rule 766 governs referrals from the ARDC to LAP. It states, in part, "…the ARDC may refer a lawyer to LAP despite an otherwise confidential investigation when there is reasonable cause to believe that a lawyer is, or may be, addicted or abusing alcohol or other chemicals or is, or may be, experiencing a mental health condition or other problem that is impairing the lawyer's ability to practice law."

Regarding the obligations of the impaired lawyer's colleagues and law firm, Illinois Rule of Professional Conduct Rule 5.1 requires lawyers with supervisory authority over other lawyers to make reasonable efforts to ensure the conduct of these individuals is consistent with the ethical obligation of a lawyer. Discipline procedures regarding impairment issues dictate that if the lawyer is not incapacitated (is in treatment or recovery): they can be either subjected to probation, maintain active status with conditions, receive "108 supervision," or receive "diversion," which permits the file to be closed.

Anderson next spoke about Illinois Rules and amendments to the rules. Illinois Supreme Court Rule 758 outlines what happens in the setting of a lawyer's "Mental Disability or Addiction to Drugs or Intoxicants." It states that a lawyer is incapacitated if their judgment is impaired due to mental infirmity, mental disorder, or addiction. It states that the Inquiry Board votes that a petition be filed with the Hearing Board. It also obliges the lawyers to transfer to disability inactive status or active status with conditions. Further, Anderson delineated the new changes to the MCLE rules that now require lawyers to complete one hour of mental health and substance abuse as a part of their Professional

Responsibility CLE requirement. In addition, Anderson discussed Illinois' new PMBR requirement, which requires lawyers who lack legal malpractice insurance to complete a four-hour, online, self-assessment regarding the operation of their law firm. Illinois is the first state that has made this mandatory.

Finally, Anderson discussed lawyers' wellness. The ARDC administers a confidential questionnaire on their website, which provides lawyers the opportunity to test their knowledge on how to handle issues surrounding impaired lawyers. It highlights that lawyers are three times more likely than the general population to suffer from depression and that almost t 20percent of lawyers report that they suffer from anxiety. Also, in relation to the topic Anderson had previously discussed on colleague and supervisor intervention, the ARDC's online tool provides some guidance in this regard, as well.

The final speaker was Madeleine M. Sharko. She is an attorney with the Illinois Office of the State Guardian (OSG), where she has practiced law since 1991. Sharko practices in the adult guardianship arena, primarily in Cook and Will counties. She is a National Certified Guardian with the Center for Guardianship Certification. Sharko has been a volunteer with the Illinois Lawyers' Assistance Program (ILAP) since February 2012. Further, she received the "Carl Rolewick Award" at their Annual Dinner. She also holds a Master of Arts in Counseling.

Sharko stated that many clients are now referring themselves. Lawyers who are 30 years old and younger are more aware. Substance issues account for 47 percent of the clients' bases for becoming an LAP client; psychological issues account for 51 percent of them.

When Sharko began volunteering for LAP in February 2012, she became a mentor and a "lawyer's lawyer." She can serve as a peer mentor and as "an affirmation." She runs a men's group, a women's group, and a new lawyers' group. LAP gives them a referral for the group rather than accepting walk-ins. LAP does not have to reveal the source of the call and / or the referral. The groups are confidential and free. She speaks with law students during office hours who state they want a "good life," as their goal, rather than merely stating that they want to be a good lawyer. She also helps at law schools.

The LAP services are successful because stigma is reduced, as everyone there is a lawyer. A good majority of attorneys who have used LAP services are better for it and are more financially successful because of it.

Lawyers are (more) at risk for a few reasons. One reason is that student debt is eclipsing even the larger attorney salaries. Financial pressure can be a strong contributing factor. Other causes involve the competitive nature of lawyers and high expectations from clients.

In order to spot substance abuse problems in a lawyer, one may "follow the 'MAP.'" One may notice "Mood" or attitudinal disturbances. One may see changes to the person's "Appearance" or physical changes. Finally, a drop in "Productivity" and quality of work may be present.

If a lawyer notices a colleague exhibit signs of depression, anxiety, or suicidality, the lawyer can take a few steps to help. The lawyer can "ask, care, and escort, or ACE." In terms of escorting the colleague, the two may call LAP together (LAP is *not* connected to the ARDC.) and ask to speak to a clinician. Also, the lawyer may call LAP on their own and report their colleague but LAP needs a contact number. LAP will contact a trained LAP volunteer (who is bound by confidentiality). Further, LAP will reach out to the person, sharing that someone (who may choose to remain anonymous) expressed concern for their well-being and invite them to come to the office.

To volunteer for LAP, members can be trained as peer mentors every June for about six to seven hours. LAP will contact volunteers to ask whether they are free to serve as a mentor, who is not a therapist but rather a confidential peer support. Volunteers' time commitment can be as little as a couple hours a year to fifteen-minute increments. LAP works with volunteers to find a time commitment that fits best.

Rob Connor closed the program with concluding remarks. He expressed appreciation for each of the speakers and thanked participants for attending the program in person. ■

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Editor's Note: SB 2609 was signed into law as Public Act 100-0710.

Mental illness and parenting

BY SUSAN O'NEAL

A recent second district case, *In re K.E.S.*, 2018 IL App (2d) 170907, makes it clear that the fact that a parent may be living with a serious mental illness does not mean that this parent is unfit or unable to parent their children.

The state filed a petition, alleging that K.E.S. was a dependent minor, because her mother was hospitalized for her mental illness, and thus, the minor was without proper care. They also alleged neglect by reason of an injurious environment because the mother and the minor were involved in a car accident, at a time when the mother had been driving erratically and her mental illness was not well controlled The mother stipulated that the minor was dependent and neglected at the time the petition had been filed.

After an adjudication of abuse, neglect, or dependency, the court must hold a dispositional hearing, usually within 30 days, to determine what needs to be done in light of its findings. In this case, over 6 months had passed since the car accident. The mother had been hospitalized once, a few months after her initial inpatient psychiatric hospitalization, in order to get her stabilized on her medication. It was a voluntary admission. The mother's counselor testified at the dispositional hearing that she had been seeing the mother every two weeks for three months, that she was compliant with her medication, was doing well, and so long as she continued to take her medication and attend counseling, she was stable enough to resume parenting K.E.S., who had been in foster care until the dispositional hearing could take place.

The mother had been diagnosed with bipolar disorder and PTSD. DCFS noted that the mother's home was clean and appropriate, that she had support, and that her visits with K.E.S. went well. Witnesses at the dispositional hearing also testified that the mother had complied with all of the services contained in her DCFS service plan. The mother also testified that she realized that K.E.S. would benefit from continued contact with his foster mother and that she would be willing to allow her to continue to see the foster mother and also would agree to a gradual return home.

The judge, however, found the mother to be an unfit parent, saying that she "suffers from severe mental health issues" and that these issues "prohibit her from properly caring for the child at this time." The judge did acknowledge, however, that the mother had made progress since the case had been initiated months earlier.

At the dispositional hearing the state had the burden to prove, by a preponderance of the evidence, that the mother was unfit. But the second district found that at the time of the dispositional hearing, none of the evidence showed that the mother was unfit or unable to care for K.E.S. or that the child's safety or wellbeing would be in jeopardy if she were returned home to her mother. While the reviewing court understood the trial court's concerns about whether or not the mother would continue to comply with her mental health treatment, the Court noted that this concern would be true of any parent with a mental illness and held that the possibility that it could happen does not, by itself, render a parent unfit. Nor does the fact that a parent has a serious mental illness, by itself, render that parent unfit. ■

Susan O'Neal is a senior attorney with Equip for Equality in Springfield. She can be contacted at susan@equipforequality.org.

Outgoing chair presented with plaque

2018-19 Chair Sandy Blake (right) presents a plaque to Rob Connor (left) for his work last year as the Mental Health Law Section Council Chair.

7 health organizations file lawsuit to protect consumers with pre-existing conditions, allege the short-term, limited-duration plan final rule discriminates

Association for Community Affiliated Plans (ACAP), National Alliance on Mental Illness (NAMI), Mental Health America, American Psychiatric Association (APA), AIDS United, National Partnership for Women and Families, and Little Lobbyists recently filed suit in the U.S. District Court for the District of Columbia to invalidate the short-term, limited-duration insurance (STLDI) plan rule issued in August by three federal agencies. This rule will harm patients and their families, as well as others in the health care system, by undermining access to quality, affordable coverage; will significantly disrupt insurance markets in states across the country, and threatens to bring back abusive practices that harm consumers specifically prohibited by the Affordable Care Act (ACA).

The groups argue in their complaint that the final rule violates the plain-English meaning of "short-term" by defining it as 364 days instead of three months, as currently allowed , and "limited duration" as up to 36 instead of 12 months. The plaintiffs also argue that the rule arbitrarily reverses previous limits on these plans to create an "alternative" to ACA-compliant plans that Congress did not authorize and that violates the ACA by effectively undercutting ACA plans and making them increasingly unaffordable and unsustainable for consumers who have nowhere else to turn. As such, the plaintiffs believe that the courts will agree that the rule is unlawful.

The rule expands the availability of discriminatory, inadequate short-term "junk" plans, which can: set higher premiums based on age, gender and health status; deny access to basic benefits; undermine catastrophic protections; deny coverage for any pre-existing conditions; and increase uncompensated care for health care providers. Expansion of short-term plans also threatens people's access to quality coverage. Middle-income families with comprehensive coverage will see their premiums increase while limited, medically underwritten plans lure healthy people out of the quality plans that include consumer safeguards. Such plans are not subject to mental health parity, nor the non-discrimination rules that protect people with conditions like HIV/AIDS. Additionally, rushing sale of short-term plans will undercut health plans that play by the rules and will confuse consumers when they are signing up for 2019 coverage starting on November 1.

Examples of the real-world consequences of these "junk" plans cited in the complaint include:

- A woman in Illinois went to the hospital with heavy vaginal bleeding resulting in a five-day hospital stay and a hysterectomy, only to be denied coverage under her short-term plan on the ground that her menstrual cycle constituted a pre-existing condition.
- A man in Washington, D.C., purchased a short-term plan with a stated maximum payout of $750,000; when he sought coverage for a $211,000 bill resulting from a hospitalization, however, he was paid only $11,780, in part due to a denial of coverage based on his father's medical history.

"Short-term, limited-duration health plans are like the small spare tire in a car: they get the job done for short periods of time, but they have severe limitations and lead to trouble if you drive them too fast or too long," said Margaret A. Murray, CEO of the Association for Community Affiliated Plans. "Consumers who substitute comprehensive coverage with a STLDI plan will be rudely reintroduced to denials of care on the basis of pre-existing conditions, coverage limits and fine print should they need care in a meaningful way."

Mary Gilberti, CEO of National Alliance on Mental Illness, said: "For the past 20 years, NAMI has fought for parity--the fundamental tenet that mental health care is just as important as physical health care. This rule change rolls back the clock on Congress' bipartisan efforts to ensure patient protections and fair insurance coverage of mental illness--and will start a downward spiral that leaves people with mental health conditions right back to where we were, excluded from lifesaving healthcare."

"At a time when suicide and overdose deaths have hit epidemic levels and continue to rise, the last thing we need is a rule that confuses consumers and offers worse mental health and substance use benefits. The STLDI rule not only violates the intent of Congress in the ACA, it also rips away needed treatment and threatens the lives of countless Americans," said Paul Gionfriddo, President and CEO of Mental Health America.

"The Administration's rule harms our patients by allowing plans that deny coverage for pre-existing conditions or that discriminate against those with mental illness and substance use disorder," said Altha Stewart, M.D., President of the American Psychiatric Association. "This rule jeopardizes the insurance coverage of many Americans with complex medical needs that require strong, predictable insurance protection and care. Without this coverage, patients with complex medical needs will suffer and often end up in emergency rooms, raising health care costs. Our lawsuit is necessary to protect our patients. We call

upon the Administration to drop this rule and enforce the protections of the Affordable Care Act."

"The plans and protections of the ACA have been life savers for people living with HIV. Discrimination based on pre-existing conditions, including HIV, was prolific before the ACA. These plans are a giant step backwards and will effectively sanction discrimination by the insurance industry and will deny access to thousands, including people living with HIV. Access to essential medications for HIV treatment not only preserve individuals' health, but achieving viral suppression through medications can also prevent new HIV infections. These short term plans are not only a threat to people with HIV, but to our nation's public health by making it harder to end the HIV epidemic in America," said Jesse Milan, Jr., JD, President & CEO, AIDS United.

Debra Ness, President, National Partnership for Women & Families, said: "Women and families depend on quality, comprehensive health insurance. Yet the Trump administration is putting that at risk by pushing skimpy, junk plans that don't offer the coverage we need and deserve. The National Partnership is proud to join allies in filing suit against these dangerous and discriminatory policies that undermine women's health and economic security. We refuse to go back to a time when families were victim to predatory practices and one illness away from financial ruin."

"Children with complex medical needs require access to affordable health insurance that covers essential health benefits, pre-existing conditions, and does not impose monetary caps on care. The ACA assures these families that any plan they buy will have these protections. The STLDI rule destroys that assurance. Those who buy these STLDI plans will have necessary care for their children go uncovered and face financial ruin. Those fortunate enough to have ACA-compliant plans will face skyrocketing premiums because of the effects of the STLDI plans on the market. Our children deserve better," said Elena Hung, President of Little Lobbyists.

The plaintiffs represent a broad array of insurers, health care providers and consumer groups that advocate for patients, particularly those with pre-existing conditions and serious illnesses. A deluge of overwhelmingly negative comments from across the health care sector has warned that short-term plans will leave many enrollees uncovered when they need health care, increase premiums for those who buy quality plans, increase costs to taxpayers, and reduce choices. One analysis found that 98 percent or 335 of 340 health care group comments either raised problems with the rule or expressed outright opposition to it.

The Trump administration's final rule was issued without Congressional approval or public support: a recent survey found that 90 percent of people say it is important that the ACA's pre-existing protections remain law. This final rule unilaterally undermines federal health insurance protections for people with private insurance, especially the 133 million Americans with pre-existing conditions.

About the Association for Community Affiliated Plans

The Association for Community Affiliated Plans (ACAP) represents 62 Safety Net Health Plans, which provide health coverage to more than 21 million people in 29 states. Safety Net Health Plans serve their members through Medicaid, Medicare, the Children's Health Insurance Program (CHIP), the Marketplace and other health programs. For more information, visit www.communityplans.net.

About the National Alliance on Mental Illness

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. Learn more about www.nami.org | facebook.com/nami | twitter.com/namicommunicate | instagram.com/namicommunicate.

About Mental Health America

Mental Health America--founded in 1909--is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the overall mental health of all Americans. Its work is driven by the commitment to promote mental health as a critical part of overall wellness, including prevention services for all, early identification and intervention for those at risk, integrated care, services, and supports for those who need it, with recovery as the goal.

About the American Psychiatric Association

The American Psychiatric Association (APA), founded in 1844, is the oldest medical association in the country. The APA is also the largest psychiatric association in the world with more than 37,800 physician members specializing in the diagnosis, treatment, prevention and research of mental illnesses. APA's vision is to ensure access to quality psychiatric diagnosis and treatment. For more information please visit www.psychiatry.org.

About AIDS United

AIDS United has the singular mission of ending the HIV/AIDS epidemic in the United States. They work to achieve this ambitious mission through strategic grant making, technical assistance and capacity building services, formative research, and advocacy based on sound public policy analysis. Headquartered in Washington, D.C., AIDS United's staff of public health and policy professionals work daily on building power for HIV efforts at national, regional, and community levels and funding initiatives for improved health outcomes for people living with HIV, and prevention strategies for those most likely to be impacted by the epidemic. AIDS United's Public Policy Council (PPC) of 47 HIV/AIDS Service organizations, national and regional coalitions is the largest and longest-running community-based HIV/AIDS domestic policy coalition in the country. For the last 35 years, the PPC has led initiatives to shape and inform federal policies that impact people living with and affected by HIV. AIDS United additionally represents more than 200 grantee and subgrantee AIDS Service Organizations serving people living with

HIV throughout the United States.

About the National Partnership for Women & Families

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting access to quality, affordable health care, reproductive health and rights, fairness in the workplace, and policies that help women and men meet the dual demands of work and family. More information is available at www.nationalpartnership.org.

About Little Lobbyists

Little Lobbyists is an organization working to protect and expand the rights of children with complex medical needs through advocacy, education and outreach. The group was founded and is led by families of children with complex medical needs and disabilities requiring specialized and ongoing health care. These families face significant challenges in caring for their children and experience firsthand the impact that federal and state laws and policies have on their lives. The mission of Little Lobbyists is to support , inform and advocate for this growing community of families and their unique needs . For more information, please visit www.littlelobbyists.org and @LittleLobbyists on Twitter, Facebook and lnstagram .

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