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ILLINOIS STATE BAR ASSOCIATION

MENTAL HEALTH MATTERS

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

Letter from the Chair

By Scott D. Hammer

Welcome to the first newsletter of the Mental Health Law Section Council. Mental health issues affect the broken-hearted with broken dreams from broken families as well as stable, affluent families. As an attorney, you will most likely have to deal with clients or colleagues with a variety of mental illnesses. Mental health issues often pop up in tort actions, divorce cases, elder law, employment law, school law, medical malpractice cases, criminal matters, etc. More people are being diagnosed with mental illnesses than ever before. Our goal is to educate ourselves and others to the challenges faced in the mental health community when interacting with persons with mental illness, providers, professional associations, governmental agencies, the legislature and the judiciary.

The Mission of the Mental Health Law Section Council is to:

Mental Health Law Section Chair Scott Hammer.

- Review proposed and existing statutes, legislation, rules and court decisions affecting persons with mental illnesses, substance abuse disorders and developmental and intellectual disabilities and make recommendations to the Board of Governors concerning these matters;

Continued on page 2

Some new (and old) ways to fix the mental health system in Illinois

By Meryl Sosa and Mark J. Heyrman

The mental health system in this country is badly broken.[1] Over the past 60 years we failed to invest in community mental health services while we have eliminated most state hospital beds. The numbers are remarkable. The United States had 560,000 state-operated psychiatric beds in 1955 and now has 45,000.[2] The number of state-operated beds in Illinois has declined from 33,000 to 1,200 during this same period. Among the many negative outcomes of our failed deinstitutionalization policy have been excessive, expensive, and unproductive use of emergency departments. Over seven million emergency department visits are made by people with mental illnesses each year and more than one in eight is uninsured.[3] Another result has been the criminalization of people with mental illnesses. Here again the numbers are remarkable. There are 8,000 people with serious mental illnesses in state prisons and 3,000 in the Cook County Jail.[4]

But there is some good news for people with mental illnesses and their families and communities: (1) the Affordable Care Act provides a sub-

Continued on page 3

INSIDE

Letter from the Chair 1

Some new (and old) ways to fix the mental health system in Illinois . . . 1

Requirement that parents relinquish custody of their children in order to get mental health services addressed by new state law 6

Mental health legislation adopted by the Illinois Legislature in 2014 6

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Letter from the Chair

Continued from page 1

- Provide training and education to lawyers concerning the interaction between mental illnesses and developmental and intellectual disabilities and the law and legal practice;
- Provide information to mental health professionals and the public concerning laws and rules affecting persons with mental illnesses and developmental and intellectual disabilities; and
- Collaborate with other professional and advocacy organizations to promote improved knowledge about mental illnesses and mental health and to increase mental health services.

The Council's work covers a wide variety of issues such as: homelessness, institutional and community services, and the court system, which includes the criminal justice system.

The Council strives to have a diversity of members who practice in the areas of mental health and developmental and intellectual disabilities. Traditionally, our membership includes attorneys representing (1) persons with mental illnesses and intellectual and developmental disabilities, (2) community providers and hospitals, (3) professional associations, (4) state and local government agencies and (5) others whose work involves persons with mental illnesses and developmental and intellectual disabilities. The Council also includes a small number of mental health professionals who are not attorneys.

We welcome all attorneys to join our Council and read our newsletters.

Thank you,
Scott Hammer ■

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Some new (and old) ways to fix the mental health system in Illinois

Continued from page 1

stantial new source of funding for mental health services in Illinois; (2) the Community Mental Health Act provides an underutilized source of funding for mental health services in Illinois; and (3) there are some innovative new models for delivering mental health services in Illinois.

I. The Affordable Care Act Will Provide Health Care Funding for More than One Million New People in Illinois

The Affordable Care Act (ACA)[5] will dramatically increase the number of people with mental illnesses in Illinois who will have funding for mental health services. That is largely because of Illinois' decision to expand Medicaid under the ACA.[6] The Medicaid expansion provisions extend Medicaid coverage to those with incomes up to 138% of the poverty level from the previous limit of 100% of the poverty level.[7] This expansion will add 672,000 people to the number of people eligible for Medicaid in Illinois.[8] Another 724,000 persons will be eligible under the ACA health insurance exchange in Illinois.[9] Of these newly eligible Illinoisans, 85,000 have a serious mental illness,[10] 190,000 have serious psychological distress[11] and 210,000 have a substance use disorder.[12]

Among the ways that Illinois will benefit from the ACA is its substantial, positive effect on reducing the number of persons with mental illnesses in the criminal justice system. Currently fewer than 10% of the people entering the criminal justice system were enrolled in Medicaid, Medicare or had private insurance prior to their arrest.[13] There are elevated rates of substance abuse[14] and mental illness[15] in this population. For persons with mental illnesses, the lack of insurance or Medicaid coverage usually means that their illnesses have not been treated. In states like Illinois which have chosen to expand Medicaid under the ACA, the vast majority of the people in the criminal justice system will either be covered by Medicaid or be eligible for subsidized health insurance.[16] The Illinois Department of Corrections and county jails will be able to connect those persons with mental illnesses to mental health services promptly upon discharge.[17] This should reduce recidivism in this population.[18]

The ACA will also help Illinois to expand other efforts to divert persons with mental illnesses out of the criminal justice system. For example, in 2008, Illinois enacted the Mental Health Court Treatment Act[19] and then in 2010, the Veterans and Servicemembers Court Treatment Act.[20] These laws are designed to encourage criminal courts across Illinois to identify persons with mental illnesses who are charged with non-violent offenses and divert them to community treatment rather than imprisonment by using probation, supervision or other means. At least 15 counties in Illinois now have some form of mental health court.[21] The number of these courts and the number of participants can be increased now that many more of the eligible participants will have their treatment funded by Medicaid or private insurance.[22]

Other innovative diversion efforts, such as the acclaimed Bexar County (Texas) Jail Diversion Program,[23] can also be more easily implemented in Illinois with the infusion of new Medicaid funding to cover the costs of behavioral health services provided through these programs.

Of course, the Affordable Care Act will not solve all of the problems with the mental health system. For example, Medicaid rates in Illinois remain insufficient to cover the cost of mental health services and our current state Medicaid plan will not pay for many evidence-based and cost-effective services such as supportive housing and supported employment. But we should see substantial improvements in mental health services across Illinois due to the ACA.

II. The Community Mental Health Act Provides an Opportunity for Increased Funding and Local Control of Mental Health Services

In 1967 Illinois enacted the Community Mental Health Act ("the Act").[24] The Act permits a local government unit to hold a referendum to authorize a small property tax (not to exceed 0.15%)[25] to support mental health, developmental disabilities, and substance abuse services within the area served by that governmental entity. The entities permitted to levy such a tax include counties, cities, villages, townships, public health departments, and school districts.[26] The Act requires the creation of a seven-member community mental health board[27] to administer and distribute the funds generated by the property tax levy.[28] This local control is designed to create a process for communities to identify their own priorities and to fill gaps in the behavioral health services funded by the state or other funding sources. Although many counties, cities and townships across Illinois have taken advantage of the Act,[29] most areas of the state are not participating. The Association of Community Mental Health Authorities of Illinois was created in 1972.[30] It is a useful source of information about how to create or improve a community mental health board. Communities across Illinois may wish to take advantage of this Act to improve mental health services.

In 2012 a similar program was established for neighborhoods within Chicago.[31] The Community Expanded Mental Health Services Act[32] now permits neighborhoods to tax themselves at a rate of .025% to .044% to support mental health services.[33] This law operates very much like the Act described earlier. Thus far, only one neighborhood has chosen to pursue this funding strategy. Others may wish to do so.

III. Innovative Mental Health Services in Illinois

Psychiatric boarding is the practice of detaining someone in an emergency department for an extended time due to the unavailability of in-patient psychiatric beds or unavailability of a mental health professional to evaluate the patient. Boarding of psychiatric patients in emergency rooms was found unlawful by the Supreme Court of Washington State.[34] While this decision was based on Washington State law, the problem exists here in Illinois as well. Unlike, patients with non-psychiatric conditions, psychiatric patients typically do not receive any treatment while they are in the emergency department. Also, they must be under surveillance by a security guard or other hospital personnel which is an expensive proposition for the hospital. So, the Illinois Psychiatric Society created a task force to look for solutions to the issue. In fact, the Task Force found that Illinois has some innovative models for reducing the prevalence of psychiatric board-

ing and improving the care of persons with serious mental illnesses. The following summarizes some of these innovations identified by the ISP Task Force.

Living Rooms

The Living Room concept has been implemented in a variety of ways.[35] Some include crisis beds while others do not. The more common model is a comfortable living room where persons in mental health crisis can come and receive immediate treatment. Some Living Rooms are located near emergency rooms so people in crisis can easily be referred to them. They are staffed by peer crisis counselors and usually a clinician (APN/PA). Persons in crisis either walk in or are referred there from an emergency room. The peer crisis counselors sit and talk with the person to try and work through the present problem. The clinician can prescribe medications if the crisis is a result of the person running out of their medications or if medications would help.

Most Living Rooms are open for limited hours and limited days per week. This is due to the cost involved. For example, Peoria started a Living Room with a federally qualified health center (FQHC) with a federal grant. It was used to deflect patients from the hospital or the police department. The Living Room stabilized the patient and connected the patient with medical and psychiatric help. The Living Room was staffed with nurses 24/7. The grant ran out after one year and it was too expensive to maintain so it closed. Now, the State has funded a crisis facility in Peoria with a Living Room, a detox center, emergency services and acute crisis beds for stabilization. The beds have just been started. Patients are actively treated. Other examples of Living Rooms in Illinois include:

a. **Robert Young Hospital:** They are going to build a Living Room into the ED.
b. **MacNeal Hospital:** This hospital is opening a Living Room kitty-corner from the Hospital's ER.
c. **Turning Point:** independent site in Skokie, Illinois
d. **Association for Individual Development**: independent site in Aurora, Illinois.

Telepsychiatry/Telemental Health into Emergency Rooms

Many small and rural hospitals do not have a psychiatrist on staff or even nearby. Thus, when a psychiatric patient presents in an emergency room at such a hospital, the only thing the ER can do is start calling other hospitals to see if they have any open in-patient beds even though the patient may not actually need to be hospitalized. By having equipment set up to do telepsychiatry/telemental health, the patient can actually be treated in the ER and the patient may not even need to be hospitalized. One example of a company offering these services is InSight Telepsychiatry which operates a national call center.[36] Insight Telepsychiatry works with specific ERs. It makes sure psychiatrists are licensed for the state in which the ER is located and has credentialed the psychiatrist at the particular hospital that has contracted with Insight. The psychiatrist is on call and does psychiatric evaluations as needed. Telepsychiatry is being used in Critical Access Hospitals as well. This is a growing area.

Another way telepsychiatry is being used is where a hospital with in-patient and outpatient psychiatric services provides telepsychiatry services to other hospitals in its hospital network. For example, Advocate Christ Hospital is acting as a telepsychiatry hub providing telepsychiatry services to three other Advocate hospitals.

On Site Treatment in the Emergency Department

Like many other Chicago area hospital emergency rooms, due to the decrease in State Operated Facility beds, Advocate Illinois Masonic Medical Center used to have patients staying in the ER for four or five days. While they ended up admitting many uninsured patients, the sheer volume threatened the fiscal viability of the hospital's psychiatric unit. So, the hospital had to put a plan together. They developed a 24/7 Crisis Team staffed by a masters level psychologist or Licensed Clinical Social Worker available to the ER. The ER also has four psychiatric beds that are monitored by round the clock security. A psychiatrist rounds one to two times per day, five to six days/week. Medications are prescribed and staff provides therapy, both Activity Therapy and focused interventions, towards crisis stabilization, often with in-patient staff assistance to make the level of care consistent with care in the in-patient unit. The patients are still under the ER doctor's care but the crisis workers are helping the ER doctors with the psychiatric patients. ED physicians feel more comfortable discharging patients after they have been evaluated by a psychiatrist. In evaluating a psychiatric patient, the hospital has three goals:

a. Can the patient be discharged to a shelter or other community alternative such as Thresholds, Trilogy, or First Access?
b. With patients who have significant substance use comorbidities, can they be sent to a rehab program once their psychiatric status is stable?
c. For those patients to be transferred to a State Operated Facility, patients will be given medication while awaiting transfer, with the rounding psychiatrist titrating the dosage.

Another option to having permanent psychiatric beds in the ER is the use of a pod system in the ER. In this model, regular ER rooms include "garage" type doors that would be used to cover the oxygen and other potentially dangerous ER equipment so they would not be accessible, thereby creating an in-patient room. By having patients in a pod, one security guard can be used for four beds. The doors are kept open so the patients can be monitored. Lurie Children's Hospital and Cadence Health are both using this option.

Treating Patients Outside the Emergency Department

Advocate Illinois Masonic realized that just adding the psychiatric beds in the ER was not sufficient to eliminate psychiatric boarding. Therefore, they created two additional programs designed to keep patients out of the ER.

1. First Access Program. This program is located in a wing of the outpatient clinic across the street from the Advocate Illinois Masonic hospital. When appropriate, patients are walked over from the ER to an intensive out-patient program. The patients go through the program for one or two weeks. The warm hand off and immediate access to treatment are what makes this a good solution to the psychiatric boarding issue. This program has decreased over-crowding in the ER substantially.

2. Medically Integrated Crisis Community Support System (MICCSS) A key problem in healthcare is that 5% of patients use 50% of healthcare resources. By keeping patients out of the ER, substantial savings can be achieved. The third program at Advocate Illinois Masonic, MICCSS, focuses on the patients that frequently use the ER. For example, one patient had 90 ER visits in one year. A team that includes a social worker, nurse and

masters level psychologist, with a back-up psychiatrist, go to shelters to treat targeted patients. Medication is administered to the patient and therapy provided. This prevents the patients from coming to the ER. This is a grant funded program and some of the grant is being used for temporary housing as housing is often an issue for patients with severe mental illness. It also pays for the psychiatrist and the medications.

The IPS Task Force is continuing to research further solutions to the issue of boarding of psychiatric patients in emergency rooms and will be conducting a survey of emergency departments this year to gather more data on the issue. ■

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2. Torrey, *et al.*, "No Room in the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals" (Treatment Advocacy Center, 2012).
3. Owens, *et al.*, "Mental Health and Substance Abuse-Related Emergency Visits Among Adults" Agency for Healthcare Research and Quality (July, 2010); See also, "Increased Emergency Room Use by People with Mental Illnesses Contributes to Crowding and Delays," Report of the Bazelon Center for Mental Health Law: <http://www.bazelon.org/LinkClick.aspx?fileticket=Epvwc7WBOHg%3D&tabid=386>.
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5. The full name is the Patient Protection and Affordable Care Act, 124 Stat.119, P.L.11-148 (2010).
6. In *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566, 183 L. Ed. 2d 450 (2012),the United States Supreme Court held that in order for the ACA to be constitutional, states must be allowed to chose whether or not to participate in the Medicaid expansion portion of the ACA. As of this writing, 27 states (including Illinois) and the District of Columbia have chosen to participate in Medicaid expansion.
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11. *Id.*, Table 2.
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19. Public Act 95-606 (eff. 6/1/08), codified at 730 ILCS 168/1, *et seq*.
20. Public Act 96-924 (eff. 6/14/10) codified at 730 ILCS 167/1, *et seq.*
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23. The Center for Mental Health Services, Jail Diverson Program: <http://www.chcsbc.org/innovation/jail-diversion-program/>; "San Antonia Reduced Its Jail Population by Treating the Mentally Ill" Chicago Magazine online (August 20, 2014): <http://www.chicagomag.com/city-life/August-2014/San-Antonio-Reduced-Its-Jail-Population-By-Treating-the-Mentally-Ill/>
24. 405 ILCS 20/0.1, *et seq.*
25. 405 ILCS 20/4.
26. 405 ILCS 20/2.
27. These boards are often known as "708 boards' because the original legislation authorizing their creation was in a statutory section numbered 708.
28.405 ILCS 20/3a
29. A partial list of participants is available at: <http://www.acmhai.org/membershiplist.htm>.
30. <http://www.acmhai.org/index.html>.
31. Public Act 96-1548 (effective 1/1/12).
32. 405 ILCS 22/1, *et seq.,*
33. 405 ILCS 22/15.
34. *In the Matter of the Detention of: D.W. v. Department of Social and Health Services*, 332 P.3d 423 (Wa. 2014).
35. See For Psychiatric Crises, Alternatives to ERs Have Their Advantages: <http://psychcentral.com/news/2014/01/15/helping-ers-better-care-for-people-in-crisis-or-with-a-mental-illness/64580.html>.
36. See <http://insighttelepsychiatry.com/>.

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Requirement that parents relinquish custody of their children in order to get mental health services addressed by new state law

By Patti Werner

For decades, Illinois parents who could not afford intensive mental health services for their child had two options: deny the child needed mental health services or give custody to the Department of Children and Family Services (DCFS) so the child could receive the necessary treatment. Intensive community-based services are not generally covered by employer-based insurance plans, even when those plans cover outpatient and acute hospital care, leaving parents to pay for services such as residential treatment programs. Parents who could not afford these services were often told that their only option was to relinquish custody to the state so that the child could receive appropriate services.

This practice, also known as psychiatric lockout, is devastating to families, signaling children that they are unwanted. Parents forced to give up a child report feeling as though they have failed as parents. A new law that became effective on January 1, 2015 aims to resolve this issue.

The Custody Relinquishment Prevention Act, 20 ILCS 540, requires DCFS, DHS, and other state agencies to enter into an interagency agreement to prevent children and youth from entering the custody or guardianship of DCFS solely in order to receive services for serious mental or emotional problems. The interagency agreement must address exhaustion of private insurance, income-based cost sharing, and crisis stabilization and care planning for children who are not Medicaid eligible. The law applies to situations where there is no evidence of abuse or neglect.

Although the Act leaves many details to the several state agencies affected by the issue, it does require annual reports to the General Assembly on the progress of the efforts to eliminate psychiatric lockouts. The agencies that must complete the interagency agreement by June 30, 2015, are the Departments of Children and Family Services, Human Services, Healthcare and Family Services, Juvenile Justice, Public Health, and the State Board of Education. ■

Patti Werner is Associate General Counsel for Presence Health.

Mental health legislation adopted by the Illinois Legislature in 2014

By Mark Heyrman

During its 2014 session, the Illinois legislature enacted a number of provisions affecting persons with mental illnesses. This article summarizes the most important of these enactments:

Changes to commitment procedures

Public Act 98-0853 (effective January 1, 2015). When the Mental Health and Developmental Disabilities (MHDD) Code was enacted in 1978, it gave an important right to persons facing involuntary commitment: the right to an independent examination by an expert. 405 ILCS 5/3-804. Unfortunately, the wording of this section is confusing and does not clearly specify who should pay for this examination. As a result, trial courts have sometimes refused to order these examinations. Although reviewing courts have consistently upheld the right to an independent examination, confusion about the implementation of this right has continued. Adding to that confusion is whether the right also applies beyond commitment hearing to include involuntary treatment hearings (medication and electro-convulsive therapy) under Section 2-107.1 and release hearings under Section 3-901. Public Act 98-0853 provides that the county of residence must pay for the examination and that the right applies to treatment and release hearings.

Public Act 98-0975 (effective August 15, 2014). The MHDD Code has long provided for a peace officer to transport someone to a mental hospital if the officer believes that the person meets the criteria for hospitalization. However, that belief has to have been the "result of personal observation." Several years ago, the requirement of personal observation was removed from Section 3-606 of the MHDD Code governing the transportation of adults. This change was based upon the fact that peace officers can arrest and transport to jail someone for whom there is probable cause of criminal behavior without "personal observation." Often peace officers will have discretion about whether to treat particular behavior as criminal or as the basis for hospitalization. The MHDD Code should not make the latter more difficult than the former. Public Act 98-0975 makes a similar change to Section 3-504 governing the transportation of a minor by a peace officer.

Public Act 98-0865 (effective August 8, 2014). A person may be detained pending an involuntary commitment hearing based upon the timely completion and filing of a petition and two certificates. The MHDD Code has clearly required that the petition and the first certificate be promptly served on the respondent. The law has been less clear about serving the second certificate on the respondent, and some hospitals have failed to do so. This amendment clarifies that both certificates must be served on the respondent.

Psychologist prescribing privileges

Public Act 98-0668 (effective June 25, 2014). After many years of conflict between physicians and psychologists over such legislation, 2014 saw the enactment of a law permitting psychologists, with special additional training, to be licensed to prescribe

medications. This law may help relieve the shortage of psychiatrists, which may be exacerbated by the number of people newly enrolled in health insurance or eligible for expanded Medicaid under the Affordable Care Act. Illinois joins a small number of states which have taken this step.

Sale of state psychiatric hospitals

Public 98-0815 (effective August 1, 2014). Like every other state, Illinois has been reducing the number and size of its state-operated psychiatric hospitals. Most recently, it closed Tinley Park Mental Health Center in the south suburbs of Chicago and Singer Mental Health Center in Rockford. Public Act 98-0815 amends existing statutes (20 ILCS 1705/18.4 and 405 ILCS 30/4.6) to strengthen the requirement that the funds from the sale of the land under closed hospitals be spent on mental health services and to provide that some of those funds be set aside for the geographic area served by the closed hospitals.

Access to psychotropic medications

Public Act 98-0651 (effective June 16, 2014). Several years ago, as part of the effort to reduce Medicaid spending, the legislature passed a law requiring prior authorization whenever a Medicaid recipient exceeded four prescription medication in a month. Because the prior authorization process for Medicaid is quite burdensome and people with serious mental illnesses often need many medications, many persons were cut off of their psychotropic medications. Public Act 98-0651 has now exempted antipsychotic medications from the four-drug restriction.

Public Act 988-1035 (effective August 25, 2014). Requires health insurance companies to provide additional information to consumers about the coverage being provided and streamlines the process for obtaining access to medications that are not on the provider's preferred drug list.

Changes to procedures for "forensic patients"

Public Act 98-1025 (effective August 28, 2014). As the Department of Human Services (DHS) has reduced the number of state-operated psychiatric beds, the percentage of those beds devoted to so-called "forensic patients"–insanity acquittees and unfit criminal defendants–has grown dramatically. Currently, the majority of state beds are devoted to this population. The number of forensic patients has exceeded capacity for a number of years, leading to forensic patients being kept in county jails for extended periods while waiting for a bed in a state facility. Public Act 98-1025 contains two provisions which were designed to speed up the processing of forensic patients and to give DHS greater flexibility about where to place forensic patients. The special statutes governing the confinement of unfit criminal defendants (USTs) and insanity acquittees (NGRIs) have for some time required that these patients be confined in "a secure setting" within DHS unless placement in some other setting was approved by specific court order. This provision has proven confusing since "secure setting" is not defined, and all DHS settings are quite secure. Public Act 98-1025 eliminates the requirement for court approval for placement in any DHS facility. The law governing the confinement of USTs limits the confinement of unfit felons to a period relating to their maximum sentence but is silent about misdemeanants. Public Act 98-1025 places a similar limit on the confinement of misdemeanants. The law also clarifies that Section 2-107.1 of the Mental Health and Developmental Disabilities Code, 405 ILCS 5/2-107.1, applies to unfit defendants. This provision authorizes hearings to determine whether someone who cannot consent to psychotropic medication may be ordered to take such medications.

Reducing custody relinquishment as a condition for obtaining services for children with disabilities

Public Act 98-0808 (effective January 1, 2015). See companion article by Patti Werner.

Videotaping of fitness examinations

Public Act 98-1025 (effective January 1, 2015). An amendment to 720 ILCS 5/104-15 requires that a person conducting an examination concerning the fitness to stand trial of a criminal defendant may be required to turn over her/his notes to another examining expert. An examination done by someone retained by the state or the defense must also be videotaped unless that would be "impractical." ■

Mark J. Heyrman is a Clinical Professor at the University of Chicago Law School.

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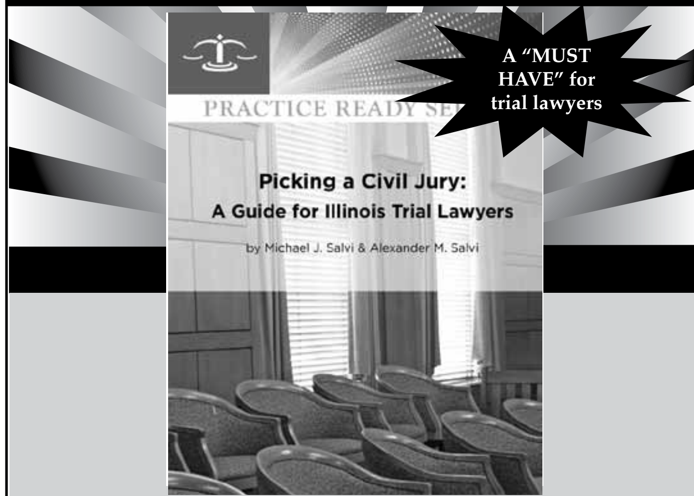

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