ILLINOIS STATE BAR ASSOCIATION

SEPTEMBER 2017 VOL 4 NO. 1

Mental Health Matters

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

Summary of "Innovations in Mental Health Law: Outpatient Treatment in Illinois"

BY DARA M. BASS

On May 17, 2017, the ISBA Mental Health Law Section Council hosted a Continuing Legal Education event, focused on the innovations in mental health law surrounding outpatient treatment. A number of speakers participated in this live, half-day event, sharing their professional involvement with outpatient commitment.

Cook County Assistant State's Attorney David S. Lee, was the first speaker. He works in his office's Division of Seniors and Persons with Disabilities. He discussed the new Cook County outpatient commitment program, initiated by the Assisted Outpatient Treatment (AOT) grant. The grant is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Lee

Continued on next page

Summary of appellate opinions

BY ANDREAS LIEWALD

District Court Cases

***In re Carol B.,* 2017 IL App (4th) 160604 (August 24, 2017)**

The Fourth District reversed trial court's orders for involuntary admission and involuntary treatment for "egregious" and "cumulative" violations of section 2-107(a) of the Mental Health and Developmental Disabilities Code (Code). 405 ILCS 5/2-107(a). ¶3, 59, 67.

Background

After 34 days after respondent's admission to a mental health facility, a hearing on the State's petitions for involuntary admission and involuntary treatment (psychotropic medication and 12 sessions of electroconvulsive therapy - ECT) commenced. ¶2, 10, 16. A week prior to the hearings, respondent's counsel pointed out the lengthy period of time respondent had been hospitalized while awaiting a hearing and emphasize the importance of moving forward with the hearings as soon as possible due to the State's administration of psychotropic medication and ECT without respondent's

Continued on page 3

***(Notice to librarians:** The following issues were published in Volume 3 of this newsletter during the fiscal year ending June 30, 2017: October, No. 1; December, No. 2; February, No. 3; June, No. 4).*

If you're getting this newsletter by postal mail and would prefer electronic delivery, just send an e-mail to Ann Boucher at aboucher@isba.org

Summary of "Innovations in Mental Health Law..."

CONTINUED FROM PAGE 1

highlighted the goals of the program as including: working with families and courts to prevent homelessness, incarcerations, and interactions with the criminal justice system. He discussed in detail how the Illinois Mental Health and Developmental Disability Code ("the Code") addresses outpatient commitment and the role of the State's Attorney in those proceedings. For instance, he outlined how the Code already provides for many contingencies, such as a respondent's non-compliance. It also gives process for contested orders, though the standard of proof is higher (clear and convincing evidence) in those cases. Ultimately, the goals of the programs are to strengthen the existing infrastructure in the Code and to expand an evidence-based treatment system.

Matthew Davison, contract counsel under the AOT grant for Legal Advocacy Services, a division of the Illinois Guardianship and Advocacy Commission, spoke about some of the benefits and practical aspects of outpatient commitment. He noted that it provides infrastructure at facilities, a mechanism for referring medication, and a provision for treatment outside the facility. Davison spoke about committing the system to an individual rather than committing an individual to the system. He discussed the role of the court in ensuring that a patient in outpatient commitment has adequate services and residential placement. He emphasized the challenges surrounding the population of homeless persons and the importance of securing housing and extending services to shelters. He noted that hospitals' commitment to this process may save money for both the consumers and for the state.

Robert Connor, a 30-year veteran attorney for the Illinois Department of Human Services, introduced the second portion of the program, involving case scenarios and practical tips for outpatient mental health treatment. Connor has extensive knowledge on the Mental Health and Developmental Disabilities Code as well as the Illinois Confidentiality Act, and he has been involved in the development of the AOT legislation. He described all the forthcoming speakers as being pioneers of outpatient commitment, with experience in the area before it was even a part of the statute.

Mark Epstein, of the law firm Epstein and Epstein, was the first to speak in this section. He practices in the areas of metal health, guardianship and elder law. An adjunct professor of law at Northwestern University Law School, he has litigated leading mental health law cases in the state of Illinois and is a past chairperson of the Illinois State Bar Association's Mental Health Law Committee. Epstein delivered a presentation discussing the extension of agreed outpatient admission orders. He stated that the order for outpatient admission may be extended, by agreement, for additional 180-day periods. He discussed strategies for better implementation of assisted outpatient treatment. Epstein explained that Illinois has solid laws in this area though it needs to improve its implementation of these laws. He mentioned that judges are willing to implement this tool when they see that it is a less-restrictive alternative. He discussed, as well, the concept of therapeutic jurisprudence, wherein consumers benefit merely from receiving representation, as they gain an ability to negotiate with their illness.

Barbara Goeben, a graduate of Northwestern University Law School, currently works for the Legal Advocacy Service, representing clients at both the trial and appellate levels. She previously worked for Land of Lincoln Legal Assistance Foundation. Goeben spoke about various aspects of entering outpatient orders. She uses modified outpatient orders to provide for respondents who have a history of non-compliance once they are discharged from the hospital. These orders can specify the respondent's responsibilities and detail what is to happen in the event of non-compliance or need for re-hospitalization. This provides a better connection between the consumer and a service provider who gives supportive

Mental Health Matters

Published at least four times per year. Annual subscription rates for ISBA members: $25.

To subscribe, visit www.isba.org or call 217-525-1760.

OFFICE
ILLINOIS BAR CENTER
424 S. SECOND STREET
SPRINGFIELD, IL 62701
PHONES: 217-525-1760 OR 800-252-8908
WWW.ISBA.ORG

EDITOR
Sandra M. Blake

MANAGING EDITOR / PRODUCTION
Katie Underwood
kunderwood@isba.org

Postmaster: Please send address changes to the Illinois State Bar Association, 424 S. 2nd St., Springfield, IL 62701-1779.

services.

Bruce Jefferson, who has been the general counsel for Thresholds for 11 years, discussed the role of Thresholds in mental health treatment and the ability of the organization to provide housing for those in outpatient treatment programs. Thresholds is a community-based, not-for-profit mental health provider in the Chicago metropolitan area. Jefferson mentioned that Thresholds works to reduce the number of emergency room visits by consumers. Further, Thresholds has started to provide wrap-around services. They also maintain a veteran and youth program. Jefferson emphasized how the outpatient orders have helped consumers to participate in their care plans and stay informed.

The morning's final speaker was Joseph Monahan, the founder of Monahan Law Group and is one of the preeminent mental health law attorneys in Illinois. His firm represents over 78 hospitals in the Chicago metropolitan area and provides legal representation and advocacy to numerous mental health clinics and child welfare agencies in the state. Monahan is an adjunct professor of law at Loyola University School of Law. He said that from the standpoint of hospitals, the outpatient commitment order can help get consumers the residential treatment they need and can provide tools to provide the continuity of care that consumers need. He explained that due to penalties for re-admission within 30 days of hospital discharge, hospitals have an interest in consumers getting the outpatient services that they need. Monahan said that an ideal situation is a structure whereby the consumer will no longer need a court involved. ■

Dara M. Bass is an independent contractor attorney, based out of the Chicago area, who is licensed in Illinois and Missouri. She has been a member of the ISBA's Mental Health Law Committee since 2006, currently serving as the Section Council Secretary. She may be contacted at: darabasslaw@gmail.com.

Summary of appellate opinions

CONTINUED FROM PAGE 1

consent. ¶13. Respondent's counsel further argued that the administration of the medication and ECT violated section 2-107 of the Code because no emergency situation necessitated that administration of medication prior to the hearing, as medical records showed respondent was eating regularly with prompting. ¶13. Respondent's counsel asserted, as a result of the delayed proceedings, the mental health facility would be nearly finished with respondent's ECT treatments before she received a hearing, which circumvented the provisions of the Code and respondent's rights. ¶13. Respondent's counsel also stated that she would ask for a temporary restraining order to prevent the further administration of medication, but suddenly halting the medication would place respondent's health at risk. ¶13.

Respondent declined to attend the hearings. ¶17, 28. The treating psychiatrist testified that upon respondent's admission, respondent was delusional and displayed catatonic symptoms (staring, engaging in repetitive behaviors, exhibiting bizarre behaviors, displaying waxing flexibility, and refusing to eat or cooperate with treatment plans). ¶18. One of the psychiatrist's biggest concerns was respondent's inconsistent eating, as she would sometimes eat nothing and sometimes would eat everything on her tray. ¶18. "She required prompting from staff to eat." ¶18. The psychiatrist opined that respondent lacked the capacity to consent to treatment. ¶19. Because she lacked capacity, the psychiatrist determined that she also lacked the capacity *to refuse* treatment. ¶19. Therefore, starting on the day of her admission, the psychiatrist authorized the administration of three psychotropic medications without respondent's consent. ¶17, 19. At the time, the psychiatrist admitted respondent's condition would not cause serious and imminent physical harm to herself or others. ¶19, 33. The psychiatrist provided respondent with written documentation of the side effects of every recommended medication approximately four days after beginning treatment. ¶31.

Thirteen days after respondent's admission and 21 days prior the hearings, the psychiatrist found respondent posed a risk of serious and imminent physical harm to herself by her failure to eat and engage in basic hygiene. ¶20, 33. He therefore ordered ECT on an emergency basis four days later for three times per week. ¶20. By the date of the hearing, she had completed 8 of 12 rounds of ECT, some of which were administered despite her resistance. ¶20, 33, 35. The psychiatrist opined that respondent lacked the capacity to refuse. ¶35. In justifying the emergency ECT, the psychiatrist explained that a person could die of malnutrition in a matter of weeks or months. ¶21. He testified that respondent's eating was inconsistent and that from the date of her admission, she had lost 5 pounds – from 160 pounds down to 155 pounds. ¶21. At 5 feet 4 inches tall, respondent's ideal weight was 120 pounds. ¶21. He testified that respondent's condition was not so serious as to warrant a feeding tube and that she would eat when prompted. ¶21. Although respondent had developed depressive symptoms such as hopelessness and passive thoughts of death (such as hoping to die), she never expressed any desire or intention to kill herself and did not require any one-on-one monitoring. ¶22.

The trial court found the State violated section 2-107(a) of the Code by administering psychotropic medication to respondent without her consent when there was no threat of serious and imminent physical harm. ¶2, 40, 405 ILCS 5/2-107(a). However, the court found the violation to be harmless and granted both orders for a period not to exceed 90 days. ¶2. Respondent appealed both orders, asserting violations under section 2-107 of the Code. ¶3.

Analysis

(1) Mootness

Respondent's appeal centered on the State's involuntary administration of medication in violation of section 2-107 of the Code and the consequences that can arise from such a violation. ¶47. The appellate court found that this question is of a public nature and likely to recur in the future, as the State's application and interpretation of the Code affects any patient involuntarily admitted. ¶47. Thus, there exists a need for an authoritative determination to guide mental health professionals and the State when those professionals decide to administer involuntary treatment prior to the trial court entering an order authorizing the treatment." ¶47. Respondent argued that the State's administration of involuntary treatment prior to the involuntary-admission proceedings affected her due-process rights by altering her mood and behavior prior to her opportunity to be heard. ¶49. The appellate court concluded that, under these circumstances, the public-interest exception to the mootness doctrine applied for both the involuntary admission and involuntary treatment orders. ¶49.

(2) The mental health facility violated section 2-107(a) of the Code

"Involuntary-admission proceedings implicate an individual's liberty interest." ¶51, *In re Torski C.,* 395 Ill. App. 3d 1010, 1017 (4th Dist. 2009). "The Code's procedural safeguards are not mere technicalities but essential tools to safeguard these liberty interests." ¶51, *In re John R.,* 339 Ill. App. 3d 778, 785 (5th Dist. 2003).

Absent a situation where respondent posed a threat to cause serious and imminent physical harm to herself or others, the psychiatrist lacked a legal basis to administer the medication. ¶54. The psychiatrist began administering three psychotropic medications to respondent on the date of her admission, despite his belief that she was not at risk for serious and imminent physical harm at that time. ¶54. "He did this under the belief that respondent's lack of capacity rendered her 'unable to refuse' treatment." ¶54. The appellate court found that the psychiatrist's "opinion that he could administer treatment to respondent because she was incapable of refusing is a gross misinterpretation of section 2-107(a) of the Code." ¶55. Under the psychiatrist's logic, "when a patient lacks capacity, regardless of whether that patient's condition may cause serious and imminent physical harm, he may choose whatever treatment he deems appropriate prior to any court hearings because the patient can neither consent to nor refuse his decision." ¶55. "Here, because respondent lacked the capacity to consent to treatment and her condition did not require administration of medication to prevent her from causing serious and imminent physical harm to herself or others, the trial court properly found the State violated section 2-107(a)." ¶55, 405 ILCS 5/2-107(a).

(3) Remedy for violation of section 2-107(a) of the Code

The appellate court noted that the Code sets no specific remedies for violation of section 2-107(a). ¶57, 405 ILCS 5/2-107(a). It rejected the State's argument that section 2-107(a) violation constituted harmless error as to respondent's involuntary admission where respondent is unable to demonstrate prejudice. ¶57. Instead, it agreed with respondent that "the egregious, cumulative errors" in this case were not harmless and, instead, violated respondent's due-process rights. ¶59.

First, the psychiatrist administered psychotropic medication when respondent's condition did not require the administration of medication to prevent respondent from causing serious and imminent physical harm to herself or others. ¶59. Following the harmless-error analysis (citation omitted), the appellate court noted that respondent was not in a position to make a timely objection to the involuntary administration of treatment because, at the time the psychiatrist authorized the medication, the court proceedings and appointment of counsel would not commence for more than three weeks. ¶59. Moreover, in the psychiatrist's own words, "respondent's lack of capacity rendered her incapable of refusing any medication he chose to administer." ¶59. "Given these circumstances, the violation of section 2-107(a) could not be easily cured." ¶59. As noted by respondent's counsel, respondent had been administered psychotropic medication for more than three weeks by the first court appearance, and such medication could not be suddenly stopped without placing respondent's health at risk. ¶59.

The appellate court rejected the State's assertion that the violation of section 1-107(a) made no difference in the end, as the trial court granted the petitions. ¶60. The appellate court was not willing to accept the argument that "the ends justify the means" in this situation. ¶60. It noted that by placing respondent on psychotropic medication when she did not pose a risk to cause serious and imminent physical harm to herself or others, the trial court lost the ability to determine respondent's mental capacity for itself. ¶60. "In this situation, we have evidence the medication altered respondent's mood and behavior" and "we cannot say the premature administration of medication 'made no difference.'" ¶60. The court noted, for example, that although respondent self-reported as "happy" at the time of her admission, by the hearing date, her mental state had declined to the point that she hoped to die. ¶60.

Second, the appellate court found that the State's delay in filing its amended petition left respondent involuntarily admitted for more than a month before she received a hearing date. ¶61. During this time the psychiatrist subjected respondent to psychotropic medications in the face of no evidence that the medication was necessary to prevent respondent from causing serious and imminent physical harm and subjected respondent to undergo eight rounds of ECT – which required anesthesia and triggered seizures – on the basis that she was a serious and imminent threat to herself, as she was not eating properly or bathing regularly. ¶61.

The appellate court held that the legislature could not have contemplated that a patient would wait over a month for a hearing, all the while being administered medication involuntarily. ¶62. "Where a respondent lacks the capacity to consent, she relies on the Code to protect her rights." ¶62. A delay of over a month nearly permitted the mental health facility to circumvent the Code by treating and

releasing respondent before she had the opportunity for a hearing. "Such a delay is inexcusable and shows a complete disregarding for respondent's liberty interests." ¶62.

Third, the psychiatrist admitted that he did not initially provide respondent with written information regarding the risks, benefits, side effects, and alternative treatment prior to starting the psychotropic-treatment regimen when respondent was first admitted. ¶64. The appellate court rejected the State's argument that the delay was *de minimis,* as she received the written documentation prior to her hearing. ¶64. It noted that the psychiatrist failed to gather that "[t]he rights provided in the statute were not placed in the Code to ensure that a respondent understands a medication's side effects but to ensure a respondent's due process rights are met and protected." ¶64, *In re John R.,* 339 Ill. App. 3d 778, 784 (5th Dist. 2003).

The appellate court found that the trial court was charged with determining whether respondent possesses the capacity to make a reasoned decision about her treatment. ¶65. Here, respondent was deprived of her opportunity to refuse the medication, and because she was already on medication for a significant period of time prior to the long-delayed hearing, the trial court had no way of determining whether respondent lacked the capacity to consent at the time of her admission. ¶65. The appellate court also found that whether the side effects of the medications were worth the risk was an issue for the trial court, yet the psychiatrist took it upon himself to decide that the possible side effects—which included death for dementia patients, heart attack, and suicidal behavior—were worth the risk. ¶66. "Respondent was entitled to her day in court before the long-term administration of mind—and behavior—altering medication." ¶66.

Conclusion

The appellate court declined to find the error harmless, and accordingly reversed the trial court's involuntary-admission order. ¶67. Further, because the appellate court reversed the trial court's involuntary-admission order, respondent no longer qualified as a "[r]ecipient of services" for the administration of involuntary treatment under section 1-123 of the Code. ¶67, 405 ILCS 5/1-123, citing *In re John N.,* 364 Ill. App. 3d 996, 998 (3rd Dist. 2006). The appellate court therefore also reversed the court's involuntary-medication order. ¶67.

***People v. Gunderson,* 2017 IL App (1st) 153533 (June 20, 2017)**

The First District Court affirmed a trial court's denial of Petition for Discharge from the custody of Department of Human Services (DHS) for a recipient found not guilty by reason of insanity on an attempted murder charge. ¶1. Gunderson-petitioner argued that section 5-2-4(g) of the Unified Code of Corrections (Code) violated his right to due process, because it requires him to prove by clear and convincing evidence that he no longer suffers from a mental illness. ¶1, 730 ILCS 5/5-2-4(g). The appellate court found the statute constitutional. ¶1.

Background

In 2002, following a bench trial, petitioner was found not guilty by reason of insanity on attempted murder and aggravated battery charges. ¶2. In 2015, Gunderson filed a motion for discharge from DHS, or for on-grounds pass privileges. ¶4. At the hearing on the motion, petitioner's mother testified that she believed that he had recovered from his illness, that he did not present a threat of harm to anyone, and that he could live with his parents. ¶4. Petitioner's treating psychiatrist recommended on-grounds pass privileges. ¶5. The treating psychiatrist testified that petitioner no longer showed any symptoms of mental illness – with schizophrenia in remission, that he was not prescribe any medication, and that he progressed well without medication since 2011. ¶5. Petitioner's social worker testified that although no one on the treatment team recommended discharge for him, she never saw petitioner act aggressively, saw no signs or symptoms of schizophrenia, and signed onto the recommendation for on-grounds passes to assess how well defendant could handle increased freedom. ¶6. A psychologist, who reviewed the treatment team's recommendations, agreed that petitioner should have on-grounds passes and that petitioner presented little risk of violent behavior. ¶7. Another psychiatrist who examined petitioner in 2003 and 2004 and briefly in 2015, opined that schizophrenia is always a lifelong illness that patients can control only with antipsychotic medication. ¶8. The psychiatrist did not know of any studies that support his assertions, but he knew of no instance in which a schizophrenic patient recovered without remaining on antipsychotic medication for life. ¶9. He found that petitioner showed several signs of continuing schizophrenia and opposed the request for on-grounds pass privileges. ¶8, 9. Finally, a clinical psychologist testified that according to every controlled study of patients treated for schizophrenia for more than one year showed that schizophrenic patients given minimal medication, or no medication at all, had much better recovery rates than patients treated regularly with antipsychotics. ¶10. The clinical psychologist tested and interviewed petitioner, found that he no longer met the criteria for a diagnosis of schizophrenia. ¶12. He opined that petitioner presented only a low level of risk for adverse behavior with more freedom and concurred with the recommendation for on-grounds passes to assess his response to increased freedom. ¶12.

The trial judge found the clinical psychologist not credible and gave little weight to the testimony of his treatment team. ¶13. Instead the judge relied on his interpretation of petitioner's body language and the testimony of the second psychiatrist. ¶13. Although the judge relied on the second psychiatrist's opinion, the judge expressly said that he was not convinced that patients must have antipsychotic drugs for life to control schizophrenia. ¶13. The judge denied the motion for on-grounds passes and the motion for discharge. ¶13.

Issue Appealed

Whether section 5-2-4 of the Code, which requires petitioner found not guilty by reason of insanity to present clear and convincing evidence that he no longer meets the criteria for involuntary commitment before he can obtain discharge, is unconstitutional. 730 ILCS 5/5-2-4(g). ¶16, 26. Petitioner abandoned his

pursuit of on-grounds passes. ¶16.

Analysis and conclusion

The appellate court found that petitioner presented a *prima facie* showing that he no longer suffered from a mental illness. ¶18. (While the treating psychiatrist diagnosed petitioner's condition as schizophrenia in remission, that diagnosis remained compatible with a finding that he no longer suffered from a mental illness. ¶17, *Levine v. Torvik,* 986 F.2d 1506, 1513-14 (6th Cir. 1993) *overruled in part on other grounds by Thompson v. Keohane,* 516 U.S. 99, 111 (1995). See also *Foucha v. Louisiana,* 504 U.S. 71, 85 (1992). ¶18.) However, section 5-2-4(g) requires a petitioner who seeks discharge to prove, by clear and convincing evidence, either that he has no mental illness or that he is not dangerous. ¶19. See *People v. Wolst,* 347 Ill. App. 3d 782, 790 (2004). The appellate court agreed with the *Wolst* court and its underlying reason under *United States v. Wattleton,* 296 F.3d 1184 (11th Cir. 2002), and held that section 5-2-4 of the Code does not violate petitioner's right to due process. ¶21, 26. Affirmed. ¶27.

***People v. Jackson,* 2017 IL App (1st) 142879 (June 27, 2017) (Corrected July 24, 2017)**

Background

After Jackson-defendant called 911 for an ambulance, paramedics arrived to find him "agitated," "nervous," "irrational," and "very uncooperative," suffering from some type of psychological issue and with an "altered" mental state. ¶1. The paramedics then called for police assistance. ¶1. After the police arrived, defendant screamed and flailed. ¶1. One police officer used his 50,000 volts taser on defendant, striking him 10 times, and the other officer tried to grab defendant and was kicked in the shins. ¶1, 3. Ultimately, the police subdued him and placed him into an ambulance to be transported to a hospital. ¶1. Defendant was charged with battery and resisting arrest, and after a jury trial, was convicted of the charges. ¶1.

Analysis

(1) The State did not prove defendant's mens rea or mental state

The appellate court found that the evidence was insufficient to support a finding that defendant had the requisite mental state to commit the crimes of battery and resisting a peace officer. ¶24, 26. Rather, there was an abundance of evidence – almost all of it from the State witnesses – defendant was not "knowingly" acting during the incident. ¶26. Both paramedics, observed, on their arrival, that defendant was "nervous" and "agitated". ¶26. One paramedic though defendant was suffering from some type of psychological issue and the other paramedic though that defendant's mental state was altered. ¶26. For example, though the paramedics were in uniform, and driving a vehicle distinctively marked as an ambulance, defendant repeatedly denied they were paramedics and continued to call 911. ¶26. Although defendant exhibited verbal coherence, it does not indicate a "knowing" state of mind indicating that he understood what was happening to him. ¶26. The appellate court did not know the cause of defendant's behavior (i.e., epilepsy, drug intoxication, some undiagnosed mental illness, or being tasered 10 times), but did not need to know. ¶27. The appellate court found the State's evidence establishing defendant's *mens rea* or mental state, here his knowledge, was so conflicting, so unsatisfactory, as to create reasonable doubt of defendant's guilt. ¶31. Accordingly, the evidence was insufficient to support defendant's conviction. ¶31.

(2) The trial court neglected to ask potential jurors proper questions during jury selection

Supreme Court Rule 431(b) mandates that a trial court ask potential jurors whether they "understand [ ] and accept [ ]" these four principles: (i) the defendant is presumed innocent; (ii) the State must prove the defendant guilty beyond a reasonable doubt; (iii) the defendant is not required to offer any evidence on his or her own behalf; and (iv) the defendant's failure to testify cannot be held against him or her. ¶37, Ill. Sup. Ct. R. 431(b), *People v. Thompson,* 238 Ill.2d 598, 606-07 (2010). Failure to question the jurors on each of these four principles violated the rule. ¶37, citing *Thompson* 238 Ill. 2d at 607. During *voir dire,* the trial court neglected to use the words "understand and accept," but rather asked potential jurors if they disagreed with the four principles or would be unable to follow them. ¶38. The appellate court found that the State rightly conceded error on this issue. ¶38.

(3) Admission of testimony of possible marijuana usage was plain error

"Other-crimes" evidence may not be admitted to prove a defendant's propensity to commit a crime because a jury might convict the defendant not based on the evidence, but that the defendant deserves punishment. ¶40, *People v. Placek,* 184 Ill.2d 370, 385 (1998). Nonetheless, this type of evidence can be admitted to prove intent, *modus operandi,* identity, motive, absence of mistake, or any material fact other than propensity that is relevant to the case. ¶40, *People v. Donoho,* 204 Ill.2d 159, 170 (2003). Even when the evidence is admissible, the trial court must weigh its prejudicial effect versus its probative value, and exclude it if too prejudicial ¶40, *Placek,* 184 Ill.2d 385.

Although the State argued that the testimony regarding a cannabis smell was relevant to the "continuing narrative" of defendant's arrest as it informed the actions of both the police and paramedics, the appellate court found that none of the evidence presented regarding the cannabis smell was, in fact, part of any continuing narrative. ¶41. Even crimes that occur in close proximity will not be admitted as part of a continuing narrative "if the crimes are distinct and undertaken for different reasons at a different place at a separate time." ¶41, (internal quotations and citations omitted) *People v. Adkins*, 239 Ill.2d 1, 33 (2010). The appellate court found that assuming the cannabis smell indicated that defendant had illegally used marijuana, no medical evidence was introduced as to when or where he had used it, or that he was still under its influence during the incident. ¶41. There was nothing linking possible marijuana use with defendant's behavior, and there was nothing to indicate that the marijuana smell impacted anyone's actions, either the defendant's, the police's and the paramedics'. ¶41, 42. The witnesses consistently testified that defendant was irrational, uncooperative, and agitated, and that they were not sure why he was behaving the way he did. ¶42. "Admission of this evidence was error." ¶43.

(4) The admission into evidence of "lay opinion" testimony from paramedics that defendant did not suffer from a seizure constituted error

Lay witnesses can testify based on a rational perception if it is helpful for the determination of a fact in issue. ¶48, Ill. R. Evid. 701(a), (b); *People v. Donegan*, 2012 IL App (1st) 102325, ¶42. But, lay witnesses cannot testify to an opinion based on scientific, technical, or other specialized knowledge. ¶48, Ill. R. Evid. 701 (c); *Donegan,* 2012 IL App (1st) 102325, ¶42. The paramedics' lay opinion testimony was improper under Illinois Rule of Evidence 701, since they were not properly qualified as an expert witness on seizures. ¶51, 53, Ill. R. Ev. 702. If the paramedics had limited their testimony to their own observations or defendant's behavior, it would have been admissible. ¶54. The appellate court held that the admission of these lay opinions was error because it violated Illinois Rule of Evidence 701 and went to the ultimate question of fact to be decided by the jury. ¶57, *People v. Brown,* 200 Ill. App. 3d 566, 579 (1st Dist. 1990).

(5) The prosecutor made improper comments during closing argument.

The appellate court found that the prosecutor made improper comments during closing argument about the marijuana smell and the opinion testimony. ¶75. However, it was not so serious that they denied defendant a fair trial or cast doubt on the reliability of the judicial process. ¶75.

Conclusion

The appellate court reversed the trial court's conviction. ¶81. The appellate court noted that battery against a police officer is a serious charge, but being kicked in the legs by a mentally unstable person (causing no serious injury) is not the type of touching that requires either specific or general deterrence. ¶3. The appellate court also noted that the officers should receive training in how to de-escalate such a situation and that the prosecution was a waste of time and money. ¶3, 4.

***In re Tara S.,* 2017 IL App (3d) 160357 (August 3, 2017)**

The Third District Court reversed orders for involuntary admission and for administration of psychotropic medication. ¶1. The appellate court found that respondent's counsel's performance was deficient for not objecting to State's omission of testimony of an expert who had not personally examined respondent. ¶23. The State's expert psychiatrist testified that she had not personally examined respondent. ¶23. Counsel's omission prejudiced the outcome of proceedings, as respondent could not be subject to involuntary admission without testimony of expert who had personally examined her. ¶23. Counsel's performance was also deficient for not raising omission of any written information on one of the medications (lithium) it had ordered. ¶26.

Background

On the date of the hearing for involuntary admission, a psychiatrist, the State's expert witness, testified that although the expert witness had reviewed respondent's medical records, she had not personally examined respondent. ¶6. The trial court found respondent subject to involuntary admission and then proceeded to a hearing on the State's petition for involuntary treatment. ¶9. After a hearing involving the testimony of the same psychiatrist, the trial court found respondent subject to involuntary treatment for a period of up to 90 days. ¶10-12. There was no record that respondent was given written information about one of the medications (lithium) ordered by the circuit court. ¶26. Respondent appealed. ¶12.

Analysis and Conclusion

1. The appellate court reviewed this case under the capable of repetition yet avoiding review exception to mootness

In addressing the mootness issue, the appellate court emphasized the importance of respondent's legal counsel in mental health proceedings. ¶17. "Absent ineffective assistance of counsel review, the statutory guarantee of counsel is rendered a ' "hollow gesture serving only superficially to satisfy due process requirements." ' " ¶17, *In re Carmody,* 274 Ill. App. 3d 46, 55 (4th Dist. 1995) (quoting *In re Commitment of Hutchinson,* 421 A.2d 261, 264 (Pa. Super. Ct. 1980)). ¶17. "Counsel's actions protect respondent's constitutionally protected liberty interest to refuse the administration of psychotropic drugs." ¶17, U.S. Const., amend. XIV; see also *In re C.E.,* 161 Ill.2d 200, 214 (1994) (holding that "mentally ill or developmentally disabled [persons] have a Federal constitutionally protected liberty interest to refuse the administration of psychotropic drugs"); *In re Benny M.,* 2015 IL App (2d) 141075, ¶ (noting "like defense counsel in a criminal proceeding, the respondent's counsel in a mental health proceeding plays an essential role in ensuring a fair trial").

"Generally, court of review do not decide moot questions." ¶16, *In re Alfred H.H.,* 233 Ill. 2d 345, 351 (2009). "However, the 'capable of repetition yet avoiding review' exception permits review of an otherwise moot issue." ¶16, *Id.* At 358. This mootness exception has two elements: (1) the challenged action is of a duration too short to be fully litigated prior to its cessation; and (2) there is a reasonable expectation that the complaining party will be subject to the same action again. ¶16, *Id.* At 358. The parties agreed that the present issue (ineffective assistance of counsel) satisfied the first prong. ¶16. However, the State argued that there was not a reasonable expectation that respondent would be subject to the same action again. ¶16.

The appellate court found that respondent's ineffective assistance of counsel issue satisfied the second prong. ¶17. The record established that respondent had a 10-year history of mental illness, which included two prior hospitalizations. ¶17. The appellate court noted that there was no evidence presented that the proposed treatment plan would alleviate respondent's mental illness entirely. ¶17. "Rather, the evidence showed that her cognitive function would be stabilized once the treatment was in full effect." ¶17. However, respondent had discontinued treatment in the past. ¶17. "Therefore, it is very likely that respondent will face future involuntary hospital admission or involuntary administration of psychotropic medication proceedings." ¶17. "As respondent is statutorily entitled to counsel during these proceedings (405 ILCS 5/3-805), ineffective assistance of counsel issues are likely to recur." ¶17.

(2) Respondent received ineffective assistance of counsel when counsel failed to object that the expert witness testifying did not personally examine her and when counsel failed to raise to the trial court that respondent was not given written information about one of the medications ordered

(A) Examination of Medical Expert

Section 3-807 of the Mental Health and Developmental Disabilities Code (Code) provides, "No respondent may be found subject to involuntary admission on an inpatient or outpatient basis unless at least one psychiatrist, clinical social worker, clinical psychologist, or qualified examiner *who has examined the respondent* testifies in person at the hearing. The respondent may waive the requirement of the testimony subject to the approval of the court." ¶21. (Emphasis added.) 405 ILCS 5/3-807.

In this case, the expert's testimony established that she had not personally examined respondent. ¶23. Respondent did not waive the testimony of the expert and the expert's review of respondent's medical records did not satisfy this statutory requirement. ¶23, *In re Michelle J.,* 209 Ill. 2d 428, 437 (2004) (reviewing a respondent's medical records does not satisfy the statutory requirement that the expert examine the respondent prior to the hearing). "Therefore, counsel's performance was deficient for not objecting to the State's omission of testimony of an expert who had not examined respondent." ¶23. Counsel's omission prejudiced the outcome of the proceedings as respondent could not be subject to involuntary admission without testimony of an expert examiner who actually examined her. ¶23, 405 ILCS 5/3-807.

(B) Written Medication Requirement

"Section 2-102 of the Code requires that State to notify the recipient of involuntarily administered psychotropic medication with written notice of the "side effects, risks, and benefits of the treatment as well as alternatives to the proposed treatment."" ¶25, 405 ILCS 5/2-102(a-5). Such information is required for respondent to make an informed decision on treatment and verbal advice does not satisfy this statutory requirement. ¶25, *In re Vanessa K.,* 2011 IL App (3d) 100545, ¶20.

The State conceded that respondent did not receive written information about one of the medications (lithium) it was requesting. ¶26. The appellate court accepted the State's confession and found that there was no indication that respondent received written notice of the side effects, risks, benefits, and alternative treatments of lithium. ¶26. "As respondent could not be compelled to take lithium without receiving the statutorily required written information, counsel's performance was deficient for failing to raise this issue." ¶26, 405 ILCS 5/2-102(a-5).

Reversed. ¶23. ■

McWilliams v. Dunn: An unseemly maneuver or a necessary compromise?

BY MATTHEW R. DAVISON

On June 19, 2017, the U.S. Supreme Court issued its 5-4 opinion in *McWilliams v. Dunn.1* Of all the cases from the Court's recent October term, *McWilliams* carried significant implications for the capital bar, as well as for those practitioners representing clients with mental illness. However, such implications were never fully realized due to what the dissent characterized as "means of a most unseemly maneuver."[2]

This strong rebuke is best understood alongside some substantive and procedural context. First, the *McWilliams* case has undeniable roots in *Ake v. Oklahoma*.[3] In *Ake*, the Court held "when a defendant demonstrates to the trial judge that his sanity at the time of the offense is to be a significant factor at trial, the State must, at a minimum, assure the defendant access to a competent psychiatrist who will conduct an appropriate examination and assist in evaluation, preparation, and presentation of the defense."[4] Approximately one year after the Court's decision in *Ake*, James McWilliams was convicted of capital murder.[5]

Less than two full days before the judicial sentencing hearing though, counsel for the defense received a flurry of previously sought updated mental-health records, as well as a written report authored by a psychiatrist appointed from Alabama's Department of Public Health. Despite strong imploration by counsel for a continuance so that the late-produced information could be interpreted and analyzed, the trial court denied such motions and sentenced McWilliams to death.

The case was appealed throughout state and federal courts. In the Alabama courts McWilliams argued, among other things, that he was denied his due process right to meaningful expert assistance under *Ake*. Upon exhausting his state appellate rights, McWilliams sought federal habeas relief—a notoriously high burden—and was denied at the magistrate and district level when the court found that the existing mechanisms for psychiatrist involvement satisfied *Ake* and, accordingly, the decision of Alabama's courts was not an unreasonable application of such clearly established federal law.

The Court of Appeals for the Eleventh Circuit affirmed this reasoning, while Judge Wilson dissented, stating, "[a]lthough his life was at stake and his case for

mitigation was based on his mental health history, McWilliams received an inchoate psychiatric report at the twelfth hour and was denied the opportunity to utilize the assistance of a psychiatrist to develop his own evidence. As a result, McWilliams was precluded from meaningfully participating in the judicial sentencing hearing and did not receive a fair opportunity to rebut the State's psychiatric experts. Put simply, he was denied due process."[6] What's more, Judge Wilson took issue with the notion that the defense counsel could have simply consulted with the already-appointed psychiatrist that provided the written report, reminding that such expert could "cross the aisle and disclose to the State the future cross-examination of defense counsel."[7]

McWilliams petitioned for writ of certiorari to the Supreme Court of the United States. On petition, McWilliams presented two questions for review:

(1) When this Court held in *Ake* that an indigent defendant is entitled to meaningful expert assistance for the "evaluation, preparation, and presentation of the defense," did it clearly establish that the expert should be independent of the prosecution?;

(2) Did the Alabama courts unreasonably apply *Ake* in finding that McWilliams's rights were satisfied when the only mental health expert he was provided distributed his report to all parties just two days before sentencing and was unable to review voluminous medical and psychological records?

The U.S. Supreme Court granted certiorari but limited its review and the briefing to only the first question.[8]

By signaling its review would only be of the first question, the Court set off widespread speculation and commentary on its upcoming decision. Some commentators highlighted the life-and-death aspect of the looming opinion.[9] The implications were not abstract nor academic, as some pending death row matters were halted specifically due the potential effects of the *McWilliams* decision.[10] In order to prevail *via* a habeas petition, McWilliams needed to successfully argue that *Ake*'s holding was not ambiguous – that it clearly meant he was entitled to an expert to assist him (independent of the prosecution) – and that the state court's application of *Ake* was unreasonable given such law.

At oral argument, the parties navigated the nuances of the question presented and advanced various distinctions from the briefs. For instance, some justices queried whether the respondent was truly seeking an "independent" expert or someone more akin to a "partisan" expert and, whether one or the other was ever feasible given certain implications and conflicts.[11]

But the eventual outcome of *McWilliams* was an opinion that sidestepped almost all of the commentary, speculation, and indeed, even the question briefed. The real result was hidden in plain sight at oral argument. During an exchange with counsel for Alabama's Attorney General, Justice Breyer asked:

"Would you -- would you object to the following disposition of the case: That we say the issue is not partisan versus independent. The issue is whether the defense had assistance from a psychiatrist in the evaluation, preparation, and presentation of the defense, including cross-examination of hostile or State psychiatric witnesses. That's what Ake provides. That's clear. And what we want you to do, court of appeals, is decide whether that was so."[12]

This query then prompted Justice Alito to ask whether the focus of such an inquiry arguably fell under the *other* question presented for review – that is, the very question *excluded* when the Court granted certiorari. Counsel for Alabama wholeheartedly agreed, stating "[t]hat's exactly right, Justice Alito. And my point was that that was the second question presented in the cert petition. Justice Breyer's question was the second question that the Court didn't grant cert on."[13]

Sure enough, though, when the opinion was issued, Justice Breyer, writing for the majority, found that "Alabama here did not meet even *Ake's* most basic requirements."[14] Due to this fundamental failure, the majority declined to adjudicate the broader question of whether *Ake* clearly established the right to an expert independent witness. Instead, the Court remanded for further proceedings such as consideration of whether access to the type of meaningful assistance in evaluating, preparing, and presenting the defense that *Ake* requires would have mattered when applying the federal habeas standard.[15]

After all of the commentary and prognosticating, the Court ultimately issued an opinion answering the very question presented for review it had specifically excluded when granting certiorari. The majority, facing a hostile dissent, acknowledged the swap, "[w]e recognize that we granted petitioner's first question presented—which addressed whether *Ake* clearly established a right to an independent expert—and not his second, which raised more case-specific concerns. Yet that does not bind us to issue a sweeping ruling when a narrow one will do."[16] Justice Alito was not assuaged, pointing out "heeding our decision, the parties briefed the first question but scarcely mentioned anything related to the second. The Court, however, feels no similar obligation to abide by the Rules."[17]

It is easy to read *McWilliams* and wonder, with cynicism, whether the majority charted a course away from the actual question briefed in order to secure Justice Kennedy's needed fifth vote on the basis of the second question presented. At least one reporter hinted as much, highlighting how at oral argument, "Justice Breyer suggested that the Supreme Court could send the case back to the lower courts to explore that question. Justice Anthony M. Kennedy appeared intrigued by the idea."[18] Perhaps some on the Court saw the danger of a different five-person majority potentially issuing a ringing endorsement of the careless methods employed in *McWilliams* and forged a compromise in what was eventually issued. But the concept of compromise is generally accompanied by the standard refrain of neither side being altogether satisfied. *McWilliams* is no exception. ■

Matthew Davison is a Chicago-based lawyer with a private practice focused on mental-health law and fiduciary litigation. He is currently contract counsel for Legal Advocacy Service, a division of the Illinois Guardianship and Advocacy Commission. Pursuant to an Assisted Outpatient Treatment ("AOT") grant, he represents respondents throughout the AOT process. He may

be reached via email at Matthew.Davison@illinois.gov and by phone at (847) 272-8481.

1. *McWilliams v. Dunn*, 137 S. Ct. 1790, 1802, 198 L. Ed. 2d 341 (2017).
2. *McWilliams v. Dunn*, 137 S. Ct. at 1802 (Alito, J., dissenting).
3. *Ake v. Oklahoma*, 105 S. Ct. 1087, 84 L. Ed. 2d 53 (1985).
4. *Ake, 470* S. Ct. at 1096.
5. The facts of *McWilliams* should not be overlooked, nor its victim. The underlying matter centered on the brutal rape, robbery, and murder of Patricia Reynolds. As the Respondent's Brief recites, "Reynolds was a clerk at a convenience store. McWilliams went into the store, locked the front doors, took Reynold's money, forced her into a back room, brutally raped her, and then shot her with a .38 caliber pistol. She had sixteen gunshot wounds (eight entrance and eight exit) and numerous other injuries. She bled to death the following morning." Brief of Respondents at 3, *McWilliams v. Dunn*, No. 16-5294, (U.S. Sup. Ct., Mar. 29, 2017), available at http://www.scotusblog.com/wp-content/uploads/2017/04/16-5294_resp.pdf (last accessed on September 5, 2017).
6. *McWilliams v. Dunn*, 634 Fed.Appx. 698 (11th Cir. 2015) (Wilson, J., dissenting).
7. *Id.*
8. *See* <www.supremecourt.gov/qp/16-05294qp.pdf>, last accessed on September 5, 2017.
9. *See* Amy Howe, *Argument preview: What kind of help does the Constitution require for defendants in capital cases?*, SCOTUSblog (Apr. 19, 2017, 11:45 AM), <www.scotusblog.com/2017/04/argument-preview-kind-help-constitution-require-defendants-capital-cases/>
10. *See* Adam Liptak, *Court Decisions Force Arkansas to Halt Execution*, N.Y. Times, Apr. 17, 2017, at A12. Available at <www.nytimes.com/2017/04/17/us/mondays-arkansas-execution-halted-by-state-justices.html> (last accessed September 5, 2017).
11. Following oral argument, this "partisan psychiatry" dilemma and the debate on misnomers, semantics, and related complexities was cogently highlighted by *The Atlantic*. *See* James Hamblin, *Is Psychiatry Partisan?*, The Atlantic, May 5, 2017. Available at <www.theatlantic.com/health/archive/2017/05/objectivity-in-minds/525036/> last accessed September 5, 2017).
12. Transcript of oral argument before the U.S. Supreme Court, April 24, 2017, at pg. 38. Available at <www.supremecourt.gov/oral_arguments/argument_transcripts/2016/16-5294_g314.pdf>.
13. *Id*. at pg. 40.
14. *McWilliams,* 137 S. Ct at 1800.
15. Justice Alito, in his scathing dissent, castigated the majority's reasoning for a remand by stating it "relies on the thinnest of reasons to require the Eleventh Circuit to redo its analysis. That conclusion is unwarranted, and nothing in the majority opinion prevents the Court of Appeals from reaching the same result on remand." *McWilliams,* 137 S. Ct. at 1809, (Alito, J., dissenting).
16. *Id.* at 1800.
17. *Id.* at 1807 (Alito, J., dissenting).
18. Adam Liptak, *With Executions in Balance, Supreme Court Grapples Over Roles of Experts,* April 24, 2017, at A11. Available online at <www.nytimes.com/2017/04/24/us/politics/supreme-court-death-penalty.html?mcubz=3> (last accessed on September 5, 2017).

The case for agreed outpatient in Illinois

BY MATTHEW R. DAVISON

For many psychiatrists, Illinois commitment law can largely appear binary: either a court finds, by clear and convincing evidence, that an involuntary respondent meets the statutory criteria for inpatient commitment[1] or, the petitioner has not met said burden and discharge is imminent. It is ostensibly an "all or nothing" pursuit, fraught with delays and unknowns that can leave the respondent, the family, and the facility feeling frustrated and unsatisfied.

Such experiences can understandably cause an unwillingness or hesitation from facilities (and families) when it comes to whether a contested order of inpatient commitment is ultimately sought. On the other hand, many facilities also have repeat clientele that are voluntary, compliant, and cooperative, but soon after discharge, non-compliance prompts re-admission and the all-too-familiar cycle continues.

Practitioners regularly encountering both dilemmas (involuntary inpatient commitment and repeated voluntary admissions) often overlook an opportunity hiding in plain sight: outpatient commitment. Underutilization of outpatient commitment in Illinois is largely due to a widespread lack of familiarity with the process by treatment teams and a lack of adequate infrastructure in the community to address the various ancillary challenges that often accompany mental-health matters (such as housing/homelessness, substance abuse, domestic problems, and other common dilemmas). Both causes of underutilization can be addressed through education, training, and reliable funding that transcends mere platitudes.

There are two common conduits for outpatient commitment: involuntarily or through an agreed care and custody order. Both outpatient methods are examined in turn below and are accompanied by practical insights for those providers considering the viability of outpatient commitment and treatment through agreed care and custody orders.

Involuntary Outpatient Commitment

Any person 18 years of age or older may execute a petition asserting that another person is subject to involuntary admission on an outpatient basis.[2] Similar to an inpatient petition, an outpatient petition should be accompanied by two certificates of qualified examiners (with at least one of the certificates executed by a psychiatrist). In Illinois, there are two available threshold queries for whether someone meets the criteria for an outpatient commitment. Either they are:

(1) A person who would meet the criteria for admission on an inpatient basis as specified in Section 1-119 in the absence of treatment on an outpatient basis and for whom treatment on an outpatient basis can only be reasonably ensured by a court order mandating such treatment; *or*

(2) A person with a mental illness which, if left untreated, is reasonably expected to result in an increase in the symptoms

> caused by the illness to the point that the person would meet the criteria for commitment under Section 1-119, and whose mental illness has, on more than one occasion in the past, caused that person to refuse needed and appropriate mental health services in the community.

405 ILCS 5/1-119.1. Thus, by definition, the standard afforded to outpatient commitment is a lower threshold than the criteria applied for an inpatient commitment. Put another way, a treatment team may be more confident in pursuing outpatient by trial under such a threshold, if the circumstances warrant such action.

Outpatient commitment can be sought as a stand-alone remedy for an individual residing in the community already[3] or for someone who is inpatient at a mental health facility (whether voluntary or involuntary). Moreover, if a petition for inpatient commitment is filed, a petition for admission on an outpatient basis "may be combined with or accompanied by a petition for involuntary admission on an inpatient basis."[4] If an individual is found subject to involuntary admission on an outpatient basis, the court may issue an order: "(i) placing the respondent in the care and custody of a relative or other person willing and able to properly care for him or her; or (ii) committing the respondent to alternative treatment at a community mental health provider."[5]

A natural apprehension to pursuing *involuntary* outpatient commitment is whether the time, effort, and coordination are worthwhile investments if the individual is contesting said treatment. After all, if an individual does not comply, it is easy to foresee a situation wherein the respondent of an involuntary outpatient order is readmitted weeks after the trial. Given this, another route for outpatient—by agreement—should be given thoughtful consideration.

Outpatient by Agreed Order

Under the Mental Health and Developmental Disabilities Code, "[a]t any time before the conclusion of the hearing and the entry of the court's findings, a respondent may enter into an agreement to be subject to an order for admission on an outpatient basis."[6] This provision allows for a respondent and his or her counsel to resolve a pending petition (inpatient or outpatient) with a settlement agreement that contains specific terms of outpatient treatment. Entry of such an agreed order does not require a full, adversarial hearing but instead a very brief, uncontested court date where the judge reviews conformity with the applicable statute and finds that the order is in the best interest of the respondent and the public. For psychiatrists, this usually means approximately 15 minutes of time (if that) to attend court as a show of support and to recite that there is a history of noncompliance and that outpatient is the best (and least restrictive) form of available treatment.[7]

There are many benefits to an agreed care and custody order. First, it allows the respondent to review the treatment plan in-depth and have an input into the proposed treatment, which may cultivate an "investment" into his or her own treatment. Second, it artfully resolves any contested trial or adversarial hearing where the psychiatrist would be forced to undergo extensive cross-examination and potential impeachment. Third, it memorializes an extensive care plan that serves as a blueprint (signed by a judge) for the respondent's community care so that providers and agencies may easily reference it and rely on it. Finally, the agreed care and custody order, by definition, involves a "custodian" for the respondent. This term (while an unfortunate word choice) simply means that the respondent has a community partner that oversees compliance and serves as the court's "eyes and ears" throughout the relevant time period. The custodian can be a family member, neighbor, or an unrelated entity that is willing to stand in and serve in the role. It does *not* create a legal "agency" relationship.[8]

For those psychiatrists concerned that outpatient has no "teeth", agreed care and custody orders in Illinois routinely have provisions allowing "the authority to admit a respondent to a hospital if the respondent fails to comply with the conditions of the agreed order."[9] What's more, "if necessary in order to obtain the hospitalization of the respondent, the custodian may apply to the court for an order authorizing an officer of the peace to take the respondent into custody and transport the respondent to the hospital specified in the agreed order."[10]

Often, individuals that have repeated hospitalizations or even those respondents that have already been court ordered to take medications are receptive to an agreed care and custody order, as it can be a care plan that not only addresses the serious mental illness, but provides a comprehensive roadmap for: housing, therapy, substance abuse, and medication management. A large incentive for respondents to consider an agreed care and custody order are the "ancillary wrap services" that can often be creatively incorporated into the order. Similarly, some families strongly insist an agreed care and custody order be discussed prior to an individual returning home.

The agreed order can last for up to six months with the possibility of extension.[11] In this six-month window, the respondent is still represented by counsel and the attorney may be asked by the court to report in on the success of the outpatient treatment as well as alert the court to any substantive noncompliance. During this time, it would be prudent for the attorney to review and discuss an advanced directive with the client such as a declaration for mental health treatment.[12]

Agreed care and custody orders may also include psychotropic medications, provided that the court "determines, based on the documented history of the respondent's treatment and illness, that the respondent is unlikely to continue to receive needed psychotropic medication in the absence of such an order."[13] In practice, such orders almost always contain medication. Once in the community, pursuant to the order, the respondent and the community treater can continue to discuss dosages and agreed upon modifications.

Conclusion

The number of Illinois agreed outpatient orders are few and far between. This is changing. Due to federal grants, ongoing awareness among providers (and insurance companies), and an overall growing

frustration with a redundant inpatient legal system, more and more facilities are dusting off outpatient statutes and asking more questions about agreed orders. Further, such earnest endeavors by treatment teams often have the ancillary effect of developing genuine trust with respondents as the process necessarily involves the individual and gives them a voice and input into their community care. This is most apparent on the actual court date, where it looks and feels nothing like a trial and instead more like a collaborative chorus, with everyone on the same "side" and aiming for the same goal, together. ■

Matthew Davison is a Chicago-based lawyer with a private practice focused on mental-health law and fiduciary litigation. He is currently contract counsel for Legal Advocacy Service, a division of the Illinois Guardianship and Advocacy Commission. Pursuant to an Assisted Outpatient Treatment grant, he represents respondents throughout the AOT process. He may be reached via email at Matthew.Davison@illinois.gov and by phone at (847) 272-8481.

1. *See* 405 ILCS 5/1-119.
2. 405 ILCS 5/3-751(a).
3. The respondent may remain at his residence pending the hearing. If, however, the court finds it necessary, it may order a peace officer or another person to have the respondent before the court at the time and place set for hearing. 405 ILCS 5/3-756
4. 405 ILCS 5/3-751(c).
5. 405 ILCS 5/3-812.
6. 405 ILCS 5/3-801.5
7. The treating psychiatrist should also furnish a "written report" to the parties prior to the court's entry of the agreed order. The written report is essentially a one-page summation of the respondent's relevant history, diagnosis, proposed custodian, and any medications. *See* 405 ILCS 5/3-810.
8. 405 ILCS 5/3-801.5(e)
9. 405 ILCS 5/3-801.5.
10. *Id.*
11. 405 ILCS 5/3-801.5(g)
12. *See, e.g.*, 755 ILCS 43/75.
13. 405 ILCS 5/3-801.5

Letter from the Chair

BY ROB CONNOR

Welcome to the 2017-2018 Mental Health Law Section Council newsletter! In this year's newsletter we will bring you a variety of mental health news. You will see summaries on recent Appellate and Supreme Court cases in the area of mental health and confidentiality. There will be articles written by our Section Council members on "hot topics" in the practice areas under the wide umbrella of mental health law in the State. We will also announce our CLE programs and provide articles written about those programs.

We hope all our readers of this newsletter enjoy the articles and find them informative!

The Mental Health Law Section Council is composed of attorneys in both the private and public sector who all work to advance the legal mental health system in the State of Illinois in their various roles as attorneys. Our Section Council is fortunate to have both long time experts in the area of mental health law, confidentiality laws and legislative drafting in these areas, as well as attorneys who are newer to these legal areas. Together our team this year will focus on reviewing current mental health and confidentiality laws. Also, we will make proposals for changes in these laws to the ISBA Board of Governors. In each of our meetings we will be reviewing all the legislation filed this next legislative session in our practice areas and commenting on the legislation to our ISBA legislative liaison.

2017-18 Chair Robert J. Connor (left) presents a plaque to Joseph T. Monahan in recognition of his leadership of the ISBA Mental Health Section Council.

Depending on space availability, ISBA members may attend these monthly meetings in person. There is also a call-in option for those interested in attending. Contact Mary Grant at mgrant@isba.org for monthly call-in information.

Thank you for your interest in our committee!

—Rob Connor

Rob Connor is the 2017-2018 Chair of the Mental Health Section Council. He has worked for over 30 years in the areas of mental health, developmental disabilities and confidentiality laws at the Illinois Department of Human Services (previously the Illinois Department of Mental Health and Developmental Disabilities).

ISBA LAW ED
CLE FOR ILLINOIS LAWYERS

SAVE THE DATE

Illinois Medicaid Rules and Procedures Bootcamp

October 12, 2017 • 8:30 a.m. - 4:30 p.m. Central
Live program in Chicago
Presented by the ISBA's Elder Law Section
CLE Credit: 6.75 MCLE

FREE ONLINE CLE:
All eligible ISBA members can earn up to 15 MCLE credit hours, including 6 PMCLE credit hours, per bar year.

For more information:

www.isba.org/cle/upcoming

Program Coordinator/ Moderator:
Kristi M. Vetri, O'Fallon

CHICAGO

ISBA Regional Office
20 S. Clark Street, Suite 900

Are you thinking of expanding your practice to include helping your clients apply for and receive Medicaid benefits to help pay for the cost of Long Term Care? Then you won't want to miss this nuts-and-bolts seminar that teaches you everything you need to know about the Illinois Medicaid rules and procedures. Estate planning practitioners, family law attorneys, elder law lawyers, and new attorneys with basic to intermediate practice experience who attend this seminar will learn:

- How to represent your clients when it's time to apply for public benefits;
- How a homestead or family farm can affect Medicaid eligibility;
- The concepts and strategies you can use to legally and ethically protect assets while facilitating Medicaid eligibility;
- How to prepare and submit applications in Decatur and Chicago;
- How to appeal a denial of benefits; and
- Much more!

AGENDA

8:30 – 9:30 a.m. The Facts & Nothing But the (Medicaid) Facts

9:30 – 9:45 a.m. Break (beverages provided)

9:45 – 11:15 a.m. Digging Deeper

11:15 – 11:45 a.m. Panel Discussion: You Have Questions, We Have Answers

11:45 a.m. – 12:30 p.m. Lunch (Provided)

- **11:45 a.m. 12:00 p.m.** Lunch Served
- **12:00 – 12:30 p.m.** Tabletop Discussions (No MCLE credit)

12:30 – 2:00 p.m. Advanced Issues: The Intersection of Long Term Care Costs, Estate Planning, Asset Preservation, and Ethics

2:00 – 2:15 p.m. Break (refreshments provided)

2:15 – 4:15 p.m. Nuts & Bolts of the Application Process and Appeals

4:15 – 4:30 p.m. Q&A Discussion

Member Price: $150.00

Upcoming CLE programs

TO REGISTER, GO TO WWW.ISBA.ORG/CLE OR CALL THE ISBA REGISTRAR AT 800-252-8908 OR 217-525-1760.

October

Wednesday, 10-04-17 LIVE Webcast— Issues to Recognize and Resolve When Dealing With Clients of Diminished Capacity. Presented by Business Advice and Financial Planning. 12-2 pm.

Thursday, 10-05-17 - Webinar— Introduction to Legal Research on Fastcase. Presented by the Illinois State Bar Association – Complimentary to ISBA Members only. 12:00-1:00 pm.

Thursday, 10-05-17 – Chicago, ISBA Regional Office—The New Bankruptcy Rules and Advanced Topics in Consumer Bankruptcy. Presented by Commercial Banking, Collections & Bankruptcy. 8:55am – 4pm.

Thursday, 10-05-17 – LIVE Webcast—The New Bankruptcy Rules and Advanced Topics in Consumer Bankruptcy. Presented by Commercial Banking, Collections & Bankruptcy. 8:55am – 4pm.

Friday, 10-06-17 – Holiday Inn and Suites, East Peoria—Fall 2017 Beginner DUI and Traffic Program. Presented by Traffic Law. Time: 8:55 am – 4:45 pm.

Friday, 10-06-17 – Holiday Inn and Suites, East Peoria—Fall 2017 Advanced DUI and Traffic Program. Presented by Traffic Law. Time: 8:55 am – 4:30 pm.

Friday, 10-06-17 – Chicago, ISBA Regional Office—Pathways to Becoming Corporate General Counsel and the Issues You Will Face. Presented by Corporate Law. Time: 9:00 am – 12:30 pm

Monday, 10-09-17 – Chicago, ISBA Regional Office—Workers' Compensation Update – Fall 2017. Presented by Workers' Compensation. Time: 9:00 am – 4:00 pm.

Monday, 10-09-17 –Fairview Heights—Workers' Compensation Update – Fall 2017. Presented by Workers' Compensation. Time: 9:00 am – 4:00 pm.

Tuesday, 10-10-17 – Webinar—Outlook for Mac. Practice Toolbox Series. 12:00 -1:00 p.m.

Wednesday, 10-11-17 – LIVE Webcast—Enforcing Illinois' Eviction Laws: A Basic Guide to Landlord Remedies and Tenant Rights. Presented by Real Estate Law. 12-1 pm.

Wednesday, 10-11-17 – LIVE Webcast—Working Effectively with Interpreters. Presented by Delivery of Legal Services. 2-3:30 pm.

Thursday, 10-12-17 – Chicago, ISBA Regional Office—Illinois Medicaid Rules and Procedures Bootcamp. Presented by Elder Law. 8:15 am – 4:30 pm.

Thursday, 10-12-17 - Webinar— Advanced Tips for Enhanced Legal Research on Fastcase. Presented by the Illinois State Bar Association – Complimentary to ISBA Members only. 12:00-1:00 pm.

Monday-Friday, 10-16 to 20, 2017 – Chicago, ISBA Regional Office—40 Hour Mediation/Arbitration Training Master Series. Master Series. Monday, Wednesday, Thursday and Friday 8:30-5:45. Tuesday 8:30-6:30.

Tuesday, 10-17-17 – Chicago ISBA Regional Office (ISBA Mutual Classrooms)—Mediation Roundtable: The Discussion of Hot Topics in the Mediation of Disputes. Presented by Alternative Dispute Resolution. 12:15 – 1:15 (lunch served at noon).

Thursday, 10-19-17 - Webinar— Fastcase Boolean (Keyword) Search for Lawyers. Presented by the Illinois State Bar Association – Complimentary to ISBA Members only. 12:00-1:00 pm.

Thursday, 10-19-17 – Bloomington— Real Estate Law Update – Fall 2017. Presented by Real Estate.

Tuesday, 10-24-17 – Webinar—Law Firm Accounting 101. Practice Toolbox Series. 12:00 -1:00 p.m.

Wednesday, 10-25-17 – Webinar— Working with Low Income Clients. Presented by Delivery of Legal Services. 12-1:30 pm.

Thursday, 10-26-17 – LIVE Webcast— Diversity and Inclusion in the Practice of Law. Presented by LOME. 12-1 pm.

Friday, 10-27-17 – Chicago, ISBA Regional Office—Solo and Small Firm Practice Institute. All Day.

Friday, 10-27-17 – LIVE Webcast—Solo and Small Firm Practice Institute. All Day.

November

Wednesday, 11-01-17 – ISBA Chicago Regional Office—Anatomy of a Medical Negligence Trial. Presented by Tort Law. All Day.

Thursday, 11-02-17 - Webinar— Introduction to Legal Research on Fastcase. Presented by the Illinois State Bar Association – Complimentary to ISBA Members only. 12:00-1:00 pm.

Friday, 11-03-17 – NIU Naperville— Real Estate Law Update – Fall 2017. Presented by Real Estate.

Thursday, 11-09-17 - Webinar— Advanced Tips for Enhanced Legal Research on Fastcase. Presented by the Illinois State Bar Association –

Complimentary to ISBA Members only. 12:00-1:00 pm.

Friday, 11-10-17 – Chicago, ISBA Regional Office—Profession Under Pressure; Stress in the Legal Profession and Ways to Cope. Presented by Civil Practice and Procedure. 8:15 am-4:45 pm.

Tuesday, 11-14-17 – Webinar—Speech Recognition. Practice Toolbox Series. 12:00 -1:00 p.m.

Wednesday, 11-15-17 – Chicago, ISBA Regional Office—Microsoft Word in the Law Office: ISBA's Tech Competency Series. Master Series with Barron Henley. All Day.

Thursday, 11-16, 2017 – Chicago, ISBA Regional Office—Microsoft Excel In the Law Office: ISBA's Technology Competency Series. Master Series with Barron Henley. Half Day.

Thursday, 11-16, 2017 – Chicago, ISBA Regional Office—Adobe Acrobat and PDF Files in the Law Office: ISBA's Technology Competency Series. Master Series with Barron Henley. Half Day.

Thursday, 11-16-17 - Webinar— Fastcase Boolean (Keyword) Search for Lawyers. Presented by the Illinois State Bar Association – Complimentary to ISBA Members only. 12:00-1:00 pm.

Friday, 11-17-17 – Webcast—Obtaining and Using Social Media Evidence at Trial. Presented by Young Lawyers Division. 12:00-1:30 pm.

Tuesday, 11-28-17 - Webcast—Ethics Questions: Multi-Party Representation – Conflicts of Interest, Joint Representation and Privilege. Presented by Labor and Employment. 2:00-4:00 pm.

Tuesday, 11-28-17 – Webinar— Understanding Process Mapping. Practice Toolbox Series. 12:00 -1:00 p.m.

December

Wednesday, 12-06-17 - Webcast— Defense Strategies for Health Care Fraud Cases. Presented by Health Care. 12:00-1:30 pm.

Tuesday, 12-12-17 – Webinar—Driving Profitability in your Firm. Practice Toolbox Series. 12:00 -1:00 p.m.

Thursday, 12-14-17 – Chicago, ISBA Regional Office—Vulnerable Students: A Review of Student Rights. Presented by Education Law. 9:00 am – 12:30 pm.

Friday, 12-15-17 – Chicago, ISBA Regional Office—Guardianship Boot Camp. Presented by Trusts and Estates. 8:30 – 4:30.

Friday, 12-15-17 – LIVE Webcast— Guardianship Boot Camp. Presented by Trusts and Estates. 8:30 – 4:30.

January

Thursday, 01-11-18 – ISBA Chicago Regional Office—Six Months to GDPR – Ready or Not? Presented by Intellectual Property. 8:45 AM – 12:30 PM.

Thursday, 01-18-18 – ISBA Chicago Regional Office—Closely Held Business Owner Separations, Marital and Non-Marital. Presented by Business and Securities. 9AM - 12:30 PM.

Wednesday, 01-24-18 – ISBA Chicago Regional Office—Mentoring Luncheon.

Thursday, 01-25-18 – ISBA Chicago Regional Office—Starting Your Law Practice. Presented by General Practice. 8:50 AM – 4:45 PM.

February

Monday, 02-05 to Friday, 02-09—ISBA Chicago Regional Office—40 Hour Mediation/Arbitration Training. Master Series, presented by the ISBA—WILL NOT BE ARCHIVED. 8:30 -5:45 daily.

Feb 6 - Fred Lane's ISBA Trial Technique Institute.

March

Thursday, 03-08-18 – ISBA Chicago Regional Office—The Complete UCC. Master Series, Presented by the ISBA. 8:30-5:00.

Monday, 03-12 to Friday, 03-16— Pere Marquette Lodge, Grafton IL—40 Hour Mediation/Arbitration Training. Master Series, presented by the ISBA—WILL NOT BE ARCHIVED. 8:30 -5:45 daily.

Friday, 03-16-18 – Holiday Inn & Suites, Bloomington—Solo and Small Firm Practice Institute. All day.

Friday, 03-23-18 – ISBA Chicago Regional Office—Applied Evidence: Evidence in Employment Trials. Presented by Labor and Employment. 9:00 am – 5:00 pm.

Friday, 03-23-17 – LIVE Webcast— Applied Evidence: Evidence in Employment Trials. Presented by Labor and Employment. 9:00 am – 5:00 pm.

June

Friday, 06-01-18 – NIU Naperville, Naperville—Solo and Small Firm Practice Institute. All day. ■

Mental Health Matters
Illinois Bar Center
Springfield, Illinois 62701-1779
September 2017
Vol. 4 No. 1

Non-Profit Org.
U.S. POSTAGE
PAID
Springfield, Ill.
Permit No. 820