

No. 1-10-0603

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IN THE APPELLATE
COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

IN THE MATTER OF S.P.,)	Appeal from the
Found to be a Person Subject to the Involuntary)	Circuit Court of
Administration of Psychotropic)	Cook County.
Medication and ECT,)	
(THE PEOPLE OF THE STATE OF ILLINOIS,)	
)	
Petitioner-Appellee,)	No. 09MH4061
)	
v.)	
)	
S.P.,)	The Honorable
)	Edward P. O'Brien,
)	Judge Presiding.
Respondent-Appellant.))	

PRESIDING JUSTICE JAMES FITZGERALD SMITH delivered the judgment of the court.

Justices Joseph Gordon and Howse concurred in the judgment.

HELD: Appeal dismissed; court will not review involuntary treatment order where issue is moot because the 90-day period covered by trial court's order has expired and case does not fall into any of the established exceptions to the mootness doctrine.

¶ 1

ORDER

¶ 2 Following a hearing, the circuit court found respondent S.P. subject to the involuntary administration of psychotropic medication and electroconvulsive therapy (ECT). On appeal, respondent contends the court erred where: (1) the medication and therapy authorized by the court were the not the least restrictive treatment available; (2) the court failed to comply with the Mental Health and Developmental Disabilities Code (Mental Health Code) (405 ILCS 5/2-107.1 (West 2006)) where it authorized medication based on respondent's future condition; and (3) the court authorized the concurrent administration of ECT and psychotropic medication contrary to medical evidence presented at the hearing. For the following reasons, we find respondent's contentions to be moot and we dismiss the appeal.

¶ 3

BACKGROUND

¶ 4 On December 31, 2009, the State filed a petition on behalf of S.P.'s treating psychiatrist, Dr. Stanislav Pavlovsky, to begin the involuntary treatment of respondent with electroconvulsive therapy and psychotropic medications pursuant to section 2-107.1 of the Mental Health Code (405 ILCS 5/2-107.1 (West 2006)). In the petition, Dr. Pavlovsky alleged that petitioner had suffered from schizoaffective disorder since 2006 and had been hospitalized for the mental illness eight times. As a result of this mental illness, petitioner, who previously was "a very good student at college" and functioned well in social situations, was catatonic, "almost not eating or drinking," and was at high risk for dehydration. According to Dr. Pavlovsky, respondent lacked the capacity to give informed consent to medication. He stated:

No. 1-10-0603

“[DR. PAVLOVSKY:] The patient has no insight into her illness and does not believe she has a mental illness. Her mental condition is so severe that her symptoms prevent her from being able to weigh benefits versus side effects. Her judgment is so impaired that she cannot make reasoned decisions about far less complicated matters such as need to shower or to eat.”

Dr. Pavlovsky requested an order of the court authorizing the involuntary administration of various medications, as well as electroconvulsive therapy at a maximum of three treatments per week for five weeks.

¶ 5 On January 11, 2010, a hearing was held based on the petition. At the hearing, respondent’s father, M.P., testified that since 2005, respondent had been hospitalized for mental illness ten times. He testified that, previous to her illness, respondent attended DePaul University and studied finance and worked part-time for three months after college. Since her illness began in 2006, however, she stopped leaving the house and stopped eating and drinking. M.P. testified that he was concerned about what would happen to his daughter if she were not treated.

¶ 6 M.P. further testified that, when respondent was hospitalized in January 2009, she was dehydrated and had been losing weight. Prior to her hospitalization, she stayed in one place and would not move around the house. After one week, she was transferred to the hospital’s behavioral center where she remained for 25 days. Respondent was then transferred to Chicago Read Mental Health Center. After her discharge from Read in May 2009, respondent’s father

No. 1-10-0603

administered respondent's medicine to her. After some time, however, he determined that respondent was only pretending to take her medication.

¶ 7 Respondent was hospitalized again in October 2009 when she stopped eating and drinking and remained in one place without moving. Respondent lost weight and only spoke briefly if she wanted something. She remained in the hospital for one day and then stayed three days in the behavioral center. Respondent stopped eating again a few days after her release.

¶ 8 Respondent was hospitalized again in November 2009. Again she remained in the hospital for one day and then stayed three days in the behavioral center. According to M.P., respondent's condition briefly improved, but then worsened throughout November and December. In December 2009, respondent's symptoms were the same as they were prior to her January 2009 hospital admission: she was dehydrated, had lost weight, and was immobile. Respondent was hospitalized on December 9, 2009.

¶ 9 Dr. Pavlovsky testified that he first examined respondent on December 9, 2009. He examined her many times thereafter. According to Dr. Pavlovsky, respondent suffered from schizoaffective disorder, a serious mental disorder, with frequent decompositions that led to frequent hospitalizations. He based his opinion, with a reasonable degree of psychiatric certainty, on his observations of respondent, her social history, current and past hospital records, his discussion with his peers including social workers and other psychiatrists, and information from her family.

¶ 10 Dr. Pavlovsky testified that respondent was symptomatic at the time of the hearing, and demonstrating "perceptual disorders," responding to internal stimuli, showing "completely

No. 1-10-0603

inappropriate affect” and was selectively mute and catatonic. Respondent was agitated, restless, and her facial features showed decompressing. She had medical complications from not eating. Dr. Pavlovsky believed that respondent was progressively deteriorating.

¶ 11 Dr. Pavlovsky also opined that respondent exhibited suffering behavior. She became increasingly agitated, restless, and very anxious. At one point during the hospitalization which was contemporaneous with the hearing, she began slamming the cabinet in her room and screaming. Respondent refused to bathe, and her hygiene was so poor that she was at risk for additional medical complications. Dr. Pavlovsky determined that respondent did not have a power of attorney for health care, nor a declaration for mental health treatment.

¶ 12 Dr. Pavlovsky testified that less restrictive treatments had been explored, including psychotherapy, individual therapy, and milieu therapy, but that respondent was non-participatory. Dr. Pavlovsky believed that, even if respondent participated, these treatments would not be sufficient without ECT or the requested medications. Dr. Pavlovsky testified that respondent's condition was so severe at the time of the hearing that it would be unreasonable to administer oral medication and then switch to injectable medicine to reach her necessary dosage. He testified:

"[DR. PAVLOVSKY:] I would say at this time it is a question of life and death because the patient's condition progressively deteriorates and we cannot wait until [] four months like it used to be in May. At this time it might take a much longer period of time, so we need to do something for her quicker, have improvement;

No. 1-10-0603

and then after that, after ECT, to continue with injectable medications. We feel that after ECT, several procedures of ECT, her compliance as well as her response to medications would be much better."

¶ 13 When questioned as to respondent's prognosis if she were treated with the requested ECT and medications, Dr. Pavlovsky testified:

"[DR. PAVLOVSKY:] In this particular case I believe that this patient will show good response to treatment and I truly believe that she will be able to live her life and hopefully to follow aftercare recommendations."

¶ 14 Dr. Pavlovsky testified that he had previously given respondent written information regarding the treatments he was seeking. Respondent did not respond to the information she was given. Dr. Pavlovsky believed respondent lacked the ability to understand and to make a reasoned judgment. He described her as "completely, totally psychotic" and explained that she lacked "judgment about simple, simple things like taking a shower or keeping up her hygiene or about her eating habits." She experienced perceptual disorders, auditory hallucinations, and disorder of thought process.

¶ 15 Dr. Pavlovsky sought treatment for a minimum of 90 days. Dr. Sharpe, who would administer the ECT, would decide how many treatments of ECT were necessary. Dr. Pavlovsky testified that Dr. Sharpe is an expert in ETC. Dr. Pavlovsky testified that usually six to twelve procedures of ECT are required to obtain results.

No. 1-10-0603

¶ 16 The trial court noted that it had never before seen a petition for combination treatment like the one before it. Dr. Pavlovsky explained that the ECT was for all of respondent's symptoms and that:

"[DR. PAVLOVSKY:] ECT is indicated for patients with catatonic symptoms, with depression, even not psychotic, even severe major depressive disorder. But I would like to make another observation. We are not seeking combination treatment. We are seeking different treatment modalities, start from ECT and see what is left, what is treated."

Dr. Pavlovsky explained that he sought an "individualized approach," meaning flexibility with both the primary and secondary medications because each hospitalization is different and a patient may require different treatment on different admissions. He further explained that ECT and medication are usually not administered at the same time. Rather, the patient is re-evaluated following ECT to determine what medications Dr. Pavlovsky testified that he believed respondent would improve after the ECT, but he did not know the degree of improvement. Accordingly, he sought flexibility as to how to proceed after the ETC. Dr. PAVLOVSKY preferred to begin administering Risperdal after ETC. If post-ECT Risperdal was ineffective or respondent failed to cooperate, he wanted to have more choices available. The medicines listed in his petition are listed in the order in which they would be administered. Dr. Pavlovsky testified to the side-effects of the various medications and concluded that the benefits to respondent outweighed the risks.

No. 1-10-0603

¶ 17 Dr. Robert Sharpe testified that he examined respondent on December 23, 2009, and found her to be severely withdrawn, mute, akinetic, and had her eyes closed. She appeared malnourished. Dr. Sharpe reviewed respondent's chart from December 4, 2009, through the time of the exam and diagnosed respondent with schizoaffective disorder with symptoms including catatonia and hallucination.

¶ 18 Dr. Sharpe concluded that ECT was appropriate for respondent to address her catatonic or near catatonic state. He testified that, if the petition were granted, he would administer the ECT himself. He had previously administered ECT on over 1,000 occasions. He testified that, during ECT, patients are put to sleep using a short-acting anesthetic. Patients are also given a muscle relaxant to prevent them from having the physical manifestations of a seizure and to protect them from further complications. If the ECT is successful, a seizure is induced. The patient remains asleep throughout the procedure.

¶ 19 Dr. Sharpe sought authorization for both bilateral and unilateral ETC. These two types of ECT differ in the placement of the electrodes. Unilateral ECT would be the primary mode and bilateral would be the "fall back" treatment if unilateral were unsuccessful.

¶ 20 Dr. Sharpe anticipated that a maximum of 10 to 15 treatments over the course of 2 months would be necessary in respondent's case. Then, if respondent required medication following ECT, the additional 30 days requested in the order would be beneficial.

¶ 21 Dr. Sharpe planned to administer the psychotropic medication listed in the petition either subsequent to or concurrent with the final few ECT treatments. The court questioned Dr. Sharpe as to why he was requesting both ECT and psychotropic medication. Dr. Sharpe explained that

No. 1-10-0603

ECT alone is associated with a higher relapse rate than when in conjunction with medication.

Dr. Sharpe testified that the benefit of treatment involving both ECT and medication is to prevent rehospitalization and relapse.

¶ 22 Dr. Sharpe believed respondent was suffering and had deteriorated. He opined that, with the requested treatment, she would likely respond to the extent that she could become productive again, probably work, function fully at home, and that her "very high premorbid functioning" would be restored. He believed the benefits outweighed the risks in this situation, where the risks were "fairly minor" and the benefits included restoring respondent to function fully. When questioned regarding his assessment of respondent's prognosis without treatment, Dr. Sharpe responded:

"[DR. SHARPE:] The prognosis is very poor. I would imagine she would have a prolonged hospitalization. It is even conceivable she would be relegated, under the worst possible circumstances, to a life of institutionalization."

¶ 23 After hearing the evidence, the court granted the petition. In so doing, the court stated:

"[THE COURT:] "Again I do think the State has established by clear and convincing evidence that respondent does suffer from a serious mental illness, and that is schizoaffective disorder. And I do believe that based on the doctors' testimony as well as that of her father there is deterioration and there is also suffering and that the illness or disability has existed for a period of time marked by

No. 1-10-0603

the continuing presence of these symptoms, and that the respondent currently lacks the capacity to make a reasoned decision about the treatment. Also, other less restrictive services were explored and found to be inappropriate, and that the testing and other procedures are necessary for the safe and effective administration of treatment. A health care power of attorney or some other dispositive instrument does not exist."

The court reviewed the testimony and recognized respondent's record noted some temporary improvement during her prior treatment with medication. The court stated:

"[THE COURT:] I would say each form of these treatments [ECT and medication] is medically recognized as being acceptable; not only acceptable, but state of the art medicine."

The court cited Dr. Sharpe's testimony which noted that relapses can occur after ECT without a course of medication. It also cited Dr. Pavlovsky's testimony that respondent's current condition was life-threatening and that it could take months before any improvement was seen if respondent was treated only with medication.

¶ 24 The court stated that this was an unusual case in that both ECT and medication was being requested. The court noted, however, that the law allows flexibility in these types of cases, and said:

"[THE COURT:] Basically I don't see anything in the law and I certainly didn't see anything or hear anything in the doctors'

testimony that indicates that these are incompatible or mutually exclusive treatments."

¶ 25 Both parties filed post-hearing motions. Respondent argued, in relevant part, that the court's authorization of all treatments should be vacated. She argued that the testimony showed that ECT and medication were "two separate treatments" and, consequently, both cannot be least restrictive. Additionally, respondent argued that the State failed to meet its burden of showing that the benefits of ECT with medication outweighed its harm. Finally, respondent argued that the State failed to prove the benefits of the medication.

¶ 26 The State responded that it had shown at the hearing that, when ECT is administered in collaboration with medication, there is greater longevity to the benefits of the treatment. Moreover, because respondent was at risk of dying without effective treatment, a quicker effective treatment, specifically ECT, must be used. Finally, the State argued that the court's order did not authorize "two different treatment options," but rather was similar to more common orders where courts authorize multiple and alternative medications.

¶ 27 The trial court ruled that the Mental Health Code did not prohibit a petition seeking both ECT and medication. It rejected respondent's argument that a treatment plan which included both ECT and medication was a *per se* violation of the least restrictive requirement of the Mental Health Code, stating:

"[THE COURT:] [] I don't believe consistent with the least restrictive alternative requirement that the use of one modality or one treatment excludes the other."

No. 1-10-0603

The court noted that it accepted the expert witnesses' opinion that the benefits of the treatment outweighed the harm. The court modified the order to reflect that the authorization was for unilateral ECT as the "primary form" to be followed by bilateral ECT if clinically appropriate, and that, though the order was valid for 90 days, ECT was authorized for only 60 days.

¶ 28 Respondent appealed the court's modified order.

¶ 29 ANALYSIS

¶ 30 On appeal, respondent contends the court erred where: (1) the medication and therapy authorized by the court were the not the least restrictive treatment available; (2) the court failed to comply with the Mental Health and Developmental Disabilities Code (Mental Health Code) (405 ILCS 5/2-107.1 (West 2006)) where it authorized medication based on respondent's future condition; and (3) the court authorized the concurrent administration of ECT and psychotropic medication contrary to medical evidence presented at the hearing.

¶ 31 The State, however, argues that, because the order authorizing treatment was for a period of up to 90 days and that order has expired, respondent's case is moot. The State argues that respondent's case fails to satisfy any exception to the mootness doctrine. Respondent concedes that the case is indeed moot, but contends that we should address the issues under three exceptions to the mootness doctrine: addressing the issue is in the public interest; the case is capable of repetition yet avoids review; and respondent will suffer collateral consequences as a result of the court's decision.

¶ 32 This appeal is moot because the 90-day period covered by the trial court's order has

No. 1-10-0603

already expired. *In re Robert S.*, 213 Ill. 2d 30, 45 (2004). "An appeal is considered moot where it presents no actual controversy or where the issues involved in the trial court no longer exist because intervening events have rendered it impossible for the reviewing court to grant effectual relief to the complaining party." *In re J.T.*, 221 Ill. 2d 338, 349-50 (2006). Generally, reviewing courts do not decide moot questions, render advisory opinions, or consider issues where the result will not be affected regardless of how those issues are decided. *In re Barbara H.*, 183 Ill. 2d 482, 491 (1998). However, reviewing courts recognize exceptions to the mootness doctrine such as: (1) the public-interest exception, applicable where the case presents a question of public importance that will likely recur and whose answer will guide public officers in the performance of their duties; (2) the capable-of-repetition exception, applicable to cases involving events of short duration that are capable of repetition yet evading review; and (3) the collateral consequences exception, applicable where the involuntary admission order could return to plague the respondent in some future proceeding or could affect other aspects of the respondent's life. *In re Alfred H.H.*, 233 Ill. 2d 345, 355-62 (2009); *J.T.*, 221 Ill. 2d at 350. The question of whether an issue is moot is a question of law, and our review is *de novo*. *Alfred H.H.*, 233 Ill. 2d at 350. "[W]hether a case falls within an established exception to the mootness doctrine is a case-by-case determination." *Alfred H.H.*, 233 Ill. 2d at 355.

¶ 33

1. The Public Interest Exception

¶ 34 We first consider respondent's argument that we should consider her appeal under the public interest exception to the mootness doctrine. Under this exception, a reviewing court may

No. 1-10-0603

consider an otherwise moot case when the party seeking review makes a clear showing that: "(1) the question presented is of a public nature; (2) there is a need for an authoritative determination for the future guidance of public officers; and (3) there is a likelihood of future recurrence of the question. *Alfred H.H.*, 233 Ill. 2d at 355. The public interest exception may be invoked on "rare occasions when there is an extraordinary degree of public interest and concern." *Fisch v. Loews Cineplex Theatres, Inc.*, 365 Ill. App. 3d 537, 542 (2005). This exception is narrowly construed, and if any factor is not proven, the exception may not be invoked. *In re Commitment of Hernandez*, 239 Ill. 2d 195, 202 (2010).

¶ 35 Respondent asserts that the requirements of the public interest exception are met because: (1) whether the Code permits simultaneous authorization of both psychotropic medication and electroconvulsive therapy is a matter of public concern because it challenges the limits of the State's *parens patriae* interest; (2) there is a need for an authoritative determination to guide public officers because no reviewing court has yet determined whether the Code permits court authorization of both ECT and medication; and (3) the issue is likely to recur. We disagree.

¶ 36 Even if respondent could make a sufficient showing that her case is one of public concern and that there is a need for an authoritative determination to guide public officers, we would nevertheless find that her argument fails because she cannot show that this issue is likely to recur.

The trial court noted:

"[THE COURT:] This is an unusual kind of case, and in ten years of hearing these I have never heard a case where the state was seeking both forms of involuntary treatment, both ECT and

No. 1-10-0603

psychopharmaceutical medication, and it does create some confusion. I would say each form of these treatments here is medically recognized as being acceptable. Not only acceptable, but state of the art medicine."

In *Alfred H.H.*, our supreme court determined, *inter alia*, that the respondent, who had been involuntarily committed to a mental health facility and, on appeal, challenged the commitment order, had failed to show the likelihood of future recurrence under the public interest exception to the mootness doctrine, saying:

"[E]ven if the prior two criteria had been met, there is no substantial likelihood that the material facts that give rise to respondent's insufficiency claim are likely to recur either as to him or anyone else. Any future commitment proceedings 'must be based on the current condition of the respondent's illness and the ' 'decision to commit must be based upon a fresh evaluation of the respondent's conduct and mental state.' " " Therefore, it is highly unlikely that a determination as to the sufficiency of the evidence in this case would have any impact on future litigation." *Alfred H.H.*, 233 Ill. 2d at 358 (quoting *In re Houlihan*, 231 Ill. App. 3d 677, 683 (1992), quoting *People v. Nunn*, 108 Ill. App. 3d 169, 174 (1982)).

¶ 37 Here, the challenge in the underlying appeal to the sufficiency of the evidence does not

No. 1-10-0603

meet the public interest exception. See *Alfred H.H.*, 233 Ill. 2d at 356-57. In her appeal, respondent challenges the sufficiency of the evidence regarding the least-restrictive treatment alternative, the treatment based on respondent's future condition, and argues that the concurrent administration of ECT and psychotropic medication was contrary to medical evidence. The facts in regard to respondent's case are specific to her and do not involve anybody else. These facts are unique to the case at bar to the extent that the trial court stated at the hearing that, in its ten years' experience hearing cases, it had never seen a petition like the one before it. Accordingly, there is no substantial likelihood that the facts giving rise to respondent's claims are likely to recur either as to her in future proceedings or to anyone else. See *Alfred H.H.*, 233 Ill. 2d at 358. As such, we find that because respondent is unable to fulfill the necessary requirements in order to be considered under the "public interest" exception, such exception does not apply.

¶ 38 2. The Capable of Repetition Yet Evading Review Exception

¶ 39 Next, respondent argues that we should address her case under the "capable of repetition yet evading review" exception to the mootness doctrine. Under this exception (1) the challenged action must be of duration too short to be fully litigated prior to its cessation; and (2) there must be a reasonable expectation that the same complaining party would be subjected to the same action again. *Alfred H.H.*, 233 Ill. 2d at 358. The 90-day order in the case at bar, now expired, meets the duration requirement here. However, respondent cannot establish the second prong.

¶ 40 Respondent argues that, because of her history of mental illness, it is likely that she will again be subject to involuntary commitment proceedings. Our supreme court, however, has held

No. 1-10-0603

that "there must be substantial likelihood that the issue presented in the instant case, and any resolution thereof, would have some bearing on a similar issue presented in a subsequent case." *Alfred H.H.*, 233 Ill. 2d at 360. Respondent argues "the record shows that [respondent] has frequent hospitalizations with similar symptoms preceding her admissions. Given that her symptoms include catatonia, and that catatonia is treated with the medication Lorazepam and with electroconvulsive therapy, she could be subject to court-authorized medication and ECT in the future." This statement, however, alleges only that a repeat is *possible*; it does not show it is *likely* respondent will be subject to a similar order in the future. See *Alfred H.H.*, 233 Ill. 2d at 358 (under this exception, "the present action and a potential future action must "have a substantial enough relation that the resolution of the issue in the present case would be likely to affect a future case involving respondent").

¶ 41 Moreover, respondent has never had the authorized treatment of ECT followed by medication before, and both expert witnesses at the hearing testified that they expected she would respond well to the treatment. Specifically, Dr. Pavlovsky testified that he expected respondent to respond to the treatment and be able to return home. Likewise, Dr. Sharpe believed that respondent would likely respond fully to the point that she could be productive again, probably work, and function fully at home. Thus, if treatment were successful, respondent's health care providers would not seek a similar order. And, if the treatments were not successful, nothing in the record indicates that they would seek a repetition of an order which failed to work the first time. Respondent's argument fails because she is unable to show she is likely to be subject to a similar order in the future. Accordingly, the "capable of repetition yet evading review" exception

No. 1-10-0603

does not apply to respondent's case.

¶ 42 3. The Collateral-Consequences Exception

¶ 43 Respondent's final contention regarding mootness is that her case falls within the "collateral consequences" exception. The collateral consequences exception to mootness allows for appellate review even though a court order or incarceration has ceased, because a plaintiff has "suffered or [is] threatened with, an actual injury traceable to the defendant and likely to be redressed by a favorable judicial decision." *Lewis v. Continental Bank Corp.*, 494 U.S. 472, 477 (1990). Therefore, " 'subsistence of the suit requires * * * that continuing 'collateral consequences' be either proved or presumed.' " *Alfred H.H.*, 233 Ill. 2d at 361 (quoting *Spencer v. Kemna*, 523 U.S. 1, 7 (1998)). Our supreme court noted in *Alfred H.H.* that it has "never expressly addressed whether in a mental health case collateral consequences must be proven by the party asserting justiciability as in the ordinary civil case or whether they will be presumed as in a criminal appeal that is brought after a defendant's sentence has terminated." *Alfred H.H.*, 233 Ill. 2d at 361, n. 3. In *Alfred H.H.*, the supreme court affirmed that the collateral consequences exception can be applied in mental health cases. *Alfred H.H.*, 233 Ill. 2d at 361-62. The application of the collateral consequences exception is decided on a case by case basis. *In re Scaria*, 21 Ill. App. 3d 889, 894 (1974).

¶ 44 In *Alfred H.H.*, our supreme court found there were no collateral consequences warranting an exception to the mootness doctrine where the respondent had been previously subject to multiple orders for involuntary admission and was a convicted felon who had served a

No. 1-10-0603

sentence for murder. Accordingly, the court found that there were no collateral consequences that could stem solely from the underlying adjudication, and that every collateral consequence that could be identified already existed as a result of the respondent's previous adjudications and felony conviction. See *Alfred H.H.*, 233 Ill. 2d at 362-63.

¶ 45 A subsequent line of cases has developed that calls for review under the collateral-consequences exception for any first-time involuntary treatment adjudication. See, e.g., *In re Val Q.*, 396 Ill. App. 3d 155 (2009) (Second District); *In re Daryll C.*, 401 Ill. App. 3d 748 (2010) (Third District); *In re Joseph P.*, 406 Ill. App. 3d 341 (2010) (Fourth District); *In re Joseph M.*, 398 Ill. App. 3d 1086 (2010) (Fifth District); *In re Linda K.*, 407 Ill. App. 3d 1146 (2011) (Fourth District); but see *In re Merrilee M.*, 409 Ill. App. 3d 377 (2011) (Second District) (finding the collateral-consequences exception to the mootness doctrine inapplicable where "any negative consequences that respondent might suffer as a result of the trial court's order for involuntary treatment would otherwise exist due to respondent's involuntary admission during the present treatment, her two hospital admissions for mental health treatment prior to the present case, and her previous use of psychotropic medication").

¶ 46 Like the Second District in *Merrilee M.*, we do not think our supreme court intended to draw such a bright line requiring review under the collateral-consequences exception to the mootness doctrine for all respondents for whom the adjudication in question is the first. Rather, as instructed in *Alfred H.H.*, we are to decide the issue on a case-by-case basis, determining in each individual circumstance whether collateral consequences attach. See *Alfred H.H.*, 233 Ill. 2d at 364 (the application of the collateral-consequences exception is decided on a case-by-case

No. 1-10-0603

basis).

¶ 47 In this case, our review of respondent's particular medical history indicates that, prior to the present case, respondent had been a recipient of mental health treatment on numerous occasions. Some of these treatments resulted in hospital admissions while respondent was apparently in a catatonic-like state. The record does not indicate whether these admissions were voluntary or involuntary. The collateral-consequences exception is inapplicable here because any negative consequences that respondent might suffer as a result of the trial court's order for involuntary treatment would otherwise exist due to her admission during the present treatment, her multiple hospitalizations for mental health treatment prior to the present case, and the previous administration of psychotropic medication. Accordingly, we find that the collateral-consequences exception does not apply to respondent's case.

¶ 48

CONCLUSION

¶ 49 Respondent's case is moot and she has failed to establish that any exception to the mootness doctrine applies in this case. Accordingly, we dismiss respondent's appeal as moot.

¶ 50 Appeal dismissed.