

Nos. 2—09—1151 & 2—09—1152 cons.
Order filed June 21, 2011

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IN THE
APPELLATE COURT OF ILLINOIS
SECOND DISTRICT

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| <i>In re</i> THERESA C., Alleged to |) | Appeal from the Circuit Court |
| be a Person Subject to Involuntary |) | of Du Page County. |
| Admission and to Involuntary Psychotropic |) | |
| Medication |) | |
| |) | |
| |) | Nos. 09—MH—140 & 09—MH—146 |
| |) | |
| (The People of the State of Illinois, |) | Honorable |
| Petitioner-Appellee, v. Theresa C., |) | Thomas C. Dudgeon, |
| Respondent-Appellant). |) | Judge, Presiding. |

JUSTICE HUTCHINSON delivered the judgment of the court.
Presiding Justice Jorgensen and Justice Hudson concurred in the judgment.

ORDER

Held: Although the appeals are moot, we determined that the collateral-consequences exception applied to all issues. In light of our recent decision in *Merrilee M.*, the definition of “dangerous conduct” found in section 1—104.5 of the Act is unconstitutionally vague. Because respondent’s commitment was based on one of the “dangerous conduct” standards found unconstitutional, her admission may not be sustained. We vacated the trial court’s order authorizing respondent’s involuntary admission. Moreover, because Dr. Sheikh’s testimony as to respondent’s capacity was conclusory and insufficient to sustain a forced order of psychotropic medication, we held that the trial court’s finding was against the manifest weight of the evidence and reversed the trial court’s judgment.

On August 18, 2009, the State filed a petition for the involuntary admission of respondent, Theresa C., pursuant to section 3—600 of the Mental Health and Developmental Disabilities Code

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(the Code) (405 ILCS 5/3—600 (West 2008)). On August 20, 2009, the State filed a petition pursuant to section 2--107.1 of the Code (405 ILCS 5/2--107.1 (West 2008)), seeking to have psychotropic medication administered to respondent. The case proceeded to trial, after which the trial court granted both petitions. In this consolidated appeal, respondent challenges both the trial court's order authorizing the involuntary admission for 30 days and the involuntary administration of psychotropic medication to respondent for up to 90 days. Specifically, respondent seeks reversal because, *inter alia*, the trial court applied an unconstitutional standard when it found that she was a person subject to involuntary admission. Respondent also seeks reversal of the trial court's order for the involuntary administration of psychotropic medication. For the reasons that follow, we vacate the trial court's judgment in appeal No. 2—09—1151, and we reverse the trial court's judgment in appeal No. 2—09—1152.

The State's petition for involuntary admission alleged that respondent was mentally ill and by reason of the mental illness (1) was reasonably expected to engage in dangerous conduct; (2) was unable to provide for her basic physical needs so as to guard herself from serious harm; and was unable to understand her need for treatment and, if not treated, was reasonably expected to suffer mental deterioration to the point that she was reasonably expected to engage in dangerous conduct. In support of those allegations, the petition provided the following factual basis:

“[Respondent] has been approaching neighbor[s] telling them about involvement in child pornography and child trafficking [*sic*]. Neighbors have made complaints to the police and asked her to stay off of their property. [Respondent] has begun to [bill] these neighbors for millions of dollars due to her services. Family members report that patient is []stalking these neighbors.”

The trial court set a hearing on the petition for September 9, 2009. The parties presented their cases and following closing arguments, the trial court found that the State proved by clear and convincing evidence that respondent suffered from a mental illness. The trial court further found, *inter alia*, that, because of respondent's mental illness, she was reasonably expected to engage in dangerous conduct. The trial court found that there was not a lesser restrictive treatment alternative to hospitalization that would improve her condition. The trial court further found that the State, however, failed to prove that respondent was unable to provide for her basic physical needs. The trial court ordered respondent committed to Hinsdale Hospital for a period of 30 days.

With respect to appeal No. 2—09—1152, the trial court conducted a hearing on the State's petition for the involuntary administration of psychotropic medication. By agreement of the parties, the trial court took judicial notice of the evidence and findings from the hearing on the State's petition for the involuntary admission of respondent. At the hearing, Dr. Tahir Sheikh, a psychiatrist, testified that he examined respondent on August 24, 2009. Sheikh testified regarding the medications he sought to prescribe and administer to respondent. Sheikh testified that he was seeking only to administer Risperdal to respondent, one milligram, twice per day. Sheikh testified that he preferred Risperdal because it had fewer side effects out of the four mentioned in the petition. Sheikh testified that Risperdal came in two forms, oral and injection and that he would administer the oral medication first and then switch to the longer-lasting injection form.

On cross-examination, Sheikh admitted that respondent was currently taking Lisinopril for high blood pressure.

The trial court allowed the State to amend its petition to remove the psychotropic medications other than Risperdal and to add Risperdal Consta (injection), and the dosage amount of 25 to 37

milligrams for two weeks. The trial court then issued its findings and allowed the State's amended petition for the involuntary administration of psychotropic medication to respondent. The trial court authorized the administration for 90 days.

Following the trial court's denial of respondent's motions for new trials, respondent filed a timely notice of appeal.

On appeal, respondent contends (1) her case is moot, but an exception applies; (2) the trial court's commitment order must be reversed because of the State's failure to identify the peace officer who brought respondent to the hospital, in violation of section 3—606 of the Code (405 ILCS 5/3—606 (West 2008)); (3) the State failed to prove respondent suffered from a mental illness by clear and convincing evidence; (4) alternatively, that the trial court's commitment order must be vacated because it was based on a statutory standard found unconstitutional in *In re Torski C.*, 395 Ill. App. 3d 1010 (2010); (5) the commitment violated her constitutional and statutory right to treatment in the least restrictive environment; and (6) the State failed to prove a lack of capacity by clear and convincing evidence. In her reply brief, respondent withdraws her argument regarding a constitutional determination of the former commitment standard (405 ILCS 5/1—119(1), (3), 1—104.5 (West 2008)).

Both parties agree the issues raised by respondent on appeal are moot. The trial court's orders, entered September 10, 2009, were limited in duration to 30 days for the involuntary commitment, and limited in duration to 90 days for the involuntary administration of psychotropic medication. In this case, as in *In re Barbara H.*, 183 Ill. 2d 482, 490 (1998), respondent could be held involuntarily only if a new petition were filed and a new hearing conducted. Irrespective of the order's validity, it can no longer serve as the basis for adverse action against respondent. See

Barbara H., 183 Ill. 2d at 490. Any decision on the merits would result in an advisory opinion, in which this court cannot engage. See *Barbara H.*, 183 Ill. 2d at 490-91. Respondent argues any or all of three exceptions to the mootness doctrine apply: (1) capable of repetition but avoiding review; (2) collateral consequences; and (3) public interest.

We determine that the collateral-consequences exception applies because respondent could be plagued in the future by the adjudication at issue. See *Alfred H.H.*, 233 Ill. 2d at 361. If respondent were faced with civil commitment again, having once been judged mentally ill and in need of commitment, she would now have a history of mental illness that would work against her. See *In re Val Q.*, 396 Ill. App. 3d 155, 159 (2009). Our supreme court recognized in *Alfred H.H.* “a host of potential legal benefits” accrue if a commitment were reversed. See *Alfred H.H.*, 233 Ill. 2d at 362. “For instance, a reversal could provide a basis for a motion *in limine* that would prohibit any mention of the hospitalization during the course of another proceeding.” *Alfred H.H.*, 233 Ill. 2d at 362.

The collateral-consequences exception applies to a first involuntary-treatment order. *In re Joseph P.*, 406 Ill. App. 3d 341, 346 (2010); *Val Q.*, 396 Ill. App. 3d at 159. If respondent had previous involuntary commitments or felony convictions, collateral consequences would have already attached and would not be attributable to the commitment at issue. Thus, the collateral-consequences exception would not apply. See *Alfred H.H.*, 233 Ill. 2d at 362–63. Both respondent and the State recognize that respondent never had any prior mental health treatment. The record reflects no evidence that respondent is a convicted felon, and neither party claims otherwise. The record also fails to show respondent was previously subject to an order for involuntary administration of medication. See, e.g., *In re Daryll C.*, 401 Ill. App. 3d 748, 753 (2010) (holding

that collateral consequences had never previously attached where the respondent was never previously involuntarily committed, forcibly medicated, or convicted of a felony). If the commitment and medication orders stand, adverse consequences will attach and can be used against respondent in future proceedings. See *In re Gloria C.*, 401 Ill. App. 3d 271, 275-76 (2010). Therefore, the collateral-consequences exception to the mootness doctrine applies in this case to all issues on review in both appeals.

Although respondent presents a number of issues for our review, we need not address most of them because we determine that the trial court's holding that respondent was subject to involuntary admission on the basis that she was reasonably expected to engage in dangerous conduct must be vacated as void.

On May 6, 2011, during the pendency of this appeal, respondent filed a Motion to Cite Additional Authority with this court. Respondent is asking that we consider *In re Merrilee M.*, No. 2—10—0103 (Ill. App. Apr. 28, 2011), in resolving this appeal. We order the motion to be taken with the case, and we allow respondent's motion.

In *Merrilee M.*, this court recognized and approved *In re Torski C.*, 395 Ill. App. 3d 1010 (2009), a decision from the Fourth District, which held that the Act's definition of "dangerous conduct" was unconstitutionally vague. *Merrilee M.*, slip op. at 6 (citing *Torski C.*, 395 Ill. App. 3d at 1024-27). The Fourth District in *Torski C.* explained that the definition of "dangerous conduct" encompassed conduct that would not constitutionally support the liberty deprivation associated with involuntary admission. *Torski C.*, 395 Ill. App. 3d at 1024-25. The Fourth District also noted that the definition allowed for the arbitrary application of the statute to individuals who are mentally ill and who are engaged in merely unusual or annoying behavior. *Id.* at 1025. In *Merrilee M.*, this court

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determined that both sections 1—119(1) and 119(3) of the Act require a finding that the respondent is reasonably expected to engage in dangerous conduct as defined in the unconstitutional section 1—104.5 (405 ILCS 5/1—104.5, 119(1), (3) (West 2008)). *Merrilee M.*, slip op. at 6-7. The *Merrilee M.* court concluded that the respondent’s admission could not be sustained under either section 1—119(1) or section 1—119(3) of the Act. *Id.* at 7.

On our review of the relevant statutes and case law, and for the reasons stated in *Torski C.* and *Merrilee M.*, we agree with the reviewing courts’ rationale and holding that the definition of “dangerous conduct” found in section 1—104.5 of the Act is unconstitutional vague and adopt it here.

In the present case, the trial court found that respondent suffered from a mental illness and that, because of her mental illness, respondent was reasonably expected to engage in dangerous conduct. The trial court further found that the State, however, failed to prove that respondent was unable to provide for her basic physical needs. Because respondent’s commitment was based on one of the “dangerous conduct” standards found unconstitutional, her admission may not be sustained. See *Merrilee M.*, slip op. at 7. Therefore, we vacate the trial court’s order authorizing respondent’s involuntary admission.

With respect to appeal No. 2—09—1152, respondent contends that the State failed to prove by clear and convincing evidence that she lacked the capacity to make a reasoned decision about the medication. Respondent argues that the evidence showed that she possessed the capacity to make a reasoned decision or, at the very least, failed to establish a lack of capacity. We agree with respondent.

Again, this case is not moot, because it is the first time that respondent has been subject to the involuntary administration of psychotropic medication. Therefore, the collateral-consequences exception to the mootness doctrine applies to consider the merits of this appeal. See *Val Q.*, 396 Ill. App. 3d at 159-60. Section 2—107.1(a—5)(4)(E) of the Code requires that the State prove by clear and convincing evidence that the respondent lacks the capacity to make a reasoned decision about the treatment. “Clear and convincing evidence is defined as the quantum of proof that leaves no reasonable doubt in the mind of the fact finder as to the veracity of the proposition in question.” *Suzette D.*, 388 Ill. App. 3d at 984–85. The clear-and-convincing-evidence burden is higher than a preponderance of the evidence, but falls short of the reasonable doubt standard applied in criminal proceedings. *In re Lisa P.*, 381 Ill. App. 3d 1087, 1092 (2008). “An individual has the capacity to make treatment decisions for himself when, based upon conveyed information concerning the risks and benefits of the proposed treatment and reasonable alternatives to treatment, he makes a rational choice to either accept or refuse the treatment.” *In re Israel*, 278 Ill. App. 3d 24, 36 (1996). We review the trial court's findings under the manifest-weight-of-the-evidence standard. *Suzette D.*, 388 Ill. App. 3d at 985. We will not reverse the trial court unless “the opposite conclusion is apparent” or its findings are “unreasonable, arbitrary, or not based on the evidence.” *Lisa P.*, 381 Ill. App. 3d at 1092.

In *In re Israel*, 278 Ill. App. 3d 24 (1996), this court established guidelines to consider when determining a respondent’s capacity:

- “(1) The person’s knowledge that he has a choice to make;
- (2) The person’s ability to understand the available options, their advantages and disadvantages;

- (3) Whether the commitment is voluntary or involuntary;
- (4) Whether the person has previously received the type of medication or treatment at issue;
- (5) If the person has received similar treatment in the past, whether he can describe what happened as a result and how the effects were beneficial or harmful; and
- (6) The absence of any interfering pathologic perceptions or beliefs or interfering emotional states which might prevent an understanding of legitimate risks and benefits.” n *Israel*, 278 Ill. App. 3d at 37.

No single factor is dispositive and the court should consider any other relevant factor. *In re Gloria C.*, 401 Ill. App. 3d at 282.

In the present case, the evidence established that the respondent knew that she could choose whether to take medication. This is evident from respondent’s agreement to take Lisinopril but not any other medication. Merely because a respondent disagrees with the medical professional does not indicate a lack of capacity to make a reasoned decision. See *Robert S.*, 213 Ill. 2d at 53 (noting the testifying psychiatrists “simplistic assessment” that the respondent lacked the capacity because he refused to do what the psychiatrist recommended). The State did not question Sheikh regarding respondent’s ability to understand treatment options. With respect to respondent’s involuntary commitment, addressed above, we discussed the unconstitutional findings of the trial court in committing respondent. The State did not question Sheikh regarding whether respondent had previously received the type of treatment at issue, and the State did not present any evidence that respondent had been treated previously. With respect to the sixth *Israel* factor, the State asked

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Sheikh only whether he had a medical opinion as to whether respondent had the capacity to make a reasoned decision regarding treatment; Sheikh responded that she did not have the capacity.

Because psychotropic medication is invasive and includes possibly significant side effects, and because involuntary administration implicates important liberty interests, courts must exercise caution in entering such orders and require “firm proof” of the necessary statutory elements. See *In re David S.*, 386 Ill. App. 3d 878, 883–84 (2008) (reversing the trial court’s order for lack of sufficient evidence in support of the State’s petition). Our review of the record indicates that Dr. Sheikh’s testimony as to respondent’s capacity was conclusory and insufficient to sustain a forced order of psychotropic medication. Accordingly, we hold that the trial court's finding was against the manifest weight of the evidence.

For the foregoing reasons, we vacate the judgment of the circuit court of Du Page County in appeal No. 2—09—1151 and reverse the judgment of the circuit court of Du Page County in appeal No. 2—09—1152.

Appeal No. 2—09—1151: Vacated.

Appeal No. 2—09—1152: Reversed.