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NO. 4-10-0534

Order Filed 3/7/11

IN THE APPELLATE COURT  
OF ILLINOIS  
FOURTH DISTRICT

In re: OLIVER H., a Person Found ) Appeal from  
Subject to Involuntary Admission, ) Circuit Court of  
THE PEOPLE OF THE STATE OF ILLINOIS, ) Champaign County  
Petitioner-Appellee, ) No. 10MH11  
v. )  
OLIVER H., ) Honorable  
Respondent-Appellant. ) Michael Q. Jones,  
Judge Presiding.

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JUSTICE POPE delivered the judgment of the court.  
Justices Turner and Appleton concurred in the judgment.

**ORDER**

*Held:* (1) Respondent's appeal falls under the collateral-consequences exception to the mootness doctrine where (a) collateral consequences have not already attached from respondent's previous voluntary admission to Pavilion Hospital and (b) the June 30, 2010, involuntary admission could have collateral consequences in future proceedings.

(2) Although the medical certificates accompanying the petition for involuntary admission used the term "dangerous conduct," where the rest of the certificates, including the doctors' written findings, complied with section 3-602 of the Mental Health Code and where respondent did not object to the form of the certificates in the trial court, and where respondent does not show prejudice, the issue is forfeited on appeal.

(3) The State presented sufficient evidence from which the trier of fact could reasonably have found hospitalization was the least-restrictive treatment alternative available.

On June 30, 2010, Matt Taylor, an assessment specialist for Pavilion Hospital, filed an emergency petition for involun-

tary admission against respondent, Oliver H. On July 6, 2010, the trial court found Oliver H. to be mentally ill and subject to involuntary admission under section 1-119 of the Mental Health and Developmental Disabilities Code (Mental Health Code) (405 ILCS 5/1-119 (West 2008)). Respondent appeals, arguing (1) his appeal is not moot because it falls under the capable-of-repetition-yet-evading-review, the collateral-consequences, and the public-interest exceptions to the mootness doctrine, (2) the medical certificates attached to the petition for involuntary admission violated the requirements of section 3-602 of the Mental Health Code by using the term "dangerous conduct"; and (3) the court erred by failing to consider less-restrictive alternatives in treatment. We affirm.

#### I. BACKGROUND

On June 30, 2010, Matt Taylor, an assessment specialist working at Pavilion Hospital, filed an emergency petition for involuntary admission against respondent. The petition included allegations respondent had suicidal tendencies, appeared paranoid, heard voices, and asked whether he could hit Taylor and the patients at the hospital. Prior to the June 30, 2010, involuntary admission, respondent had been voluntarily admitted to Pavilion Hospital from November 25, 2009, to January 12, 2010.

On July 6, 2010, the trial court held a hearing on the petition for involuntary admission. The State's first witness

was Dr. Gerald Welch. Dr. Welch testified he was a psychiatrist specializing in child and adult psychiatry currently maintaining an inpatient practice at Pavilion Hospital.

Dr. Welch first testified regarding his observations of respondent during respondent's November 2009 admission. Dr. Welch testified he met respondent on November 27, 2009, because respondent's parents admitted him to the psychiatric unit after respondent was arrested for destruction of property. (Respondent had been arrested for breaking the headlights and mirror of a friend's car when the friend refused to admit respondent to his residence.) His parents reported he had paranoid tendencies, had exhibited unusual behavior, had dropped out of school because of poor academic performance, and was most likely using drugs. According to Dr. Welch, at the November 27, 2009, meeting, respondent was alert and obviously intelligent, but his thought process was incoherent, he struggled with boundary issues and paranoid tendencies, and he exhibited mood swings. After this meeting, Dr. Welch diagnosed respondent with psychosis, a mental illness characterized by a presence of disordered thought and difficulty with appreciating reality and conforming behavior with the requirements of his environment. He noted respondent attempted to conform his behavior to treatment, but he never had "a real internalized sense" of his illness and his need for treatment. He also noted respondent gave guarded answers to particu-

lar questions.

Additionally, Dr. Welch noted hospital staff reported respondent had not regularly participated in group sessions, and when he would participate, he would make bizarre comments and was unable to coherently express his thoughts. Specifically, on November 28, 2009, staff members reported respondent spit on people in group, talked of hearing music, was inappropriately smiling and chuckling, appeared paranoid, and had difficulty tracking his thoughts.

Dr. Welch testified respondent's condition deteriorated after his January 12, 2010, release from inpatient treatment. On June 29, 2010, respondent's father brought him to Pavilion Hospital for involuntary admission because he voiced suicidal tendencies. Dr. Welch testified he met with respondent on June 30, 2010, to determine if involuntary admission was appropriate. During this meeting, respondent appeared tense and angry, exhibited paranoid tendencies, struggled with focusing his thoughts, acknowledged he heard voices, and appeared "internally preoccupied." Based on this interview, Dr. Welch involuntarily admitted respondent to Pavilion Hospital.

Dr. Welch next testified regarding his observations of respondent's behavior during this second admission. He testified hospital staff reported respondent had exhibited aggressive behavior toward staff and patients by making verbal threats of

physical violence. Additionally, staff reported respondent physically attacked another patient on June 30, 2010, and was given a dose of Zyprexa to calm him down. On July 1, 2010, staff reported respondent was again making verbal threats of physical violence and was uncontrollably yelling and screaming. Dr. Welch also testified respondent was placed in a safe room several times during his admission because staff was concerned he would hurt himself or others. On July 2, 2010, the staff reported respondent was agitated, threw water on the floor, and then cleaned it up. On July 3, 2010, staff reported he was yelling and pounding on walls and doors. Dr. Welch also noted respondent repeatedly refused to take his prescription medicine.

Dr. Welch concluded respondent was a danger to himself and others because he had suicidal tendencies, threatened others with physical violence, and exhibited aggression toward his physical environment. He testified respondent had admitted using marijuana in the past, and he opined respondent would be unable to refrain from continued drug use. He concluded respondent would be unable to provide for his basic needs if released into society because he would be unable to maintain employment or stay in school. Additionally, he believed respondent would have difficulty maintaining an independent living situation for any length of time because, without medication, his psychosis would continue to interfere with his thought processes and cause

paranoid reactions to people.

Dr. Welch opined respondent failed to understand the nature of his mental illness as evidenced by his refusal to take medication. Dr. Welch concluded outpatient treatment was not appropriate for respondent because he believed respondent would not take his psychiatric medications and would continue to use illicit drugs. Dr. Welch expressed fear that respondent, if not committed, would end up on the street "doing things that will be dangerous to support himself." Dr. Welch referred to an e-mail sent to respondent's father by a friend of respondent indicating respondent was considering doing sexual favors in order to buy crack cocaine. He also concluded respondent would need hospitalization for a minimum of three months. However, he stated respondent's "prognosis [was] very guarded, even with longer term treatment."

The State's next witness was Rudolf H., respondent's father. Rudolf testified respondent's behavior drastically changed after his parents divorced when he was 12 years old. Shortly after the divorce, Rudolf took respondent to the emergency room at Carle Clinic because he observed 37 self-inflicted knife wounds on respondent's forearm. Despite Rudolf's wishes, respondent was not admitted to Pavilion Hospital at that time, apparently because Oliver's mother did not want him admitted.

Rudolf testified respondent was very bright and tested

for the gifted program in elementary school. However, once he reached middle school and high school, he was increasingly hostile toward teachers and received several discipline referrals for behavioral issues. When respondent was approximately 17 years old, he burned himself with cigarettes and cigarette lighters, creating multiple blisters on his legs. Additionally, respondent exhibited signs of paranoia and had a "strong belief in telepathy and mental communication." Respondent was convinced people were sending him insulting thoughts, which made him angry. Additionally, he told Rudolf he heard voices from the afterlife and aliens. Rudolf testified respondent was repeatedly aggressive toward objects. Rudolf noted respondent refused to take his medication and was concerned, if left untreated, respondent would become homeless. Rudolf also noted respondent appeared more coherent when he regularly took his medication.

Rudolf next testified regarding the incident leading to respondent's second admission on June 30, 2010. He testified respondent had asked him for drugs to commit suicide. Rudolf responded by asking respondent if he wanted to speak with a psychiatrist, and respondent answered in the affirmative. Rudolf stated he considered respondent's suicide threats to be serious because respondent was unable to comprehend the permanency of death. On June 29, 2010, respondent had an assessment meeting at Pavilion Hospital with the assessment director, Matt Taylor.

Rudolf was present at the meeting, and he observed respondent behaving in an aggressive and disdainful manner toward Taylor. Additionally, respondent asked Taylor if he could hit him because the voices in his head wanted him to hit Taylor.

Wendi Weidner, a case manager at Pavilion Hospital, testified she observed respondent calmly conversing with a male patient when he suddenly became agitated and punched the patient in the arm on June 30, 2010. Also, she testified respondent was extremely agitated throughout the day on July 1, 2010, and punched and kicked walls and also punched a camera monitor in the nurses' station.

On cross-examination, she acknowledged she had not observed respondent making suicidal threats or engaging in self-mutilation after his admission. She noted during respondent's admission to date, he failed to regularly attend group therapy and refused to take his medication. She opined admission into Pavilion Hospital would be beneficial to respondent for stabilization and to ensure his safety and the safety of others.

After the State rested its case, defense counsel called respondent to the stand. Respondent admitted he wanted to quit taking illegal and prescription drugs because he was "afraid of getting addicted \*\*\* and not owning" himself. Additionally, he believed "natural progression" was the best treatment for him. He admitted he voluntarily agreed to speak with a counselor on

June 30, 2010, but had not anticipated being detained for longer than one day. He testified he made a statement to Taylor about committing suicide just to provoke a reaction, but although he was depressed, he had not seriously contemplated suicide.

Contrary to Weidner's testimony, respondent testified he was struck by another patient when he confronted the patient about being involved with the CIA on June 30, 2010. He also testified he attended every group session since the Friday before the July 6, 2010, hearing. Further, respondent testified he was in the proper state of mind to maintain employment, maintain his personal hygiene, and provide food for himself. He felt the testimony regarding his state of mind referred to his state of mind prior to his June 30, 2010, involuntary admission.

On cross-examination, respondent clarified his previous statement about treatment by saying a natural progression to a stable state of mind was one without drugs. Respondent testified he had control over his mental illness and would continue to maintain control by using calming techniques learned at Pavilion Hospital. He admitted using marijuana as a means to control his mental illness in the past because it would numb his feelings of anxiety and anger. He also admitted he had self-mutilated his arms in the past, but the self-mutilation was the result of peer pressure. He also admitted burning his leg with a lighter on one occasion.

Without entertaining closing arguments, the trial court concluded respondent was "a person with a mental illness who, by virtue of that illness, [was] reasonably expected to inflict serious physical harm on himself or another in the near future." Additionally, the court found as a result of respondent's mental illness, he was unable to provide for his basic needs without the assistance of family or outside help. The court noted the evidence showed respondent had not participated in group sessions despite his testimony to the contrary. The court also noted respondent lacked insight into his mental illness and conformed his behavior to posture as a person who does not need further treatment. Additionally, the court concluded "the least restrictive and most appropriate disposition [was] to authorize [respondent's] hospitalization at a secure facility." The court then ordered respondent committed to McFarland Mental Health Center for a period of 90 days, or alternatively, confined at Pavilion Hospital until he could be transferred to McFarland Mental Health Center.

This appeal followed.

## II. ANALYSIS

### A. Mootness

The trial court entered the commitment order on July 6, 2010, and limited the enforceability of the order to 90 days. The 90-day period has passed. As a result, this case is moot.

Therefore, before we can address the merits of respondent's appeal, we must first determine whether any exception to the mootness doctrine applies. Respondent argues his appeal is not moot because it falls under the capable-of-repetition-yet-evading-review, the collateral-consequences, and the public-interest exceptions to the mootness doctrine. We find this appeal falls within the collateral-consequences exception.

#### B. Collateral-Consequences Exception

The collateral-consequences exception to the mootness doctrine allows a reviewing court to consider an otherwise moot case where the involuntary admission "could return to plague the respondent in some future proceedings or could affect other aspects of the respondent's life." *In re Val Q.*, 396 Ill. App. 3d 155, 159, 919 N.E.2d 976, 980 (2009). However, according to *In re Alfred H.H.*, 233 Ill. 2d 345, 362-63, 910 N.E.2d 74, 84 (2009), the collateral-consequences exception will not apply when a respondent has previously been involuntarily committed because any collateral consequences have already attached as a result of the prior commitments.

In this case, respondent was previously admitted to Pavilion Hospital on November 25, 2009. However, respondent's prior commitment was not an involuntary commitment because he was admitted into the adolescent unit by his parents. Because respondent's previous commitment was a voluntary admission,

collateral consequences have yet to attach. Additionally, the June 30, 2010, involuntary commitment could potentially return to plague respondent in future proceedings or affect other aspects of his life. Accordingly, we find the collateral-consequences exception applies, and we will consider the issues raised on appeal.

### C. Section 3-602 Requirements

Respondent argues the medical certificates attached to the petition for involuntary admission failed to comply with section 3-602 of the Mental Health Code because the term "dangerous conduct" was used in the description of respondent's mental state. He argues "dangerous conduct" has been held an insufficient statutory standard to justify involuntary admission under *In re Torski C.*, 395 Ill. App. 3d 1010, 1027, 918 N.E.2d 1218, 1232 (2009). The State argues respondent has forfeited this argument because he failed to bring the alleged error to the attention of the trial court, and reversal is inappropriate because respondent failed to demonstrate how he was prejudiced by the use of the term "dangerous conduct" in the medical certificates. On the merits, the State argues the medical certificates complied with the requirements of section 3-602 of the Mental Health Code despite the use of the term "dangerous conduct."

If an error demonstrating noncompliance with statutory requirements is apparent on the face of the record, the error may

be considered on appeal despite not being raised in the trial court. *In re George O.*, 314 Ill. App. 3d 1044, 1049, 734 N.E.2d 13, 18 (2000). Although procedural deviations from the Mental Health Code may be apparent on the face of the record, reversal is not required when the respondent could have and should have immediately objected to the defect, the defect could have been easily cured if a timely objection was made, and the defect made no difference on the outcome of the hearing. *In re Nau*, 153 Ill. 2d 406, 419, 607 N.E.2d 134, 140 (1992). However, "[w]here the outcome of the commitment hearing may have been prejudiced by the State's failure to strictly comply with the Code, reversal of the petition is proper." *In re Adams*, 239 Ill. App. 3d 880, 885, 607 N.E.2d 681, 684 (1993).

Section 3-602 of the Mental Health Code provides the following:

"The petition [for involuntary admission] shall be accompanied by a certificate executed by a physician, qualified examiner, or clinical psychologist which states that the respondent is subject to involuntary admission and requires immediate hospitalization. The certificate shall indicate that the physician, qualified examiner, or clinical psychologist personally examined the

respondent not more than 72 hours prior to admission. It shall also contain the physician's, qualified examiner's, or clinical psychologist's clinical observations, other factual information relied upon in reaching a diagnosis, and a statement as to whether the respondent was advised of his rights under Section 3-208." 405 ILCS 5/3-602 (West 2008-).

In the present case, the psychiatrists' certificates stated respondent was a

"person with mental illness who, because of his \*\*\* illness is reasonably expected to engage in dangerous conduct which may include threatening behavior or conduct that places that person or another individual in reasonable expectation of harm; [and a] person with mental illness who, because of the nature of his \*\*\* illness, is unable to understand his \*\*\* need for treatment and who, if not treated, is reasonably expected to suffer or continue to suffer mental deterioration or emotional deterioration, or both, to the point that the person is reasonably expected

to engage in dangerous conduct; [and] [i]s in need of immediate hospitalization for the prevention of such harm."

According to *Torski C.*, 395 Ill. App. 3d at 1027, 918 N.E.2d at 1232, "dangerous conduct" as defined in section 1-104.5 and referenced in section 1-119(3) of the Mental Health Code (405 ILCS 5/1-104.5, 1-119(3) (West 2008)) is an insufficient statutory standard to justify involuntary hospitalization of a mentally ill individual. Thus, section 1-104.5 of the Mental Health Code was declared unconstitutionally vague. *Torski C.*, 395 Ill. App. 3d at 1027, 918 N.E.2d at 1232-33.

Respondent argues he was prejudiced because the preprinted medical certificates were inconsistent with the petition for involuntary admission and reflected medical conclusions based on the standard of "dangerous conduct" held unconstitutional by *Torski C.* However, respondent admits the petition for involuntary admission reflected the appropriate standard required post-*Torski C.*

Although the treating psychiatrists used the term "dangerous conduct" in the medical certificates, the petition alleged Oliver H. is

[1] "a person with mental illness who, because of his or her illness is reasonably expected to inflict serious physical harm

upon himself or herself or another in the near future, which may include threatening behavior or conduct that places another individual in reasonable expectation of being harmed;

[2] a person with mental illness and who because of his or her illness is unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm without the assistance of family or outside help;

\*\*\* and/or

[3] in need of immediate hospitalization for the prevention of such harm."

In addition, the certificates of the psychiatrists (1) stated respondent was subject to involuntary admission and needed immediate hospitalization, (2) indicated respondent was examined on June 29, 2010, and June 30, 2010, not more than 72 hours prior to admission, (3) contained the psychiatrists' observations and the factual information relied on in reaching a diagnosis which met the appropriate standard set forth in the petition, and (4) contained a statement respondent was advised of his rights under section 3-208 of the Mental Health Code.

Respondent failed to object to the form of the certifi-

cates in the trial court, the petition itself alleged the correct standard for involuntary admission, and the handwritten portions of the medical certificates also complied with the appropriate standard for involuntary admission. Thus, respondent is unable to show he was prejudiced by the preprinted portions of the medical certificates. Accordingly, the issue is forfeited for appeal purposes.

#### D. Least-Restrictive Alternative

Defendant next argues the trial court erred by failing to consider less-restrictive alternatives for respondent's treatment. We disagree.

When determining treatment options for a person found subject to involuntary admission, the trial court may order hospitalization, outpatient treatment, or order the person placed in the care of a relative or care of another person willing to take proper care of the mentally ill person. *In re Luttrell*, 261 Ill. App. 3d 221, 226, 633 N.E.2d 74, 78 (1994). However, "hospitalization may only be ordered if the State proves it is the least restrictive treatment alternative." *Luttrell*, 261 Ill. App. 3d at 226, 633 N.E.2d at 78. The State's burden is not satisfied by only presenting an expert's opinion that hospitalization is the least-restrictive treatment alternative. *Luttrell*, 261 Ill. App. 3d at 227, 633 N.E.2d at 78. Instead, the expert's opinion must be supported by the evidence. *Luttrell*,

261 Ill. App. 3d at 227, 633 N.E.2d at 78. However, when the court is justified in finding hospitalization is the least-restrictive treatment alternative, it is not error "'for the court to fail to give consideration to placing the defendant with a relative.'" *People v. Sharkey*, 60 Ill. App. 3d 257, 265, 376 N.E.2d 464, 469 (1978) (quoting *People v. Ralls*, 23 Ill. App. 3d 96, 101, 318 N.E.2d 703, 707 (1974)).

In *In re Lillie M.*, 375 Ill. App. 3d 852, 857, 875 N.E.2d 157, 162 (2007), this court previously held evidence of the respondent suffering from a mental illness and acting on harmful paranoid thoughts was sufficient to prove hospitalization was the least-restrictive treatment alternative. Despite the existence of other treatment alternatives, this court noted "ordering [respondent] to reside with her family while undergoing outpatient treatment does not seem like a reasonable treatment alternative because that appears to be the treatment [respondent] was receiving" before hospitalization. *Lillie M.*, 375 Ill. App. 3d at 859, 875 N.E.2d at 163-64.

Additionally, the court in *In re Shirley M.*, 368 Ill. App. 3d 1187, 1195, 860 N.E.2d 353, 360 (2006), held the State presented sufficient evidence to support a finding of hospitalization as the least-restrictive treatment alternative because the evidence showed the respondent had exhibited bizarre behavior, had become more dangerous and impulsive, and her mental

illness interfered with her ability to interact in a community. Also, in *In re Michelle L.*, 372 Ill. App. 3d 654, 660, 867 N.E.2d 1187, 1191-92 (2007), this court held the trial court could have reasonably found hospitalization was the least-restrictive treatment alternative because the State presented evidence of the respondent's self-destructive behavior and refusal to take medication.

In contrast, the court in *In re Alaka W.*, 379 Ill. App. 3d 251, 273, 884 N.E.2d 241, 258-59 (2008), determined the State failed to prove hospitalization was the least-restrictive treatment alternative because it failed to present evidence of available alternatives and why those alternatives were not appropriate. Additionally, in *In re Phillip E.*, 385 Ill. App. 3d 278, 284-86, 895 N.E.2d 33, 40-42 (2008), the court noted the State's expert testified the respondent remained mentally ill and would likely inflict serious harm on himself and others, but provided no foundation for these opinions. Because the State failed to provide evidentiary support for the expert's opinion, the court held the testimony was insufficient to prove hospitalization was the least-restrictive treatment alternative available. *Phillip E.*, 385 Ill. App. 3d at 286, 895 N.E.2d at 42.

Here, Dr. Welch testified outpatient treatment would likely be unsuccessful as a treatment alternative because it was reasonably certain respondent would continue refusing his medica-

tion and continue abusing illegal drugs. Respondent bolstered Dr. Welch's prediction concerning his continued refusal of medication when he testified he preferred a "natural progression" treatment, where he could use calming techniques to control his mental illness instead of medication.

In addition to this testimony, other evidence presented at the hearing suggests hospitalization would be the least-restrictive treatment alternative for respondent. Although Dr. Welch did not state an opinion on the adequacy of placing respondent in the custody of his parents while attending outpatient treatment, the evidence suggests this alternative would be inadequate. Respondent's father was called to testify in support of the petition for involuntary admission. During the years prior to respondent's voluntary admission, he was admitted into the emergency room for 37 self-inflicted knife wounds, had burned himself with a lighter, and displayed aggressive behavior toward objects and other people's property. On November 25, 2009, respondent was voluntarily admitted to Pavilion Hospital after he was arrested for destruction of property. After his discharge, Dr. Welch continued to meet with respondent over a period of approximately two months. According to Dr. Welch's testimony, at some point during the outpatient treatment, there was a dramatic deterioration in respondent's condition. He became more "actively psychotic" and talked about committing suicide. This was

supported by Rudolf's testimony that respondent asking him for "suicide drugs." After respondent voiced his suicidal tendencies, Rudolf took him to Pavilion Hospital to talk with a counselor, which led to respondent's involuntary admission.

During respondent's June 30, 2010, involuntary admission, he continued to exhibit aggressive behavior as evidenced by his punching another patient, his threatening of other patients and hospital staff with physical harm, and his physical aggression toward objects.

Additionally, the trial court recognized respondent's belief he had coping techniques to deal with his mental illness but noted Dr. Welch discarded the calming techniques as a possible treatment. The court also noted respondent lacked insight into his illness and was unable to provide for his basic physical needs without the assistance of family or outside help.

Like *Lillie M.*, the evidence in the present case suggests ordering respondent to live with his family while attending outpatient treatment is an inadequate alternative to hospitalization because it appears respondent received this type of treatment prior to his involuntary commitment. Additionally, evidence of respondent's self-destructive behavior and refusal to take medication is sufficient evidence for the trial court to find hospitalization is the least-restrictive treatment alternative available. See *Michelle L.*, 372 Ill. App. 3d at 660, 867

N.E.2d at 1191-92. Accordingly, the trial court was justified in its finding of hospitalization as the least-restrictive treatment alternative for respondent.

### III. CONCLUSION

For the reasons stated, we affirm the trial court's judgment.

Affirmed.