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2012 IL App (3d) 110121-U

Order filed March 29, 2012

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IN THE  
APPELLATE COURT OF ILLINOIS  
THIRD DISTRICT

A.D., 2012

In the Interest of LARRY G.	)	Appeal from the Circuit Court
	)	of the 13th Judicial Circuit,
THE PEOPLE OF THE STATE	)	La Salle County, Illinois
OF ILLINOIS,	)	
	)	
Petitioner-Appellee,	)	
	)	
v.	)	Appeal No. 3-11-0121
	)	Circuit No. 11-MH-3
	)	
LARRY G.,	)	Honorable
	)	H. Chris Ryan,
Respondent-Appellant.	)	Judge, Presiding.

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JUSTICE HOLDRIDGE delivered the judgment of the court.  
Justices Lytton and O'Brien concurred in the judgment.

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**ORDER**

¶ 1 *Held:* The "collateral consequences" exception to the mootness doctrine applied, allowing the court to review an order involuntarily committing the respondent to a hospital for mental health treatment even though that order had already expired, because there was no evidence in the record that the respondent had been involuntarily committed in the past. The appellate court reversed the involuntary commitment order because (1) the State failed to present either a written predisposition report or witness testimony establishing that hospitalization was the least restrictive available treatment setting, as required by 405 ILCS 5/3-810

(2010), and (2) there was no evidence that the circuit court considered any information regarding alternatives to treatment in an inpatient facility or ordered the least restrictive appropriate treatment, as required by 405 ILCS 5/3–811 (West 2010).

¶ 2 The respondent, Larry G., appeals an order of the circuit court committing him involuntarily to a hospital for inpatient mental health treatment and ordering the involuntary administration of psychotropic drugs. Although that order has expired, the respondent claims the issues raised by this appeal fall within an exception to the mootness doctrine. On the merits, the respondent claims that the circuit court's finding that hospitalization was the least restrictive available treatment setting was not supported by the evidence.

¶ 3 BACKGROUND

¶ 4 On February 15, 2011, the State filed a petition for the involuntary admission of the respondent to the Ottawa Regional Hospital for mental health treatment pursuant to the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/1–100 *et seq.* (West 2010)). Attached to the State's petition were the written statements of three health care professionals who were treating the respondent at the hospital: Dr. Craig Kestenberg, a psychiatrist; Heidi Sobkowiak, a registered nurse; and Wendy Navarro, a licensed clinical social worker and the hospital's social services supervisor. In his written statement, Dr. Kestenberg noted that he had examined the respondent and concluded that the respondent was suffering from a mental illness that rendered him in need of immediate hospitalization "subject to involuntary admission." Dr. Kestenberg noted that the respondent showed "persistently impaired judgment" with regard to both his physical and mental health needs and was neglecting ongoing medical treatment. In addition, Dr. Kestenberg stated that the respondent was suffering from "increasing paranoid \*\*\*

delusions" that his family, his neighbors, and public officials were "harming him with tasers" through the walls of his home. Dr. Kestenberg also noted that, the day before the State's petition was filed, the respondent had "held a knife refusing to let it go in the presence of the police." He stated that the respondent had "no insight into his condition" and was "denying mental illness."

¶ 5 Dr. Kestenberg opined that, unless the respondent was treated on an inpatient basis, the respondent was: (1) "reasonably expected \*\*\* to engage in conduct placing [him] or another in physical harm or in reasonable expectation of being physically harmed;" (2) "unable to provide for his \*\*\* basic physical needs so as to guard himself \*\*\* from serious harm, without the assistance of family or others;" and (3) unable to understand his need for treatment and, due to his neglect of treatment, "reasonably expected to suffer mental or emotional deterioration" that could cause physical harm to himself or others or render him unable to provide for his basic physical needs.

¶ 6 Sobkowiak's written statement described several ways in which the respondent was "exhibit[ing] self-neglect." Specifically, Sobkowiak noted that the respondent was "disheveled," "unwashed," and "extremely malodorous," and that he was refusing to take prescribed medications to treat his hypertension and his mental condition. Moreover, Sobkowiak stated that the respondent was "irritable," "minimally communicative," and "guarded and watchful of [the hospital] staff."

¶ 7 Similarly, Navarro noted in her written statement that the respondent was "distrustful of others and lack[ed] insight into his mental/physical well-being." She also noted that the respondent had "verbalized delusions that he ha[d] been tasered through his walls" by the Marseilles police and fire departments and that he had "taser strings all over his body."

Sobkowiak and Navarro agreed with Dr. Kestenberg's characterization of the respondent's mental condition and his need for immediate hospitalization.

¶ 8 On February 16, 2011, the State filed a petition for the involuntary administration of psychotropic medications. The petition alleged that the respondent lacked the ability to give informed consent to psychotropic medication and that, because of his mental illness, the respondent was exhibiting "deterioration of the ability to function, suffering, or threatening behavior." The petition also alleged that "the benefits of [psychotropic medications] clearly outweigh[ed] the harm" and that "other, less restrictive services were explored and found inappropriate[.]"

¶ 9 On February 18, 2011, the circuit court held a hearing on both of the State's petitions. Police officer Kenneth Sangston of the Marseilles police department testified for the State. Sangston testified that, on February 14, 2011, he was asked to do a well-being check at the respondent's residence. When he arrived, he noticed that windows were broken out in the respondent's house and his truck, and there was a large amount of personal property in a nearby creek. Sangston entered the residence and found the respondent inside the bathroom with the door shut. When Sangston opened the bathroom door, he saw the defendant leaning against the sink, holding a knife and staring at the ceiling. When Sangston asked the respondent what he was going to do with the knife, the respondent replied that he was going to use it for "protection." Sangston testified that the respondent appeared agitated and unkempt and was speaking irrationally. For example, the defendant told Sangston that people had been shooting him with tasers, poisoning him while he was sleeping, and pumping poisonous gas into his house. The

respondent also told Sangston that the identities of his pets had been "switched." When Sangston asked the respondent about his medication, the respondent told Sangston that he did not need it.

¶ 10 Based on the respondent's irrational speech and behavior (particularly the fact that the respondent had been holding a knife), Sangston concluded that the respondent "could have been a threat to himself or to others." Sangston called an ambulance and tried to convince the respondent to go voluntarily to the hospital. The respondent refused. When the ambulance arrived, the respondent was restrained,<sup>1</sup> handcuffed, and taken to the Ottawa Regional Hospital, where he was admitted to the inpatient psychiatric unit. Sangston signed an involuntary commitment form.

¶ 11 Dr. Kestenberg also testified for the State. Dr. Kestenberg testified that he met the respondent in November 2010 when Dr. Kestenberg "consulted to the ICU staff" and that he became reacquainted with the respondent at the onset of the respondent's recent admission to the hospital. Dr. Kestenberg stated that he had been treating the respondent at the hospital since then. Dr. Kestenberg testified that the respondent had a history of a "chronic and progressive course of paranoia, avoidance of seeking company, [and an] inability to work for a very long period of time." Dr. Kestenberg opined that the respondent had "severe paranoid delusions." For example, Dr. Kestenberg noted that the respondent believed that "his neighbors and other people in the community working in collaboration with his family [were] trying to hurt him directly through electronic means using materials such as lasers and tasers that penetrate[d] \*\*\* the walls of his home and \*\*\* cause[d] him physical pain and emotional suffering." According to Dr.

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<sup>1</sup> Sangston testified that the respondent had to be restrained for his own safety and the safety of the three police officers who were on the scene at the time.

Kestenberg, the respondent avoided social contact because he was afraid of being harmed by others and was concerned with his safety when he was at home because he believed that people were conspiring against him. However, the respondent did not believe that there was any cause for him to be admitted to the hospital. Dr. Kestenberg provisionally diagnosed the respondent as a "chronic paranoid schizophrenic."

¶ 12 Dr. Kestenberg testified that, when he first saw the respondent shortly after his recent admission to the hospital, the respondent appeared "haggard, worn, with poor hygiene, and thinner" than he was the last time Dr. Kestenberg had seen him. Moreover, the respondent was avoiding contact with others and refusing to take medications that had been prescribed for his hypertension. Dr. Kestenberg opined that the defendant was unable to care for his basic needs and unable to understand his need for treatment. He also opined that, because of the respondent's mental illness, the respondent was "reasonably expected to engage in conduct that might place himself or others in a reasonable expectation of being harmed."

¶ 13 Dr. Kestenberg testified that he had developed a treatment plan for the respondent that included routine laboratory work, psychotherapy, and the administration of anti-psychotic medications. Dr. Kestenberg opined that the respondent did not have the capacity to give informed consent to take anti-psychotic medications or to make a reasoned decision about his treatment. Dr. Kestenberg concluded that the benefits of psychotropic medications clearly outweighed any potential for harm. He testified that he had considered other alternatives to psychotropic medication and found such alternatives to be inappropriate in the respondent's case.

¶ 14 Sobkowiak and Navarro also testified. Their testimony was consistent with the written statements they had submitted in support of the State's petition for involuntary admission.

¶ 15 The State did not submit a written predisposition report describing the availability and appropriateness of alternative treatment settings, as required by section 3-810 of the Code (405 ILCS 5/3-810 (West 2010)). However, the respondent's counsel did not object to the State's failure to submit a predisposition report or argue that the information required by the report had not been adequately presented to the court. Instead, the respondent's counsel moved to dismiss the State's petition for involuntary admission on the grounds that the State failed to prove that it filed the petition within 24 hours of the respondent's admission or that the respondent was informed of his rights in a timely fashion. The circuit court denied the motion.

¶ 16 The respondent did not testify or present any evidence. During his closing argument, the respondent's counsel raised the same procedural arguments that he had raised in his unsuccessful motion to dismiss. The respondent's counsel also asserted without explanation or argument that "we do not believe that there is clear and convincing evidence to warrant [the respondent's] involuntary admission and we don't believe that they have proved each statutory element that is required."

¶ 17 The circuit court granted the State's petitions and ordered the respondent involuntarily committed for 90 days. The court also granted the State's petition for the involuntary admission of psychotropic medications as to the medications and dosages detailed in Dr. Kestenberg's treatment plan and approved Dr. Kestenberg's request to perform routine laboratory tests on the respondent. The respondent filed a timely notice of appeal.

¶ 18 On March 25, 2011, the circuit court granted the State's motion to dismiss the case. The court's order notes that the respondent had been discharged from treatment at that time.

¶ 20 The respondent argues that the State's petition for involuntary admission must be reversed because the State did not submit a predisposition report or otherwise prove that involuntary hospitalization was the least restrictive available treatment alternative. Before addressing the merits of these arguments, we must first address the issue of mootness. The 90-day involuntary commitment order that is the subject of this appeal has already expired, and the respondent has been discharged from treatment. Accordingly, this appeal is moot. *In re Robert S.*, 213 Ill. 2d 30, 45 (2004); see also *In re J.T.*, 221 Ill. 2d 338, 349–50 (2006) (an appeal is moot where it presents no actual controversy or where the issues raised in the trial court no longer exist, rendering it "impossible for the reviewing court to grant effectual relief to the complaining party").

¶ 21 Generally, courts of review do not decide moot questions, render advisory opinions, or consider issues where the result will not be affected by the court's decision. *In re Alfred H.H.*, 233 Ill. 2d 345, 351 (2009). However, there are three established exceptions to the mootness doctrine: (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 treatment order could return to plague the respondent in some future proceedings or could affect other aspects of the respondent's life. *Alfred H.H.*, 233 Ill. 2d at 355–62. Whether a particular appeal falls within one of these exceptions to the mootness doctrine must be determined on a case-by-case basis,

considering each exception in light of the relevant facts and legal claims raised in the appeal. *Alfred H.H.*, 233 Ill. 2d at 355, 364; *In re Daryll C.*, 401 Ill. App. 3d 748, 752 (2010).

¶ 22 We hold that this case falls within the collateral consequences exception to the mootness doctrine. As noted above, this exception applies where the involuntary commitment order at issue could cause harm to the respondent in the future and where such potential harm is likely to be redressed by a favorable judicial determination. *Alfred H.H.*, 233 Ill. 2d at 361; *Daryll C.*, 401 Ill. App. 3d at 752. In *Alfred H.H.*, our 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 supreme court recognized that there are a host of potential legal benefits to the reversal of an involuntary commitment. *Id.* 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. Moreover, the reversal of an order of involuntary commitment "could affect the ability of a respondent to seek employment in certain fields." *Id.*

¶ 23 The court in *Alfred H.H.* ultimately decided that the collateral consequences exception did not apply to the facts in that case because the respondent had previously been committed involuntarily multiple times and had been convicted of murder. *Alfred H.H.*, 233 Ill. 2d at 363. Thus, under the particular facts presented in *Alfred H.H.*, the court could not identify any collateral consequence that could stem solely from the involuntary commitment order at issue. *Id.* However, our appellate court has repeatedly applied the collateral consequences exception where there is no evidence that the respondent had been involuntarily committed prior to the commitment order at issue. See, e.g., *Daryll C.*, 401 Ill. App. 3d at 752-53 (applying collateral

consequences exception despite evidence that the respondent had a history of mental illness where there was "no indication that the respondent had ever been involuntarily committed in the past"); see also *In re Joseph P.*, 406 Ill. App. 3d 341, 346-47 (2010) (applying the collateral consequences exception even though the respondent's psychiatric evaluation referenced a previous hospitalization where the record did not indicate whether this hospitalization was voluntary and the record "fail[ed] to show respondent was previously subject to an order for involuntary administration of medication"); *In re Wendy T.*, 406 Ill. App. 3d 185, 189 (2010) (finding that the exception applied because "the record [did] not indicate that respondent ha[d] ever before been subject to an order for the involuntary administration of medication").

¶ 24 In the instant case, the record indicates that the respondent had a history of mental illness and arguably suggests that he was hospitalized in November 2010.<sup>2</sup> However, the record does not indicate whether any such hospitalization (assuming it occurred at all) was voluntary or involuntary, and there is no indication that the respondent had ever been committed involuntarily in the past. Accordingly, unlike in *Alfred H.H.*, the collateral consequences of having been involuntarily committed have never previously attached. If the circuit court's involuntary commitment and medication orders stand, adverse consequences will attach to the respondent and could be used against him in future proceedings. Thus, we conclude that the collateral consequences exception to the mootness doctrine applies here. See *Daryll C.*, 401 Ill. App. 3d at 752-53; *In re Joseph P.*, 406 Ill. App. 3d at 346-47; *Wendy T.*, 406 Ill. App. 3d at 189.<sup>3</sup>

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<sup>2</sup> Dr. Kestenberg testified that he first testified that he met the respondent in November 2010 when Dr. Kestenberg "consulted to the ICU staff."

<sup>3</sup> The respondent argues that the public interest exception to the mootness doctrine

¶ 25 We now address the merits of the respondent's appeal. As noted, the respondent argues that the State's petition for involuntary admission must be reversed because the State did not submit a predisposition report as required by section 3-810 of the Code or otherwise prove that involuntary hospitalization was the least restrictive available treatment alternative. Section 3-810 provides:

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applies. We disagree. That exception applies only where the party seeking review makes a clear showing that: (1) the question is of a substantial public nature; (2) an authoritative determination is needed for future guidance; and (3) the circumstances are likely to recur. *In re Commitment of Hernandez*, 239 Ill. 2d 195, 202 (2010). The public interest exception is "narrowly construed and requires a clear showing of each criterion." *Alfred H.H.*, 233 Ill. 2d at 355-56 (citations and internal quotation marks omitted). In this case, the respondent argues that the evidence presented by the State was insufficient to justify his involuntary commitment. Such claims are "inherently case-specific reviews" that depend entirely upon the particular facts relating to the respondent's current mental condition. *Alfred H.H.*, 233 Ill. 2d at 356-58. Accordingly, they do not present questions of a "substantial public nature." Nor do they present questions that are "likely to recur" in future commitment proceedings, because any such proceedings would be based on a "fresh evaluation of the defendant's conduct and mental state." *Id.* at 358. In addition, an "authoritative determination is needed for future guidance" only when "the law is in disarray or there is conflicting precedent." *Commitment of Hernandez*, 239 Ill. 2d at 202; *Alfred H.H.*, 233 Ill. 2d at 358. As shown below, the dispositive legal principles at issue in this case are clear and well-settled.

"Before disposition is determined, the facility director or such other person as the court may direct shall prepare a written report *including information on the appropriateness and availability of alternative treatment settings*, a social investigation of the respondent, a preliminary treatment plan, and any other information which the court may order. The treatment plan shall describe the respondent's problems and needs, the treatment goals, the proposed treatment methods, and a projected timetable for their attainment. If the respondent is found subject to involuntary admission, *the court shall consider the report in determining an appropriate disposition.*" 405 ILCS 5/3-810 (West 2010) (emphasis added).

¶ 26 Moreover, section 3-811 of the Code provides that, if a person is found subject to involuntary admission, "the court shall consider alternative mental health facilities which are appropriate for and available to the respondent, including but not limited to hospitalization. \*\*\* The court shall order the least restrictive alternative for treatment which is appropriate." 405 ILCS 5/3-811 (West 2010). Thus, sections 3-810 and 3-811 both require the court to consider information regarding alternatives to treatment in an inpatient facility. 405 ILCS 5/3-810, 3-811 (West 2010).

¶ 27 The purpose of section 3-810 is "to provide trial judges with the relevant information necessary to determine 'whether an individual is subject to involuntary admission to a mental health facility.'" *Daryll C.*, 401 Ill. App. 3d at 755-56, quoting *In re Robinson*, 151 Ill. 2d 126, 133 (1992). "Other purposes of the statute are to protect

against unreasonable commitments and patient neglect, and to ensure adequate treatment for mental health care recipients." *Robinson*, 151 Ill. 2d at 133.

¶ 28 Although a written predisposition report is mandatory under section 3-810, our supreme court has held that strict compliance with that section is not required where: (1) a respondent "fails to object to the absence of a predispositional report;" and (2) the legislative intent can be achieved by other means. *In re Robinson*, 151 Ill. 2d 126, 134 (1992). In other words, when a respondent fails to object to the State's failure to present a predisposition report, "oral testimony containing the information required by the statute can be an adequate substitute" for the written report. *Id.*

¶ 29 However, "[t]he State satisfies the requirements of section 3–810 absent a formal written report *only when the testimony provides the specific information required by the language of the statute.*" *Alaka W.*, 379 Ill. App. 3d 251, 270 (2008) (emphasis added); see also *Daryll C.*, 401 Ill. App. 3d at 756; *In re Daniel M.*, 387 Ill. App. 3d 418, 422 (2008). Thus, if the State fails to present any testimony regarding the availability and appropriateness of alternative treatment settings, or presents only conclusory testimony on these matters, an involuntary commitment order may not stand. See, e.g., *Daryll C.*, 401 Ill. App. 3d at 756 (reversing involuntary commitment even though the respondent failed to object to the State's failure to present a predisposition report where psychiatrist "did not testify regarding treatment alternatives to inpatient hospitalization that were available and why he had rejected those alternatives in favor of hospitalization"); *Daniel M.*, 387 Ill. App. 3d at 423 (reversing involuntary commitment where, *inter alia*, the psychiatrist "summarily concluded that hospitalization was the least restrictive alternative but did not

testify as to what alternative treatments may have been available and why they were inappropriate"); *Alaka W.*, 379 Ill. App. 3d at 270-71 (reversing an involuntary commitment where the State failed to file a predisposition report and the State's witnesses' testimony that inpatient hospitalization was the least restrictive treatment option "was conclusory and unsupported by a factual basis" because the State did not present any testimony regarding the availability of alternative treatment settings and why they were inappropriate); *In re Robin C.*, 395 Ill. App. 3d 958, 964 (2009) ("we have repeatedly recognized that, in the context of section 3-810, cursory testimony is not an adequate substitute for \*\*\* a written discussion of treatment alternatives incorporated in a formal report").

¶ 30 Here, the State admits that no predispositional report was filed at the time of the respondent's hearing. However, the respondent did not object to the absence of the report. The State argues that the oral testimony presented at the hearing contained the information required by section 3-810 and proved by clear and convincing evidence that hospitalization was the least restrictive available treatment setting. Accordingly, the State argues that its failure to present a written report was not reversible error.

¶ 31 We disagree. The oral testimony presented by the State did not contain the information required by section 3-810. Although Dr. Kestenberg asserted in conclusory fashion that he had considered other alternatives to psychotropic medication and found such alternatives to be inappropriate in the respondent's case, he offered no such testimony with regard to alternative treatment settings. The record is devoid of any evidence remotely suggesting that Dr. Kestenberg considered and rejected any alternatives to inpatient hospitalization. In fact, Dr. Kestenberg did

not even state that he had concluded that hospitalization was the least restrictive available alternative. (He was never asked the question by the State's Attorney.) Moreover, Dr. Kestenberg's testimony regarding the alternatives to psychotropic medications was unsupported and conclusory. Accordingly, the testimony presented during the hearing fell far short of meeting the requirements of section 810. As a result, there is no evidence suggesting that the circuit court considered any information regarding alternatives to treatment in an inpatient facility or ordered the least restrictive appropriate treatment, as required by section 3-811.

¶ 32 In sum, because it presented neither a predisposition report nor witness testimony detailing what alternative treatments were available and why they were inappropriate in this case, the State failed to meet its burden of proof.<sup>4</sup> The circuit court's granting of a commitment order under these circumstances was reversible error.

¶ 33 In *In re Alaka W.*, we suggested that strict compliance with section 3-810 should be required because, although we had repeatedly stated the need for strict compliance with legislatively established procedural safeguards for involuntary commitment proceedings, the case law indicated that the State continued to disregard those procedural safeguards. *Alaka W.*, 379

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<sup>4</sup> The State argued that it met its burden of proof under the statute by presenting circumstantial evidence suggesting that the respondent needed treatment and that, given his symptoms and behavior, inpatient hospitalization was the only viable alternative for him. However, such evidence does not suffice to establish that hospitalization is the least restrictive alternative in the absence of a written report or testimony expressly describing the inappropriateness or unavailability of alternative treatments. *See Daryll C.*, 401 Ill. App. 3d at 757.

Ill. App. 3d at 271-72. We reiterated our call for strict compliance with the statute in *Daniel M.*, 387 Ill. App. 3d at 422-23. Given the State's continuing disregard of both the statute and our prior pronouncements, we must once again reiterate the need for strict compliance with legislatively mandated procedural safeguards to protect and balance the competing interests of society and individuals subject to involuntary commitment.

¶ 34

#### CONCLUSION

¶ 35 For the foregoing reasons, we reverse the judgment of the circuit court of La Salle County. However, there is no reason to remand this matter for further proceedings. These proceedings are concluded. If the State believes that Larry G. remains in need of involuntary commitment and should be given psychotropic medication against his will, it must initiate new proceedings in the circuit court. See *In re Barbara H.*, 183 Ill. 2d 482, 498 (1998); *Daryll C.*, 401 Ill. App. 3d at 757-58.

¶ 36 Reversed.