

information about the alternatives of the proposed treatment. For reasons which follow, we agree with the respondent and reverse both orders.

¶ 3 On April 1, 2011, Sonja McShan, the respondent's psychiatrist at Choate Mental Health and Developmental Center (Choate Mental Health), filed a petition, seeking to involuntarily administer psychotropic medication to the respondent. Consistent with the requirements of section 2-107.1(a-5)(4) of the Code (405 ILCS 5/2-107.1(a-5)(4) (West 2010)), the addendum to the petition alleged that (1) the respondent suffered from a serious mental illness—namely, schizoaffective disorder, bipolar type; (2) he demonstrated deterioration of his previous ability to function (the addendum stated that his condition had deteriorated to the point that he received emergency medicine injections for severe agitation, aggression, and inappropriate behavior and was placed in physical restraints for severe aggressive behavior); (3) he had suffered from this mental illness for several years and had more than 15 psychiatric hospitalizations since the onset of the illness; (4) the benefits of the requested medication clearly outweighed the risks of harm (according to the addendum, the requested medications were previously administered to the respondent with no severe side effects or adverse reactions and the respondent experienced a stabilization of his condition, which allowed him to be discharged from the psychiatric hospital); (5) he lacked capacity to make a reasoned decision about the recommended treatment due to his paranoid psychosis and severely impaired judgment; and (6) less restrictive services were explored and shown to be ineffective.

¶ 4 Thereafter, on April 5, 2011, Kim Ford, a social worker, filed a petition for involuntary admission against the respondent. Consistent with section 1-119 of the Code (405 ILCS 5/1-119 (West 2010)), the petition included allegations that the respondent (1) was a person with a mental illness; (2) was reasonably expected, unless treated on an inpatient basis, to engage in conduct placing himself or another in physical harm or in

reasonable expectation of being physically harmed; (3) was unable to provide for his basic physical needs so as to guard himself from serious harm without the assistance of family or others; (4) refused treatment or was not adhering to prescribed treatment, was unable to understand his need for treatment because of the nature of his mental illness, was reasonably expected to suffer mental or emotional deterioration if left untreated, and was reasonably expected to engage in conduct placing himself or another in physical harm (or in reasonable expectation of physical harm) or was expected to be unable to provide for his basic physical needs without assistance from family or others; and (5) was in need of immediate hospitalization for the prevention of such harm.

¶ 5 Additionally, the petition alleged that the respondent (1) had a "long history" of schizophrenia; (2) expressed grandiose and paranoid delusions; (3) believed he was Jesus Christ; (4) believed that he could "play for [the] WNBA, MLB, NFL in many different positions" and that he could manage the Pittsburgh Pirates; (5) believed the guards and staff of Choate Mental Health were trying to harm or kill him; (6) had periods of agitation; and (7) had gotten "physical" with the staff.

¶ 6 On April 12, 2011, the trial court held bifurcated hearings on the petition for involuntary admission and the petition for involuntary administration of psychotropic medication. The hearing on the petition for involuntary admission was held first, and the State's only witness was Dr. Randolph Parks, a licensed clinical psychologist at Choate Mental Health. Dr. Parks testified that he had an opportunity to review the respondent's charts and records, observe the respondent's behavior at Choate Mental Health, and have a conversation with the respondent regarding his treatment. Dr. Parks diagnosed the respondent with schizoaffective disorder and noted that individuals suffering from schizoaffective disorder experience the following symptoms: delusions, hallucinations, disorganized speech, grossly disorganized behavior, "reality testing problems," extreme mood

swings, accelerated speech, and "a motor frenzy of purposeless activity." He testified that the respondent exhibited several of these symptoms during his admission at Choate Mental Health. Specifically, he noted that the respondent was physically restrained on several occasions, was observed yelling and screaming in the hallways of the treatment facility, threatened to kill the staff, and believed that he was hospitalized for "sports betting."

¶ 7 Dr. Parks opined that the respondent was reasonably expected to engage in conduct placing himself or another in physical harm or in reasonable expectation of being physically harmed unless he was treated on an inpatient basis. According to Dr. Parks, the respondent exhibited evidence of delusional beliefs by believing that he was a "Major League Baseball player, a National Football League player, and that he was a woman on the NBA basketball team."

¶ 8 Dr. Parks concluded that, as a result of the mental illness, the respondent was a person who was unable to provide for his basic needs so as to guard himself from serious harm without the assistance of family or others. He testified that on several occasions, the respondent displayed "inappropriate behavior and difficulty in providing for his needs." Specifically, the respondent had poor hygiene, frequently wore dirty clothing, and failed to adequately take care of his "activities-of-daily-living skills."

¶ 9 Dr. Parks further testified that the respondent refused medical treatment for his mental illness and was reasonably expected to suffer mental and emotional deterioration if not treated on an inpatient basis. He concluded that, as a result of the deterioration, the respondent would be at risk of committing physical harm or unable to take care of himself in a basic way. As evidence of the respondent's deterioration, Dr. Parks noted that the respondent claimed he was Jesus Christ, believed he was in "pretty good shape," and denied having a mental illness. Dr. Parks concluded admission into Choate Mental Health was the least restrictive treatment alternative for the respondent.

¶ 10 After the State rested its case, the respondent testified (the respondent acted *pro se* during the bifurcated hearings). He opined that he should not be involuntarily admitted to a hospital because he did not suffer from a mental illness. According to the respondent, his problems with depression ended on September 11, 2005, and he did not take his medication because he no longer suffered from depression. He testified the staff at Choate Mental Health attacked him, placed him in restraints for four hours, attempted to kill him, and refused to let him eat. He denied threatening to kill the staff and another patient. He claimed that the staff were starving him and he lost a lot of weight as a result.

¶ 11 On cross-examination, the respondent explained that his depression ended on September 11, 2005, because "San Francisco played St. Louis in the best football game of all time," and San Francisco won. He explained that he was so excited about the outcome of the game that he "no longer had any problems whatsoever." He also explained that he was no longer depressed because it was four years after the tragedy of September 11.

¶ 12 Based on this evidence, the trial court found the respondent subject to involuntary admission and ordered hospitalization for a period not to exceed 90 days. Specifically, the court stated as follows with regard to the involuntary commitment:

"Based upon the testimony that I've been presented with today and the evidence, I'm going to find that the burden of proof has been met that there is a mental illness and the factors are met pursuant to the statute. I find that at this point that DHS is the least restrictive services and enter a 90-day order."

¶ 13 The trial court then held the hearing on the petition for involuntary administration of psychotropic medication. The State's first witness was Dr. Diana Tracy, the medical director of Choate Mental Health. Dr. Tracy testified Dr. Sonja McShan was the respondent's attending physician at the medical facility, but she was on leave at the time of the hearing. However, Dr. Tracy explained that she reviewed the respondent's charts and records, and she

had a previous conversation with him during his commitment. She testified she reviewed the petition filed by Dr. McShan, and she was in agreement with Dr. McShan's recommendations.

¶ 14 She diagnosed the respondent with schizoaffective disorder, a serious mental illness. Dr. Tracy explained that the respondent exhibited delusions of grandiosity and paranoia, symptoms associated with this mental disorder. She opined that the respondent's delusions and paranoia influenced every domain of his existence, "both in terms of managing his activities of daily living, being able to provide for his safety, his shelter, meet his medical needs; [and] for his perception of reality, for his understanding of reality as we all know it." She noted that the respondent's records reflected that he believed he was Jesus Christ, he denied having a mental illness, and he was aggressive with staff, which resulted in injury to the staff. In her opinion, the respondent's capacity to recognize reality was profoundly impaired by his mental illness, which prevented him from being able to take care of himself. She explained the respondent's weight loss was attributable to his belief that his food was being poisoned by the hospital staff.

¶ 15 Dr. Tracy opined that the respondent's illness caused psychotic, agitated, irritable, paranoid, and threatening behavior. She believed that the respondent's mental illness caused him to repeatedly lose his independence because he was suspicious of treatment. She explained that the respondent could be restored to an independent level of function and be more comfortable and less distressed if he became "medication compliant."

¶ 16 Dr. Tracy further explained that the respondent suffered physical, mental, and emotional distress caused by his impaired judgment, his impaired ability to make good decisions on his own behalf, and his inability to care for his nutritional needs caused by his deep-seated fear of harm. She testified that the respondent exhibited threatening behavior toward staff and other patients and was involved in an altercation with another patient, which

required intervention by the staff.

¶ 17 Dr. Tracy recommended that the trial court approve the administration of the following medications: (1) haloperidol decanoate injection (300 milligrams every four weeks); (2) haloperidol decanoate taken orally (10 milligrams, three times per day); (3) haloperidol (5 to 10 milligrams twice per day up to four times per day); (4) lorazepam (1 to 2 milligrams twice per day to four times per day); and (5) benztropine (.5 milligrams to 2 milligrams once or twice per day). She testified that the respondent was informed in writing of the benefits and side effects of each medication. She explained the haloperidol decanoate would benefit the respondent by improving his concentration, allowing him increased self-control, and reducing his psychotic symptoms. She explained that the respondent needed the medication to function more fully, safely, and independently. She acknowledged that the medication had possible side effects, including muscle stiffness, rigidity, restlessness, anxiety, sleeplessness, and drowsiness. She added, however, that the respondent had previously taken the medication and experienced no serious side effects.

¶ 18 Dr. Tracy explained that the expected benefits and side effects of haloperidol were similar to haloperidol decanoate. She noted the respondent had previously taken this medication. She believed the lorazepam would bring a calming, antianxiety effect for the respondent, and the possible side effects included sedation, drowsiness, orthostasis, and confusion if taken in large amounts. She suggested benztropine be administered to treat any stiffening of the muscles caused by the haloperidol. Dr. Tracy acknowledged that the possible side effects of benztropine included constipation, "GI distress," urinary retention, dry mouth, dizziness, lightheadedness, and orthostasis. She believed the benefits of the suggested medications outweighed the risks of harm because they would make the respondent more comfortable. She opined the benefits of the respondent taking the suggested medications clearly outweighed the risk of harm because his judgment and capacity to

recognize reality were significantly impaired by a treatable mental illness. She opined that the respondent lacked the capacity to make a reasoned decision about taking his medication because his mental illness affected his capacity to make good decisions and impaired his judgment and reality. She explained that other less restrictive services were explored and found inappropriate. She testified that the respondent "demonstrated all phases of a need for inpatient hospitalization: his inability to care for himself, his lack of capacity for decision-making and judgment, and he [was] a threat to others."

¶ 19 Randolph Winston Parks, a psychologist at Choate Mental Health, testified that he was present when the respondent was informed of the side effects and benefits of the suggested medications. According to Parks, the respondent's treatment team met with him and discussed his diagnoses, the medications, and the treatment plan. Thereafter, the team attempted to give the respondent written information on what was discussed, but he refused to accept the documents. The written information included the benefits and side effects of the suggested medications.

¶ 20 The respondent testified on his own behalf. He testified that he went to the hospital because he needed a place to stay, not because he had a mental illness. He further testified that he experienced rectal bleeding, constipation, diarrhea, and shakiness in his legs and hands as side effects of taking Haldol. The respondent noted that his treatment team failed to explain the alternatives to the proposed treatment. He concluded that it was "highly dangerous" to give the suggested medication to a patient who did not have paranoid schizophrenia.

¶ 21 After hearing the evidence, the trial court found the respondent subject, for a period not to exceed 90 days, to involuntary administration of the psychotropic medications recommended by the Choate Mental Health treatment team. Specifically, the court stated as follows regarding its decision:

"I'm going to find today that the burden of proof [has] been met that there's a mental illness and that there is deterioration and/or suffering. The symptoms have been continuous for a period of time. The benefits do outweigh the harm. That the patient *** lacks the capacity to make the decision regarding that. Least restrictive services have been explored but are inappropriate. And authorize testing to make sure that the [medications] are properly given. I believe there's testimony that there's no power of attorney under the healthcare law or declaration of mental health treatment under the Mental Health Treatment Preference Declaration Act. And enter a 90-day order as to that."

¶ 22 This appeal followed.

¶ 23 The trial court entered the involuntary-commitment and involuntary-administration-of-psychotropic-medication orders on April 12, 2011, and limited the enforceability of the orders for a period not to exceed 90 days. As a result, this case is moot. Therefore, before we can address the merits of the respondent's appeal, we must first determine whether any exception to the mootness doctrine applies. The respondent argues his appeal is not moot because it falls under the capable-of-repetition-yet-avoiding review and the public-interest exceptions to the mootness doctrine. We agree and find that this appeal falls within the capable-of-repetition-yet-avoiding-review exception.

¶ 24 The capable-of-repetition-yet-avoiding-review exception to the mootness doctrine allows a reviewing court to consider an otherwise moot case when the duration of the challenged action is too short to be fully litigated before the expiration of the order and a reasonable expectation exists that the complaining party will again be subject to the same action. *In re Alfred H.H.*, 233 Ill. 2d 345, 358 (2009). The first element is clearly met, as the trial court limited the duration of the involuntary-commitment order and the involuntary-administration order to 90 days, and the order has already expired. Further, the second

element is met, as the record indicates that the respondent has a history of civil commitments and the circumstances present here are likely to reoccur. Therefore, we will address the merits of the respondent's appeal.

¶ 25 The respondent first argues that the order authorizing his involuntary commitment should be reversed because the trial court failed to comply with section 3-816(a) of the Code (405 ILCS 5/3-816(a) (West 2010)). Specifically, the respondent argues that the trial court failed to make findings of fact, *i.e.*, it failed to identify which of the three standards under section 1-119 of the Code (405 ILCS 5/1-119 (West 2010)) it determined were met for the respondent to be a person subject to involuntary admission. In response, the State counters that the respondent (1) forfeited this argument on appeal by failing to request more detailed findings at the trial court level, and (2) the findings of the trial court were sufficient because the evidence at the hearing clearly supported a finding that the respondent was a person subject to involuntary admission based on all three standards under the Code. We agree with the respondent and reverse the involuntary-commitment order.

¶ 26 The record indicates that the respondent, who was acting *pro se*, failed to request the trial court make more detailed findings when the court announced its decision on April 12, 2011. However, this court has previously addressed a respondent's argument that the trial court failed to make sufficient findings of fact on the record despite the respondent's failure to object to the findings at the trial court level. *In re James S.*, 388 Ill. App. 3d 1102, 1106 (2009). *In re James S.* involved a respondent who was found subject to an involuntary-administration-of-psychotropic-medication order, and he argued on appeal that the order should be reversed because the trial court failed to make adequate findings of fact. *Id.* Like the present case, James S. failed to make this argument in the trial court. *Id.* This court considered the issue on the merits despite the potential forfeiture of the issue, noting that plain-error review allowed consideration of the issue on appeal because the involuntary

administration of medication for mental-health purposes involved fundamental liberty interests. *Id.* This court then noted that the rule of forfeiture was a limitation on the parties and not on the reviewing court. *Id.* Similarly, we will address the merits of the arguments raised by the respondent in this appeal despite his failure to object to the findings of fact at the trial court level.

¶ 27 Section 3-816(a) of the Code (405 ILCS 5/3-816(a) (West 2010)) establishes the following requirements for final orders entered under the Code:

"Every final order entered by the court under this Act shall be in writing and *shall* be accompanied by a statement on the record of the court's findings of fact and conclusions of law." (Emphasis added.)

Because an involuntary commitment affects important liberty interests, strict compliance with the procedural safeguards contained in the Code is necessary to ensure the mental-health system does not " 'become an oppressive tool rather than a means to serve the society in which we live.' " *In re Lance H.*, 402 Ill. App. 3d 382, 386 (2010) (quoting *In re Phillip E.*, 385 Ill. App. 3d 278, 284 (2008)).

¶ 28 In support of his argument that the trial court's findings of fact in this case were inadequate, the respondent cites *In re James S.*, 388 Ill. App. 3d 1102 (2009), and *In re Joseph M.*, 405 Ill. App. 3d 1167 (2010). In *In re James S.*, 388 Ill. App. 3d at 1105, the trial court authorized the involuntary administration of psychotropic medication after making the following findings of fact: that after hearing the testimony and observing the witnesses, it found by clear and convincing evidence that the respondent was a person subject to the involuntary administration of psychotropic medication. On appeal, this court determined that the trial court's statement was not a sufficient statement of the court's findings of fact to satisfy the requirements of section 3-816(a) of the Code. *Id.* at 1107.

¶ 29 Further, this court in *In re Joseph M.*, 405 Ill. App. 3d at 1182-83, also determined

that the trial court failed to make adequate finding of facts in a case where the findings were more specific than the statements made in *In re James S.* The trial court's finding of facts in *In re Joseph M.* consisted of the following:

" 'Mr. M[.] is a person subject to involuntary admission. Although he has not exhibited any physical aggression since May of '07, there is some evidence of some severe delusions and that he is a risk to the community and himself if he is not involuntarily *medicated*. As such, the Court finds that he shall be hospitalized *** which is the least restrictive environment currently appropriate and available ***.' "

(Emphasis in original.) *Id.* at 1171.

Based on the above statement, this court concluded that the trial court "never expressly made any factual findings related to whether Joseph met the statutory criteria for an involuntary admission." *Id.* at 1183. This court explained that the trial court "merely noted that there was 'some evidence' that Joseph would be 'a risk to the community' if not *medicated*." (Emphasis in original.) *Id.* Therefore, this court concluded that the trial court's statement of facts was inadequate to satisfy the statutory requirement because it failed to make the "crucial link between medication and admission." *Id.*

¶ 30 In the present case, we find that the trial court failed to make sufficient findings of fact as required under section 3-816 of the Code. First, we note that section 3-816's findings-of-fact requirement is a mandatory requirement. See 405 ILCS 5/3-816(a) (West 2010) (every final order "*shall* be accompanied by a statement on the record of the court's findings of fact and conclusions of law" (emphasis added)).

¶ 31 Additionally, section 1-119 of the Code (405 ILCS 5/1-119 (West 2010)) provides for the involuntary admission of a person on an inpatient basis under the following conditions:

"(1) A person with mental illness who because of his or her illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing

such person or another in physical harm or in reasonable expectation of being physically harmed;

(2) A person with mental illness 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 others, unless treated on an inpatient basis; or

(3) A person with mental illness who:

(i) refuses treatment or is not adhering adequately to prescribed treatment;

(ii) because of the nature of his or her illness, is unable to understand his or her need for treatment; and

(iii) if not treated on an inpatient basis, is reasonably expected, based on his or her behavioral history, to suffer mental or emotional deterioration and is reasonably expected, after such deterioration, to meet the criteria of either paragraph (1) or paragraph (2) of this Section."

¶ 32 The petition for involuntary commitment filed against the respondent alleged all three standards as justification for the involuntary commitment. However, the trial court failed to identify under which standard it authorized the involuntary commitment of the respondent. The court's statements that the burden of proof was met and the respondent was suffering from a mental illness which caused deterioration and suffering were not sufficient findings of fact. The court's mere reference to the statute did not cure this defect because it is unclear under which standard the court involuntarily committed the respondent. Therefore, we find the trial court's statements of facts were inadequate to satisfy the statutory requirement. Accordingly, we reverse the trial court's order for involuntary commitment.

¶ 33 The respondent next argues that the State failed to prove by clear and convincing

evidence that he lacked the capacity to make a reasoned decision about the proposed treatment because he was not provided with the statutorily mandated written information about the alternatives to the proposed treatment. We agree and reverse the trial court's order.

¶ 34 Section 2-102(a-5) of the Code (405 ILCS 5/2-102(a-5) (West 2010)) provides, in pertinent part, as follows:

"If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated."

"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).

¶ 35 Here, the respondent frames the issue as a statutory-compliance claim and a sufficiency-of-the-evidence claim. The statutory-compliance claim, *i.e.*, whether section 2-102(a-5) has been complied with, presents a question of law and will be reviewed *de novo*. *In re Laura H.*, 404 Ill. App. 3d 286, 290 (2010). As for the sufficiency-of-the-evidence claim, *i.e.*, whether the State has proven by clear and convincing evidence that the respondent lacked the capacity to make a reasoned decision about the suggested medications, this court will not disturb the trial court's decision unless that decision was against the manifest weight of the evidence. *Id.* Under this standard, we will reverse a court's judgment only when the opposite conclusion is apparent or the court's findings are unreasonable, arbitrary, or not based on the evidence. *Id.*

¶ 36 "The rationale underlying the requirements of section 2-102(a-5) is to not only ensure

that a respondent is fully informed, but also 'to ensure that a respondent's due process rights are met and protected.' " *In re Nicholas L.*, 407 Ill. App. 3d 1061, 1072 (2011) (quoting *In re John R.*, 339 Ill. App. 3d 778, 784 (2003)). Therefore, strict compliance with section 2-102(a-5) is necessary to protect the liberty interests of the mental-health treatment recipient. *In re Nicholas L.*, 407 Ill. App. 3d at 1072. In *In re Nicholas L.*, 407 Ill. App. 3d at 1073, the Second District determined that the failure to provide the statutorily written notification of alternative treatment options compelled reversal.

¶ 37 The State concedes the record does not prove that the respondent was provided with written notification of the alternatives to the proposed treatment. However, the State argues reversal is not warranted in this case because no *viable* alternative treatment options existed for the respondent. The State points to the following as evidence that other less restrictive alternatives had been explored but found inappropriate: (1) the petition for administration of psychotropic medication stated that less restrictive services had been explored but found inappropriate; (2) the addendum to the petition listed the alternatives that had proven ineffective in the past (pass level reduction, supportive counseling, emergency medication, and physical restraints); and (3) Dr. Tracy's testimony that other less restrictive services had been explored and found inadequate. Accordingly, the State argues that an order for the involuntary administration of psychotropic medication should not be reversed for the failure to provide a mental-health patient with written notification of alternative treatment options where no viable alternative treatment options exist.

¶ 38 In support of its position that written notification of the alternative treatment is not warranted when no viable alternative exists, the State cites *In re Vanessa K.*, 2011 IL App (3d) 100545. In *In re Vanessa K.*, 2011 IL App (3d) 100545, ¶ 23, the Third District concluded that written information on all the alternative *medications* approved for administration by the trial court was not necessary because the respondent's treating

psychiatrist did not consider the alternative medications as viable options. However, we note that written information on appropriate nonmedication treatment alternatives should also be given to the mental-health patient, as treatment includes more than just medication. *In re Laura H.*, 404 Ill. App. 3d at 292.

¶ 39 In this case, Dr. Parks testified that he was present when the respondent was informed in writing of the side effects and benefits of the suggested medications (although the record indicated that the respondent refused to take the provided written information). Dr. Tracy testified that other services, less restrictive than involuntary administration of medication, were explored but found inappropriate. However, she did not specify what services were deemed inadequate. According to the respondent, the very fact that Dr. Tracy's testimony revealed other services were explored belies the State's claim that no alternative treatment options existed. The respondent argues that written notification of alternative treatment must be provided to him pursuant to section 2-102(a-5) regardless of whether these alternatives are *viable* alternatives.

¶ 40 Strict compliance with section 2-102(a-5) is required to protect a mental-health patient's due process rights, and section 2-102(a-5) does not limit the written-notification requirement to appropriate alternatives. Instead, section 2-102(a-5) requires that the mental-health patient be provided with written notification of the alternatives to the proposed treatment. See 405 ILCS 5/2-102(a-5) (West 2010) ("the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated"). The Code provides for a variety of treatment options for a mental-health patient—namely, counseling, outpatient services, hospitalization, partial hospitalization, electroconvulsive therapy, and administration of medication. However, the record does not indicate that written

notification of any of these alternative treatment options was given to the respondent. Therefore, the record before us shows that the State failed to present any evidence to prove that the respondent was provided with the statutorily mandated written information on the alternatives of the proposed treatment. Accordingly, we reverse the trial court's order for involuntary administration of psychotropic medication.

¶ 41 For the foregoing reasons, the April 12, 2011, involuntary-commitment and involuntary-administration-of-psychotropic-medication orders of the circuit court of Union County are hereby reversed.

¶ 42 Reversed.