

2014 IL App (2d) 130084-U
No. 2-13-0084
Order filed March 31, 2014

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IN THE
APPELLATE COURT OF ILLINOIS
SECOND DISTRICT

<i>In re</i> ROBERT S., Alleged to be a Person)	Appeal from the Circuit Court
Subject to Involuntary Treatment.)	of Kane County.
)	
)	No. 12-MH-173
)	
(The People of the State of Illinois,)	Honorable
Petitioner- Appellee v. Robert S.,)	William Parkhurst,
Respondent-Appellant).)	Judge, Presiding.

JUSTICE BIRKETT delivered the judgment of the court.
Justices McLaren and Jorgensen concurred in the judgment.

ORDER

¶ 1 *Held:* While moot, the respondent's claims could be addressed on appeal under the capable-of-repetition-yet-evading-review exception to the mootness doctrine. Substantively, the trial court correctly determined that the State's treatment complied with statutory requirements; it actually considered less-restrictive placement alternatives for respondent, and it did not improperly designate a treatment facility for respondent.

¶ 2 Respondent, Robert S., appeals the judgment of the circuit court of Kane County, ordering his involuntary commitment and treatment in the Department of Human Services (Department), and purportedly, specifically in the Elgin Mental Health Center. Respondent argues that the treatment plan did not comply with statutory requirements, that no less restrictive

treatment alternatives were actually considered, and that the trial court improperly designated a treatment facility. We affirm.

¶ 3

I. BACKGROUND

¶ 4 While this appeal is new, we note that respondent has appealed the same issues previously, albeit under different factual circumstances, in *In re Robert S.*, 2013 IL App (2d) 121134-U (*Robert S. I.*). There, we determined that the first two issues (a challenge to the treatment plan and a claim that less restrictive alternatives were not actually considered) raised factual issues that did not fall under an exception to the mootness doctrine (*id.*, ¶¶ 11, 12, 17), but the third issue (the trial court's designation of a treatment facility exceeded its statutory authority) met the capable-of-repetition exception (*id.*, ¶ 17). Addressing the third issue substantively, we held that the trial court's determination that respondent be placed at the Elgin Mental Health Center did not usurp the Department's authority, but simply implemented the Department's decision. *Id.* With that background established, this case arises from a December 31, 2012, petition for the continued inpatient involuntary treatment of respondent. The following factual summary is taken from the record on appeal.

¶ 5 On December 31, 2012, Janet Rudsinski, a social worker at the Elgin Mental Health Center filed a petition to continue respondent's involuntary commitment. Respondent had been incarcerated previously due to convictions for arson and sex crimes, and, later, he was committed to the Chester Mental Health Center for treatment. In November 2010, he was transferred to the Elgin Mental Health Center in order to prepare for his discharge from custody. Ultimately, respondent was diagnosed with bipolar disorder with psychotic features and he was involuntarily committed to the Elgin Mental Health Center. As time passed, an additional diagnosis of dementia was added.

¶ 6 In September 2011, a treatment plan was devised, and this plan was geared toward helping respondent deal with his difficulty in interpreting reality. The treatment plan included the suggestion that Elgin staff approach respondent once a shift and ask how he was feeling and whether anything could be done for him. The treatment plan also included a provision that respondent be allowed access to his room when he requested it in order to give him an area of peace and quiet.

¶ 7 On December 13, 2012, a review of the treatment plan was created. The review noted that respondent was little improved and continued to exhibit erratic behavior. The review recommended no changes to the basic treatment plan for respondent. These items were admitted into evidence at the January 11, 2013, hearing on the instant petition with no objection from respondent.

¶ 8 Dr. Eva Kurilo, a staff psychiatrist at the Elgin Mental Health Center, testified that she interviewed and observed respondent, reviewed his medical records, and discussed his case with other staff at the facility. Kurilo testified that respondent was frequently irritable with expansive, elevated moods, pressured speech, and grandiose beliefs concerning his money, his expensive houses, and his ability to predict the future. Additionally, he was periodically agitated, verbally aggressive, easily distracted, destructive, flighty, unstable, and drowsy. Respondent paced, and his capacity for physical aggression was evidenced by his previous arson and criminal sexual abuse convictions.

¶ 9 Kurilo testified that, because of his mental illness, she considered respondent to be dangerous, and she reasonably expected, unless respondent were treated on an in-patient basis, that respondent would continue to engage in conduct placing him or another in the reasonable expectation of physical harm. Kurilo further testified that respondent was unable to provide

safely for his basic needs without assistance. Kurilo explained that, since he was 10 years of age, respondent had lived in hospitals and correctional facilities, and he had last lived independently in 2008. Respondent needed reminders to continue to follow a healthy diabetic diet and to maintain his personal hygiene. Kurilo testified that, if respondent were released and if he then began to receive his social security benefits (which were currently suspended), he would likely fail to properly manage his diet and the money necessary to purchase food, and that respondent had no family available to assist him if he were released.

¶ 10 Kurilo testified that she recommended continued and immediate hospitalization for respondent based on the facts that he was a convicted sex-offender, he had no one available to assist him in the tasks of daily living, he had psychotic delusions about his available money and housing, he was presently incapable of reliably caring for his own needs, plus he needed help with his numerous medical issues, which included diabetes, Parkinson's disease, poor balance, and dementia. Kurilo further testified that any future independence was jeopardized by respondent's "mental illness, delusions, poor executive functioning, memory problems, not being able to plan, and the consequences of his behavior; disconnection from reality."

¶ 11 Kurilo offered the opinion that continued hospitalization in the Department was the least restrictive, most appropriate, available environment. She noted that, while respondent was less agitated, he remained irritable and angry, called people names, continued to have grandiose delusions about money and his homes, and was a convicted sex offender and arsonist. Kurilo opined that, based on those characteristics, placement at a halfway house or a group home was unlikely. Kurilo further testified that one of the facility's social workers had contacted at least 15 nursing home facilities that accepted mentally ill patients, but none of the contacted nursing homes had been willing to accept respondent because of his convictions and his violent and

aggressive nature. Kurilo testified that such a placement would also depend on the subject's psychological stability when the nursing home considered respondent.

¶ 12 Kurilo testified that respondent's treatment plan goal was to continue managing his moods, his irritability and psychosis with medication, behavioral intervention, and humor. Kurilo requested at least 90 days of involuntary commitment to attain the goals, and preferably 180 days. Included in the treatment plan was the November 2010 assessment which considered respondent's past noncompliance with treatment, and recommended that he receive "education; counseling; continuing care planning; [and] relapse prevention planning."

¶ 13 Respondent's treatment plan continued to recommend that he be approached once a shift and asked about his current mood and if there were anything that could be done for him as an intervention to help respondent interact more appropriately and cultivate improved social skills. Documentation of these interventions was only sporadic; thus it is uncertain how closely this facet of respondent's treatment plan was followed.

¶ 14 The April 2012 annual assessment of respondent's treatment noted respondent's diagnoses of dementia and bipolar disorder, and his status as a sex offender. The annual assessment recommended continued hospitalization based on the conclusions that respondent was unable to care for himself without a structured environment, as well as his aggressive nature evidenced in respondent's frequent loud verbal abuse, delusions, and demands to be discharged. Similarly, the December 2012 treatment plan review noted respondent's continuing erratic behavior. The plan review also noted that, although respondent's discharge plan was to find him a nursing home placement, no nursing homes willing to accept respondent despite his aggressive and erratic behavior could be found, so continued hospitalization was the ultimate recommendation.

¶ 15 The December 2012 treatment alternatives report also analyzed respondent's current behaviors and condition in order to reach a recommendation concerning the least restrictive, most appropriate placement for respondent. Significant to the analysis were the diagnoses of bipolar disorder and dementia, both of which limited respondent's ability to care for himself in an unstructured setting. Despite available funding, respondent's status as a convicted sex offender inhibited his opportunity and ability to secure a nursing home placement. When respondent's disorganized and delusional thinking was questioned, he responded with verbal accusations and threats of litigation. If respondent became enraged, he would sometimes become verbally aggressive and demanding. Based on these factors, the plan review concluded that it was doubtful that respondent had the ability either to provide for his basic day-to-day needs, or to utilize outpatient services. The plan review concluded that the Elgin Mental Health Center, with its structured environment and its ability to offer supervision to assist respondent in compensating for his deficiencies in self-care, was the least restrictive, most appropriate placement and treatment option for respondent.

¶ 16 Based on the foregoing evidence, both testimonial and documentary, the trial court concluded that the State had proved by clear and convincing evidence, that respondent was mentally ill due to a bipolar disorder with psychotic features, evident from respondent's expansive, irritable moods, his grandiosity, his inappropriate and interruptive speech, flightiness, and fantasies. The court believed that, in a less restrictive, uncontrolled setting, respondent's language and behaviors could lead to fights, danger, and the reasonable expectation that harm to respondent or others would result. Because of this, the court held that respondent still needed a structured environment. The court further held that respondent had difficulty in understanding the danger caused by his mental-illness-related behavior, as well as in regulating that behavior.

The court held that, without continued treatment, respondent's ability to safely and reliably provide shelter and food was so impaired that respondent posed a danger to himself.

¶ 17 The trial court remained concerned with continuing respondent's placement at the Elgin Mental Health Center because of respondent's past criminal behaviors, which, the trial court noted, were "likely [the] result of the same mental illness [that respondent continued to exhibit]." Notwithstanding this concern, the trial court orally held that, to help minimize and avoid the possibility of danger to respondent, either through self-neglect or continued violent behaviors, the Elgin Mental Health Center remained the least restrictive environment for respondent's placement. The trial court continued, stating that, because placement in an outside nursing home facility depended on respondent's mood and behavioral stability, "we are lucky there is a place like that [the Elgin Mental Health Center] to hold him." The trial court expressly determined that the treatment plan and goals of treatment were appropriate, and the court ordered the continued involuntary commitment of respondent for a period of 180 days.

¶ 18 In its written order, the trial court wrote that respondent was to be hospitalized in the Department, and that this was the least restrictive, available alternative. The written order further noted that respondent's commitment was for a period not exceeding 180 days. Respondent timely appeals.

¶ 19

II. ANALYSIS

¶ 20 On appeal, respondent raises the same three issues raised in *Robert S. I*: namely, the treatment plan did not comply with statutory requirements, no less restrictive treatment alternatives were actually considered, and the trial court improperly designated a treatment facility. Respondent concedes the mootness of the claims, but argues that we may consider them substantively under various exceptions to the mootness doctrine. Accordingly, we turn first to a

consideration of the mootness doctrine and its applicability to the issues raised by respondent, and then we will consider in turn the substantive issues raised by respondent as necessary.

¶ 21 A. Mootness and Exceptions to Mootness

¶ 22 As an initial matter, we note that this case is clearly moot, because the order at issue here, namely the January 11, 2013, order involuntarily committing respondent for a period of 180 days, expired by its own terms no later than July 9, 2013. See *In re Alfred H.H.*, 233 Ill. 2d 345, 350 (2009). Generally, we will not decide moot questions, give an advisory opinion, or consider an issue where the outcome will not or cannot be affected no matter what is decided. *Id.* at 351. There are, however, three exceptions to mootness that are invoked in cases involving involuntary commitment that are commonly used to secure a reviewing court's consideration of the substantive issues raised. *Id.* The questions presented when considering whether an exception to mootness applies are purely legal and we review legal issues *de novo*. *Id.* at 350. The three exceptions are the public-interest exception (*id.* at 356), the capable-of-repetition-yet-avoiding-review exception (*id.* at 359), and the collateral-consequences exception (*id.* at 361). Respondent presents his argument on these exceptions in the reverse order than we listed them; we will deal with respondent's issues in the order he has chosen.

¶ 23 1. Collateral-Consequences Exception

¶ 24 Respondent initially concedes that the collateral consequences exception to mootness does not apply to him in this case. We agree.

¶ 25 Under this exception, appellate review of a moot question is allowed, even though a court order or incarceration has ended, because the plaintiff has experienced or is likely to experience an actual injury that is traceable to the defendant, and the injury can be redressed with a favorable judicial decision. *Id.* at 361. In order to maintain the issue for review, the continuation

of the collateral consequences must be proved or presumed. *Id.* This exception has been regularly applied in involuntary commitment cases, and it is addressed on a case-by-case basis. *Id.* at 362.

¶ 26 Respondent acknowledges that he already has a lengthy history of involuntary commitments along with a history of criminal convictions. Even if the instant involuntary commitment were removed from his records by a reversal here, the previous commitments and convictions would still remain on his record, so whatever is done in this case cannot and will not change the collateral consequences that have already attached to him from his previous commitments and convictions. In other words, the collateral consequences exception may apply to a party's first involuntary commitment. *In re Val Q.*, 396 Ill. App. 3d 155, 159 (2009). Thus, the collateral consequences exception is not available here as a basis for us to review respondent's substantive issues, because even if respondent fully succeeds on the merits, he has previously been involuntarily committed, and the consequences from those previous commitments will remain to plague respondent in future.

¶ 27 2. Capable-of-Repetition-Yet-Avoiding-Review Exception

¶ 28 Respondent argues that this exception applies to allow us to review the substance of his claims on appeal. We agree.

¶ 29 The capable-of-repetition-yet-avoiding-review exception has two elements. First, the challenged action must be of a duration too short to be fully litigated before it ends. *Alfred H.H.*, 233 Ill. 2d at 358. Second, there must be a reasonable expectation that the same complaining party would be subjected to the same action again. *Id.* Here, the first requirement has been met. The involuntary commitment order was to last no more than 180 days. The parties and this court

all agree that the matter could not have been fully litigated before the end of the order. See *id.* The issue, then centers on the second requirement, and how narrowly or broadly it is interpreted.

¶ 30 Subsequent actions need not be identical, but they must be substantially related so that the resolution of the issue in the present case would be likely to affect a future case involving the respondent. *Id.* at 359. In other words, “there must be a substantial likelihood that the issue presented in the instant case, and any resolution thereof, would have some bearing on a similar issue presented in a subsequent case.” *Id.* at 360.

¶ 31 A strict application of the foregoing principle would result in a determination that some of respondent’s issues do not meet the requisite burden. Respondent’s first two issues involve, at their hearts, the sufficiency of the evidence to sustain the outcome. Respondent contends that his treatment plan did not meet the applicable statutory requirements. However, in reviewing this issue, we have to determine whether the evidence shows that the State met its burden under the statute, and this involves nothing more than a review of the sufficiency of the evidence. Similarly, respondent contends that no less restrictive treatment alternatives were actually considered. This again involves a consideration of the sufficiency of the evidence to demonstrate whether alternative, less restrictive, treatments were considered. As both of the issues involve a consideration of the sufficiency of the evidence, there does not seem to be a basis for the invocation of this exception on which to ground our review. *Id.* (the capable-of-repetition-yet-evading-review exception will not be employed for sufficiency-of-the-evidence issues; there needs to be a clear indication of how the resolution of the issue could be of use to the party in future cases, or the substantive issues should involve questions like challenges to the constitutionality of a provision or the interpretation of a provision). Indeed, this was essentially

the reasoning employed in *Robert S. I*, 2013 IL App (2d) 121134-U, ¶ 17, the direct predecessor to this case.

¶ 32 On the other hand, respondent need only point to *Robert S. I* in order to show that, indeed, the same issues are being raised in another appeal involving him. It would be perverse to deny review under the capable-of-repetition exception in the second appeal to involve precisely the same issues and the same party. In other words, we would be denying that the same issues could arise again, even though this is the second appeal to advance the issues of compliance with section 3-813 of the Mental Health and Developmental Disabilities Code (Mental Health Code) (405 ILCS 5/3-813 (West 2010)) and the actual examination of alternate treatment options. Such an outcome, while perhaps defensible, is nevertheless an exaltation of formal analysis over substance.

¶ 33 At some time, it would seem to us, we ought to give an authoritative explanation to respondent, because, if history is any guide, there will likely be future appeals involving this same respondent over the same or substantially similar issues as those raised here. (We note, however, that even if respondent were to raise another appeal on another order, but involving the same issues as those here and in *Robert S. I*, we would not be able to declare the issues barred by principles of *res judicata* or estoppel because the case would necessarily involve different evidence under a different order, but we would feel much more justified in refusing to apply a mootness exception after having provided an authoritative disposition to the similar issues in at least one in the series of hypothetical future appeals.) Weighing the reasons to refuse review on the ground that the capable-of-repetition exception should not apply versus allowing review under that ground, we conclude that we should allow review under the exception, at least this time. If, after having given an authoritative judgment in this case, those likely similar

subsequent cases may be evaluated on their own merits, and application of an exception to mootness may be allowed or refused as indicated by the circumstances of the hypothetical future case. Accordingly, as noted above, we hold that the capable-of-repetition exception to the mootness doctrine applies in this case to respondent's first two issues.

¶ 34 Respondent also argues that the trial court erroneously and improperly designated the treatment facility to which he would be involuntarily committed, in violation of section 3-811 of the Mental Health Code (405 ILCS 5/3-811 (West 2010)). In our view, this issue raises the question of the interpretation of section 3-811, and whether the trial court complied with its provisions. This is a question that appears likely to recur in the future, and a definitive judgment may help guide the court and respondent in future iterations of the issue. See *Robert S. I.*, 2013 IL App (2d) 121134-U, ¶ 16 (holding that respondent's challenge to the propriety of the trial court's purported designation of a treatment facility presented an issue that was reviewable under the capable-of-repetition exception); see also *In re Gloria C.*, 401 Ill. App. 3d 271, 276 (2010) (“[i]t is reasonably likely that the resolution of this issue would affect future cases involving the respondent, because the respondent will likely again be subject to involuntary admission and the trial court will again have to address whether the State sufficiently complied with section 3-703 of the [Mental Health] Code”). Accordingly, we also hold that this issue is reviewable under the capable-of-repetition exception.

¶ 35 3. Public-Interest Exception

¶ 36 The final exception is the public-interest exception. Under this exception, the court may consider a moot issue if (1) the question presented is of a public nature; (2) there is a need for an authoritative determination for the future guidance of public officers; and (3) there is a likelihood of future recurrence of the question. *Alfred H.H.*, 233 Ill. 2d at 355. The public-interest

exception is narrowly construed, and the party raising it must make a clear showing of the existence of each element. *Id.* at 355-56.

¶ 37 Respondent runs into difficulty with this exception from the outset. Generally, sufficiency-of-the-evidence issues are case specific and do not present questions of a public nature. *Id.* at 356-57. Here, respondent's first and second issues are unremarkable reviews of the sufficiency of the evidence. The third issue, regarding the trial court's purported selection of a treatment facility, usurping the Department's prerogative, would seem to satisfy the first element, as the extent of the court's authority vis-à-vis the Department under the statute is a matter of public concern. The second element also appears to be satisfied: there is a definite need for a determination to guide the various public officers in play in an involuntary commitment action under the Mental Health Code. Finally, as noted above, the issue seems likely to recur as evidenced by the fact that it did, actually, recur in this case. Accordingly, we hold that the third issue is also reviewable under the public-interest exception.

¶ 38 Summing up, we hold that all of respondent's claims on appeal may be reviewed under the capable-of-repetition exception, and that only respondent's third issue, claiming that the court usurped the Department's prerogative and assigned respondent to a treatment facility, may be reviewed under the public-interest exception. As explained above, none of the issues may otherwise be reviewed due to their mootness. We now turn our attention to respondent's substantive issues on appeal.

¶ 39 B. Compliance with Statutory Requirements

¶ 40 Turning to the first substantive issue on appeal, respondent contends that his treatment plan did not comply with the requirements of section 3-813 of the Mental Health Code. Section 3-813 provides, pertinently, that if, after an initial 90-day involuntary commitment, the facility

director believes that respondent's commitment should be continued, then the facility director "shall file with the court a current treatment plan which includes an evaluation of the recipient's progress and the extent to which he is benefiting from treatment." 405 ILCS 5/3-813(a) (West 2010). We note that the issue of whether there has been substantial compliance with a statutory provision presents a question of law, which we review *de novo*. *In re Laura H.*, 404 Ill. App. 3d 286, 290 (2010).

¶ 41 Respondent argues, citing to *In re Luttrell*, 261 Ill. App. 3d 221 (1994), that the written treatment plan was stale and had not been changed since his original commitment, that no evaluations of progress or prognosis was included in writing or in testimony, and that the trial court, even with Kurilo's testimony, simply did not have sufficient information before it to comply with the statutory mandates to evaluate and supervise respondent's progress while involuntarily committed. We disagree.

¶ 42 In *Luttrell*, the court held that there was no substantial compliance with section 3-813 of the Code because there was no written treatment plan submitted and the other evidence adduced during the hearing did not make up for the lack of a written treatment plan. *Id.* at 225. The court held that *In re Robinson*, 151 Ill. 2d 126, 136-37 (1992), set forth the standards necessary for oral testimony to make up for the failure to file a written treatment plan. *Id.* at 224. In order for oral testimony to make up for a missing written treatment plan, the oral testimony must include: (1) the diagnosis of the respondent's illness; (2) the fact that a treatment plan had been developed; (3) the particulars of the treatment plan; (4) a description and evaluation of the respondent's progress; and (5) an explanation about the anticipated time of the respondent's release or why it would be difficult to project the respondent's release. *Id.* An examination of the record demonstrates that the State fulfilled all of the *Luttrell* elements.

¶ 43 Kurilo first testified that respondent was diagnosed as bipolar with psychotic features. She also testified that, later, he was further diagnosed with dementia. Kurilo further testified that, in her expert opinion, respondent was likely to injure himself or others if he was not in a structured environment. All of this testimony satisfies the first *Luttrell* element.

¶ 44 Next, contrary to *Luttrell*, a written treatment plan was offered into evidence without objection. Thus, the trial court had a written treatment plan to which it could refer. Respondent notes, and the State appears to concede, that the written treatment plan was “sparse.” Respondent contends that the sparseness of the written treatment plan frustrates the intent of section 3-813 because there was insufficient information to allow the trial court to understand the treatment and goals of treatment for respondent. The State counters, noting that Kurilo testified about the parameters of respondent’s treatment plan. We agree with the State. Even if the written treatment plan were so sparse as to effectively constitute no written plan, Kurilo’s testimony made up for any defects caused by the sparseness of the written treatment plan. The second *Luttrell* element is clearly present.

¶ 45 Likewise Kurilo’s testimony about respondent’s treatment fleshed out the parameters of respondent’s treatment. She testified that he was being given medicine to control and stabilize his moods and behavior, and that staff was directed to ask respondent about his needs, and give him a chance to be alone and away from the other patients, and to use humor to defuse and direct respondent when he began to become upset. The third *Luttrell* element was clearly demonstrated by the State.

¶ 46 The fifth and final *Luttrell* element was also fulfilled. Kurilo testified that she needed 90 to 180 days in which to fulfill the goals of treatment. This express testimony satisfies the fifth *Luttrell* requirement.

¶ 47 Respondent argues (although not in these express terms) that the State did not present sufficient information about respondent's progress under his treatment plan to enable the trial court to meaningfully evaluate whether continued commitment was necessary. We agree that the State did not present this information as an individual and separate line of inquiry. That said, however, we hold that the State presented ample information from which respondent's progress and prognosis could be inferred, and that this inferential information was sufficient to satisfy the fourth *Luttrell* element.

¶ 48 Regarding respondent's progress under his treatment plan, Kurilo testified that he was still unstable and that he continued to have mood swings coupled with periods of verbal aggression and psychosis. From this, it can be inferred that, while respondent may have been making progress (there was a notation with the treatment documents admitted without objection that respondent's progress registered as a "4," but this notation was not elaborated in testimony), he was not at a point at which he would have fulfilled all of the treatment plan's goals and to allow him to live independently in an unstructured environment. Kurilo further testified about his physical illnesses, including diabetes and Parkinson's disease. She noted that respondent, when left to his own devices, would engage in an unhealthy diet and pay no attention to his diabetes, thereby aggravating that condition. Respondent's dementia also made it difficult for him to retain new information and to pay attention to his physical and medical needs. Kurilo further opined that she did not believe that respondent would have been able to find food and shelter and to otherwise care for himself if he were discharged from the Department. We believe that this testimony was sufficient to allow the trial court to determine that respondent's progress was spotty and was insufficient to justify his discharge. Further, the trial court could have inferred further that the chronic nature of respondent's dementia, diabetes, and Parkinson's

disease all suggested that respondent's chances for discharge were slim, and that Kurilo's suggestion that 180 days to fulfill the goals of the treatment plan was, in fact, understated. In any event, we hold that there was sufficient information about respondent's progress and lack of progress to allow the trial court to meaningfully oversee respondent's commitment. Accordingly, we hold that the trial court properly determined that the State at least substantially complied with section 3-813.

¶ 49 Respondent's arguments regarding the State's compliance with the requirements of section 3-813 are diffuse. Respondent recounts authority explaining the purpose of section 3-813 and the court's role in overseeing a respondent who is involuntarily committed, but these passages in respondent's brief are not directed at whether the State complied or did not comply with section 3-813. Respondent's only contention related directly to the issue respondent identifies, namely, whether the State fulfilled the statutory requirements set forth in section 3-813, is that the written treatment plan and Kurilo's testimony were insufficient to pass muster under the statute. We have analyzed the argument above, and found that, indeed, the evidence presented at the hearing plus the documentary evidence admitted without objection fulfilled the *Luttrell* requirements and did, in fact, allow the trial court to meaningfully understand respondent's condition, his treatment, his progress, and his prognosis, so that the trial court could effectively oversee and manage respondent's care under the statute while he was involuntarily committed. As that is the only substantive argument addressing respondent's issue, we need not otherwise consider any of the other preparatory or ancillary assertions made by respondent in framing this issue. Accordingly, we turn to the next issue.

¶ 50 C. Consideration of Less-Restrictive Treatment Alternatives

¶ 51 Respondent next contends that the State did not comply with section 3-811 of the Mental Health Code (405 ILCS 5/3-811 (West 2010)), and did not actually consider whether any less-restrictive treatment alternatives than hospitalization were available. Section 3-811 requires the trial court to place a respondent in the least-restrictive treatment alternative. *Id.* Moreover, in cases involving the Mental Health Code, there is a statutory preference to place respondents in a treatment setting other than hospitalization. *In re Hannah E.*, 376 Ill. App. 3d 648, 663 (2007). The trial court, therefore, is to order a respondent who is subject to involuntary commitment to be placed in the least-restrictive placement alternative. *Id.* The State retains the burden throughout the proceedings to demonstrate that hospitalization is the least-restrictive alternative. *Id.* The State may satisfy its burden by presenting an expert opinion, which is supported by the evidence adduced at the hearing, that the respondent's commitment is the least-restrictive means of treatment. *Id.* Further, where a trial court is justified in finding that a respondent is in need of hospitalization, it is not error for the trial court not to give consideration to other placements; the Mental Health Code does not require an express or specific determination that a certain treatment is the least-restrictive alternative. *In re James H.*, 405 Ill. App. 3d 897, 905 (2010). The trial court's ruling will be deemed proper if the record gives the basis for the determination that hospitalization is the least-restrictive treatment alternative. *Id.* We accord the trial court's factual findings great deference because it is in the best position to observe and weigh the testimony and credibility of the witnesses; accordingly, we review the trial court's determination for manifest error. *Hannah E.*, 376 Ill. App. 3d at 663.

¶ 52 Respondent concedes that Kurilo offered the opinion that, for him, hospitalization was the least-restrictive treatment alternative. Respondent argues, however, that the State did not present sufficient evidence to support Kurilo's opinion, and that the trial court, effectively, did

not actually consider any treatment alternatives for respondent. Respondent thus concludes that the trial court's determination that continued hospitalization in the Department was the least-restrictive alternative was manifestly erroneous. We disagree.

¶ 53 Kurilo testified that, in her opinion, hospitalization in the Department was the least-restrictive treatment alternative. She also opined that no halfway house or group home would agree to take respondent due to his unstable and frequently aggressive mental condition and because of his status as a registered sex offender and a convicted arsonist. She also opined that respondent was not psychologically stable enough to succeed in a less-restrictive environment. These opinion were supported by her other testimony.

¶ 54 The written reports indicated that, unless prompted, respondent had difficulty in managing his diet, his medications, and his hygiene. Kurilo also testified that respondent had issues in managing these things, based on her discussions with staff and her observations. This evidence supports the opinion that respondent was not stable enough to be placed in a less-restrictive environment.

¶ 55 The written reports all note that, despite the recommendation of placement in some sort of nursing home or group home, none could be found to take respondent, and the December 2012 treatment alternatives report attributed the difficulty to respondent's status as a sex offender. Kurilo also testified that staff had contacted 15 alternative, less-restrictive facilities, like nursing homes and halfway houses, but none had agreed to take respondent. She concluded, based on this record of failure in placing respondent, that his mental instability and his status as a convicted sex offender and arsonist, were primary factors in their inability to find respondent a placement in an alternative, less-restrictive facility. The reports and Kurilo's testimony support her opinion that, despite numerous attempts, respondent's unstable psychological condition and

his past criminal convictions were significant factors in the inability to actually place respondent into a less-restrictive treatment alternative.

¶ 56 Respondent testified that, to the contrary, he believed that he would be able to find shelter and successfully manage his diet if he were released from the hospital. This testimony was contradicted by respondent's past performance in managing his medications and his diet, resulting in nearly losing a foot due to complications arising from his diabetes. There was further testimony that respondent believed he was wealthy, so he spent all of his cafeteria funds on other patients, leaving him with nothing. All of this evidence contradicts respondent's testimony, and the trial court was not unreasonable to credit Kurilo's testimony over respondent's.

¶ 57 Respondent testified that he had a sister who would take care of him if he were released. Other testimony indicated that staff had tried to find and contact respondent's relatives, but with no success. Although respondent maintains that he has an able and willing sister, the trial court did not have to accept his testimony on that topic, and there is evidence to support the trial court's implicit determination that Kurilo's testimony, based on her interactions with staff and respondent, was the more credible.

¶ 58 Based on the foregoing, it was not unreasonable for Kurilo to conclude that continued hospitalization represented the least restrictive and most appropriate environment for respondent's treatment. The underlying evidence amply supports the opinion. Further, Kurilo testified about the efforts undertaken by staff to try to find an alternative placement. The court was not unreasonable to accept her testimony on this point. Accordingly, we hold that there was sufficient evidence to support Kurilo's opinions, and that the trial court did not manifestly err in accepting them.

¶ 59 Respondent argues that the evidence adduced was rather vague and was not directed at improving those aspects of respondent's condition that were amenable to treatment. Because of this, respondent concludes that the State did not meet its burden to demonstrate that hospitalization remained the least-restrictive treatment alternative. We disagree. As we noted, Kurilo's opinions were supported by the evidence, and, where the evidence supports a determination that hospitalization is the least-restrictive alternative, a trial court need not consider alternative placements. *James H.*, 405 Ill. App. 3d at 405. Accordingly, we reject respondent's contention. Based on the ample evidence of record and Kurilo's opinions drawn from that evidentiary basis, we hold that the trial court's determination that continued hospitalization represented the least-restrictive and most appropriate treatment alternative for respondent in this case was not manifestly erroneous.

¶ 60 D. Designation of a Treatment Facility

¶ 61 Respondent argues that the trial court improperly usurped the Department's discretion and designated that respondent be committed to the Elgin Mental Health Center. Respondent correctly argues that a trial court may not designate a respondent's treatment facility. See *In re Langdon*, 53 Ill. App. 3d 768, 772-74 (1977). Respondent contends that the trial court orally held that respondent should be committed to the Elgin Mental Health Center, and that this constituted an improper usurpation of the Department's discretion under the statute (405 ILCS 5/3-811 (West 2010)). We disagree.

¶ 62 Initially, we note that we are not so sure that the trial court's oral remarks constitute an actual order directing that respondent be committed to the Elgin Mental Health Center. The trial court's comments seem only to be endorsing Kurilo's opinion that the Elgin Mental Health Center was a safe and sufficiently structured environment to keep respondent safe and to offer

respondent a chance to progress on the goals of his treatment. If there was no oral pronouncement on the issue, then the written order, committing respondent to the Department, is the only order issued, and respondent's argument fails for being counterfactual.

¶ 63 Even assuming that the oral pronouncement was, in fact, an order committing respondent to the Elgin Mental Health Center, we do not believe that it represents an improper usurpation of the Department's discretion under section 3-811. The record shows that respondent's treatment committee recommended continued hospitalization at the Elgin Mental Health Center. Thus, we construe the court's remarks to be agreeing with the treatment committee, and not be dictating where respondent will be committed. Further, even if this agreement with the treatment committee were in error, it is not reversible error, because it appears that the treatment committee's recommendation was on behalf of and for the Department, and it was itself exercising the Department's discretion. Accordingly, we reject respondent's final argument.

¶ 64

III. CONCLUSION

¶ 65 For the foregoing reasons, the judgment of the circuit court of Kane County is affirmed.

¶ 66 Affirmed.