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2014 IL App (3d) 130554-U

Order filed July 29, 2014

IN THE
APPELLATE COURT OF ILLINOIS
THIRD DISTRICT

In re the Matter of Lisa A. (PEOPLE OF THE STATE OF ILLINOIS),)	Appeal from the Circuit Court of the Tenth Judicial Circuit, Peoria County, Illinois
)	
Petitioner-Appellee,)	
)	
v.)	Appeal No. 3-13-0554 Circuit No. 13-MH-89
)	
LISA A.,)	Honorable Lisa Y. Wilson, Judge, Presiding.
)	
Respondent-Appellant.)	
)	

JUSTICE HOLDRIDGE delivered the judgment of the court.
Presiding Justice Lytton concurred in the judgment.
Justice Wright dissented.

ORDER

¶ 1 *Held:* (1) The circuit court's expired orders for involuntary hospitalization and involuntary administration of psychotropic medication fell within the "capable of repetition" exception to the mootness doctrine because the orders could not have been fully litigated prior to their cessation and because it was reasonably likely that the circuit court's alleged failure to observe certain procedural and substantive requirements of the Mental Health Code in entering the orders would affect future cases involving the respondent; (2) the circuit court committed reversible error in granting the State's petition for involuntary admission because the State did not present evidence that the respondent, a voluntary admittee, had made a written

request for discharge; (3) 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, as required by the Mental Health Code; and (4) the circuit court's order granting the involuntary administration of psychotropic medication would be reversed where that order was dependent upon the invalid involuntary admission order.

¶ 2 The respondent, Lisa A., appeals orders of the circuit court admitting her involuntarily to a hospital for inpatient mental health treatment and ordering the involuntary administration of psychotropic drugs pursuant to the Mental Health and Developmental Disabilities Code (the Mental Health Code) (405 ILCS 5/1–100 *et seq.* (West 2012)). Although those orders have 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 State violated the Mental Health Code by failing to file both the respondent's written discharge request and a written predisposition report that contained information regarding a social investigation of the respondent, a preliminary treatment plan, and the appropriateness and availability of alternative treatment settings. The respondent also argues that the psychiatrist who testified at the hearing never personally examined her, as required by the Mental Health Code. Moreover, she maintains that the circuit court's finding that hospitalization was the least restrictive available treatment setting was not supported by the evidence. Finally, the respondent argues that the circuit court's order granting the involuntary administration of psychotropic drugs violated several provisions of the Mental Health Code.

¶ 3

FACTS

¶ 4

On July 12, 2013, Edith Perdew, a registered nurse at UnityPoint Health-Methodist in Peoria (UnityPoint), filed a petition for the involuntary admission of Lisa A., a voluntary

admittee who had requested to be discharged from UnityPoint. That same day, Dr. Baljit Singh, one of Lisa A.'s treating psychiatrists at UnityPoint, filed a petition for the involuntary administration of psychotropic medications and electroconvulsive therapy (medication petition). Attached to the petition for involuntary admission were the written certificates of Dr. Singh and Christopher Legan, a behavioral health clinician at UnityPoint. Both Dr. Singh and Legan stated that the respondent was agitated, delusional, and paranoid and that she was refusing to take her medication. Attached to the medication petition was a list of the psychotropic medications requested and written information for the patient regarding each of the listed medications.

¶ 5 On July 16, 2013, the circuit court conducted separate hearings on the involuntary admission and medication petitions. During the hearing on the petition for voluntary admission, the State tendered Dr. Singh as an expert in the field of psychiatry, and he was accepted as such without objection. Dr. Singh testified that he has been an attending psychiatrist at UnityPoint since 2004 and that, at the time of the hearing, he was the respondent's treating psychiatrist. He stated that the respondent was admitted to UnityPoint on July 12, 2013. According to Dr. Singh, the respondent had been brought to the emergency room by the Tazewell County Emergency Response Service (Tazewell ERS). Police had called the Tazewell ERS after the respondent had been "driving around and pointing at people." After an evaluation, the Tazewell ERS took the respondent to UnityPoint. Dr. Singh testified that the respondent was aggressive and agitated at the hospital and threw objects at the staff. He also claimed that she acted "promiscuously" toward a police officer. She was given medication as needed.

¶ 6 Dr. Singh testified that he had seen the respondent on three occasions since her admission, including once on the date of the hearing. He stated that the respondent had a history of bipolar disorder (including manic episodes) and psychiatric hospitalizations. During a prior

admission, she was diagnosed with bipolar disorder and committed to the VA hospital. Singh testified that, during her current hospitalization, the respondent told him that her mood was agitated, she had not slept for three to four days, and she felt paranoid (for example, she felt that the police were following her and monitoring everyone). The doctor also stated that the defendant had been hearing voices and "reacting to internal stimuli" while at the hospital.

¶ 7 When the prosecutor asked Dr. Singh what behaviors he observed which indicated that the respondent was currently suffering from a mental illness, Dr. Singh replied that the respondent had a "disorganized thought process," was "extremely paranoid" and believed people were poisoning her, and was seen talking to herself and reacting to internal stimuli. Dr. Singh acknowledged that he had not been able to interview the respondent or have a "meaningful interaction" with her because the respondent did "not like" him and had requested another doctor. However, Dr. Singh stated that one of the resident physicians at UnityPoint acted as a "sort of buffer" between the respondent and Dr. Singh. Based on his examinations and observations, his conferences with the resident and other staff at UnityPoint, and his knowledge of the respondent's history, Dr. Singh opined that the respondent was currently suffering from the mental illness of bipolar disorder ("most recently manic"). He also opined that the respondent: (1) was suffering mental deterioration due to her mental illness; (2) had no insight into her mental illness; (3) did not understand her need for psychiatric treatment and wanted to be discharged; (4) was taking Zyprexa only "as needed" and was not taking it consistently; (5) refused to take a mood stabilizer; (6) had put herself in danger by harassing people while driving through an area of town that she described using a racially derisive term; (7) had no judgment or insight; (8) was currently unable to provide for her basic physical needs and to guard herself from harm without assistance due, in part, to her mental illness.

¶ 8 Dr. Singh opined that the respondent should be committed to UnityPoint or the VA hospital for up to 90 days. He testified that, when he examined the respondent on the morning of the hearing, he concluded that she had not improved such that she could be released to any less restrictive facility. Dr. Singh noted that he had also filed a petition for the involuntary administration of medications to the respondent and claimed that he had filed a treatment plan with the circuit clerk. He opined that, "once [the respondent] takes medications and her mood is stabilized, she can go back to living independent[ly]."

¶ 9 During cross-examination, Dr. Singh stated that "I would assume that if the ERS and the police want the patient to be in the hospital, she's acutely psychotic and acutely dangerous to society, that's why she's in the hospital." He also testified that, because the respondent has bipolar disorder and Zyprexa works only for mania, she should also be on a mood stabilizer to help with the other polar aspect, depression. On redirect examination, Dr. Singh stated that the respondent was still responding to internal stimuli, still had disorganized thinking, and was still exhibiting poor judgment.

¶ 10 The respondent testified on her own behalf. She stated that she did not believe that she needed to stay at UnityPoint for further treatment because Dr. Singh "went off the police report instead of his own observations." She claimed that Dr. Singh had "not made any observations with me" and had "just assumed that the police report was true." She felt that Dr. Singh wanted to "overdrug and overhospitalize [her] because the police brought [her] in." The respondent testified that, if she were discharged, she could live independently and take care of herself. In support of this assertion, the respondent noted that she was participating in a program through the VA in which she visits with a case manager in her home once per day and sees a psychiatrist

once every three weeks. She stated that she is "constantly doing something every day of the week" and is "highly monitored by [her] outside sources."

¶ 11 During cross-examination, the respondent testified that her doctor told her to take Zyprexa as needed (*i.e.*, when she "felt like taking it"). She admitted that, on July 12, 2013, she drove to an area where there were black people, pointed at them, and called them names. However, she stated that "we live in a free country where I can say anything I want." She characterized her actions as an expression of her "first *** and *** second amendment rights." When asked whether she had considered that she might be putting herself in danger, she answered "[n]o" and stated that she thought that "freedom for [her] country" was "more important than putting [herself] in danger" by her comments. She opined that it was "ridiculous" that "you guys are going to put me in jail because I'm waving my finger around." She denied being sexually provocative with the police and denied throwing things at people at the ER.

¶ 12 Following closing statements, the circuit court found that the petition for involuntary admission had been proved by clear and convincing evidence. Based on the evidence presented by the parties, the court found that the respondent suffered from bipolar disorder and had suffered some mental deterioration. The court expressed concern that, because of her mental illness, the respondent may be reasonably expected to continue to suffer mental deterioration to the point that she could engage in dangerous conduct or put herself in harm's way. The court also noted that "there is a concern *** as to whether or not currently [the respondent] can provide for her basic human needs so as to guard herself from further harm." Further, the court had "serious concerns" about the respondent's ability to live independently at the current time. Accordingly, the court found the respondent subject to involuntary admission. It found that UnityPoint or the VA would be "the least restrictive environment or placement for [the

respondent]." The court therefore ordered the respondent involuntarily admitted at UnityPoint "with the idea that she would be transferred to the VA Hospital for a period not to exceed 90 days."

¶ 13 The circuit court then held a hearing on the involuntary medication petition. After considering the evidence presented by the parties, the circuit court granted the petition for the involuntary administration of psychotropic medications. The court ruled that the respondent "will receive that medication [at UnityPoint] to be administered by the members of the clinical staff at [UnityPoint] or the VA Hospital for a period not to exceed 90 days." This appeal followed.

¶ 14 **ANALYSIS**

¶ 15 1. Mootness

¶ 16 Before we address the merits of the respondent's arguments for reversal of the circuit court's involuntary admission and medication orders, we must first address the issue of mootness. The circuit court's orders authorized involuntary admission and medication for "a period not to exceed 90 days." Accordingly, those orders expired by their own terms on October 13, 2013, rendering this appeal 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").

¶ 17 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. *Id.* 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. *Id.* at 364; see also *In re Daryll C.*, 401 Ill. App. 3d 748, 752 (2010).

¶ 18 The respondent concedes that the "collateral consequences" exception does not apply here because the commitment at issue in this case was not her first involuntary commitment. See *Alfred H.H.*, 233 Ill. 2d at 363. However, she argues that the "capable of repetition" and "public interest" exceptions apply.

¶ 19 The "capable of repetition" exception has two elements. First, the challenged action "must be of a duration too short to be fully litigated prior to its cessation." *Id.* at 358. "Second, there must be a reasonable expectation that 'the same complaining party would be subjected to the same action again.'" *Id.* (quoting *In re Barbara H.*, 183 Ill. 2d 482, 491 (1998)). In the present case, there is no question that the first criterion has been met. As noted, the challenged orders were limited to 90 days, and the parties agree that the orders could not have been fully litigated prior to their cessation. Therefore, the only question with regard to this exception is whether there is a reasonable expectation that respondent will personally be subject to the same action again. That occurs when the resolution of the issue raised in the present case would be likely to "affect a future case involving the respondent" or to "have some bearing on a similar

issue presented in a subsequent case" involving the respondent. *Alfred H.H.*, 233 Ill. 2d at 359, 360.

¶ 20 This case satisfies that standard. Because of the respondent's history of mental illness and involuntary hospitalizations, it is reasonably likely that she will face additional involuntary admission and medication orders in the future. Moreover, in this appeal, the respondent contends that the State and the circuit court failed to comply with certain procedural and substantive requirements of the Mental Health Code. Specifically, among other things, she argues that the circuit court erred by granting the involuntary admission petition even though the State: (1) failed to present evidence that the respondent had submitted a written request for discharge, as required by section 3-403 of the Mental Health Code (405 ILCS 5/3-403 (West 2012)); see *In re Splett*, 143 Ill. 2d 225, 234 (1991); *In re Gail F.*, 365 Ill. App. 3d 439, 453 (2006)); (2) failed to file a pre-disposition report as required by section 3-801 of the Mental Health Code (405 ILCS 5/3-810 (West 2012)) or to present oral testimony containing the information required by that section (see *Daryll C.*, 401 Ill. App. 3d 748, 755-57 (2010)); and (3) failed to observe various prerequisites in the Mental Health Code for the involuntary administration of psychotropic medications. It is reasonably likely that the resolution of these issues will affect future cases involving the respondent, because the respondent will likely again be subject to involuntary admission and medication and the court will likely again commit the same alleged errors. See *In re Val Q.*, 396 Ill. App. 3d 155, 161 (2009) (overruled on other grounds by *In re Rita P.*, 2014 IL 115798, ¶¶ 33-34). Accordingly, the "capable of repetition" exception to the mootness doctrine applies here.¹

¹ Because we find that the "capable of repetition" exception applies, we do not need to address the respondent's argument that the "public interest exception" also applies. However, although

¶ 21 2. Evidence of the Respondent's Written Request for Discharge

¶ 22 The respondent argues that the court committed reversible error in granting the State's petition for involuntary admission because the State did not present evidence that the respondent, a voluntary admittee, had made a written request for discharge. We agree.

¶ 23 "The precedent under section 3–403 of the [Mental Health Code] *** is clear that, when a respondent is a voluntary admittee, the State must present evidence that the respondent has requested a discharge in writing before a court can properly grant a petition for involuntary admission." *Gail F.*, 365 Ill. App. 3d at 453; see also *Splett*, 143 Ill. 2d at 234-35; *In re N. S.*, 359 Ill. App. 3d 1125, 1128-29 (2005); *In re Lawrence*, 239 Ill. App. 3d 424, 427 (1993); *In re Weimer*, 219 Ill. App. 3d 1005, 1009 (1991). Unless evidence of the respondent's written request for discharge appears in the record at the time the commitment petition is ruled upon, a court's order for involuntary admission is "void for want of statutory authority." *Weimer*, 219 Ill. App. 3d at 1009.

¶ 24 Here, the State did not file the respondent's written request for discharge in the involuntary admission proceeding. The first page of the State's petition for involuntary

we do not decide the issue, we note that the public interest exception is unlikely to apply here because that exception applies only where "an authoritative determination is needed for future guidance." *In re Commitment of Hernandez*, 239 Ill. 2d 195, 202 (2010). Such a determination is needed only when "the law is in disarray or there is conflicting precedent." *Id.*; see also *Alfred H.H.*, 233 Ill. 2d at 358. As shown below, the application and scope of the statutory requirements at issue in this case are clear and well-settled. Thus, there is no need for an "authoritative determination," and the public interest exception likely does not apply.

admission checks a box indicating that the respondent had submitted a written request for discharge, but as the State correctly acknowledges, that is not evidence of the respondent's written request for discharge. *Gail F.*, 365 Ill. App. 3d at 453; *N. S.*, 359 Ill. App. 3d at 1128-29. The record contains an "Order for Hearing" on the petition for voluntary admission which reads: "This cause coming to be heard on VOLUNTARY ADMITTEE SUBMITTED WRITTEN NOTICE OF DESIRE TO BE DISCHARGED AND TWO CERTIFICATES ARE ATTACHED TO/SUBMITTED WITH THIS PETITION[,] [a] hearing on the matter is set 7/16/13 at 09:00AM at METHODIST MEDICAL CENTER in PEORIA, ILLINOIS ***." The State argues that this Order is "a clear indication that the trial judge had viewed or been informed of the written request submitted by respondent." We disagree. The Order merely recites verbatim the language next to the box checked on the State's petition. The purpose of the Order is simply to set a hearing on the State's petition. It does not constitute evidence that the respondent made a written discharge request. Nor does it represent a finding by the circuit court that such a request was made or that the record included evidence of such a request.

¶ 25 The State also argues that, during the hearing on the involuntary medication petition, the respondent testified that she "filled *** out" a discharge plan. However, the respondent gave this testimony *after* the court had already granted the State's petition for involuntary admission.² That was too late to satisfy section 3-403's requirement. See, *e.g.*, *Gail F.*, 365 Ill. App. 3d at 453 (under section 3-403, "when a respondent is a voluntary admittee, the State must present evidence that the respondent has requested a discharge in writing *before a court can properly grant a petition for involuntary admission*") (Emphasis added.)

² As noted, the hearing on the involuntary medication petition was separate from (and subsequent to) the court's hearing and ruling on the petition for involuntary admission.

¶ 26 At the time the circuit court granted the State's petition for involuntary admission, there was no evidence in the record that the respondent had submitted a written request for discharge. Accordingly, the circuit's court's order is invalid and void. *Splett*, 143 Ill. 2d at 235; *Weimer*, 219 Ill. App. 3d at 1009.

¶ 27 The State argues that the respondent forfeited any argument based on the State's failure to file evidence of her written request for discharge because she did raise the issue before the circuit court during the hearing or in a posttrial motion. We disagree. "[A]ppellate court precedent uniformly rejects the position that a respondent can forfeit the issue of the State's failure to show a written request for a discharge, and [our] supreme court has not held otherwise." *Gail F.*, 365 Ill. App. 3d at 445; see also *N. S.*, 359 Ill. App. 3d at 1129 (ruling that a respondent's failure to raise this issue does not constitute a forfeiture because "[p]roceedings for involuntary admission cannot proceed on a voluntarily admitted patient unless the patient had filed a written request for discharge" and an order of involuntary admission in the absence of evidence of such a written request is "void for want of statutory authority").

¶ 28 3. The State's Failure to File a Predisposition Report

¶ 29 The respondent also 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 Mental Health Code or otherwise prove that involuntary hospitalization was the least restrictive available treatment alternative. We agree.

¶ 30 Section 3–810 provides:

"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." (Emphasis added.) 405 ILCS 5/3–810 (West 2012).

¶ 31 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 2012). 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 2012).

¶ 32 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. "Other purposes of the statute are to protect against unreasonable commitments and patient neglect, and to ensure adequate treatment for mental health care recipients." *In re Robinson*, 151 Ill. 2d 126, 133 (1992).

¶ 33 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. *Robinson*, 151 Ill. 2d at 134. Thus, 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.*

¶ 34 However, the 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." *In re Alaka W.*, 379 Ill. App. 3d 251, 270 (2008); see also *Daryll C.*, 401 Ill. App. 3d at 756; *In re Daniel M.*, 387 Ill. App. 3d 418, 422 (2008). Accordingly, 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").

¶ 35 Here, the State admits that no predisposition 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 Dr. Singh's testimony at the hearing, together with his treatment notes (which were included in the record), 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.

¶ 36 We disagree. Dr. Singh's testimony did not contain all of the information required by section 3–810. Dr. Singh opined in conclusory fashion that, based upon his examination of the respondent on the morning of the hearing, the respondent had not "improved so that she could be released into any lesser restrictive facility." However, he offered no testimony regarding any specific alternative treatment settings and did not testify that he had actually considered any such alternatives. Moreover, assuming that he had considered less restrictive treatment options, Dr. Singh did not explain why he found those options inappropriate in the respondent's case. Accordingly, the testimony presented during the hearing was "conclusory and unsupported by a factual basis" (*Alaka W.*, 379 Ill. App. 3d at 271)), thereby failing to meet the requirements of sections 3-810 and 3-811 (*Id.*; *see also In re Lawrence S.*, 319 Ill. App. 3d 476, 484 (2001) (reversing involuntary commitment order where State's medical witnesses "each opined that commitment to a mental health facility was the least restrictive alternative but neither explained the basis for his or her opinion nor mentioned any other alternatives that were considered"); *In re Angel S.*, 376 Ill. App. 3d 42, 48-49 (2005) (ruling that hospitalization may be ordered only if the

State proves that it is the least restrictive treatment alternative and that "this requirement is not met merely because the State's expert opines that commitment is the least restrictive placement; the expert's opinion must be supported by the evidence").³ As a result, the circuit court ordered involuntary commitment without considering any information regarding alternatives to treatment in an inpatient facility and without determining that involuntary commitment was the least restrictive appropriate treatment, as required by sections 3-810 and 3-811 of the Mental Health Code.

¶ 37 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.⁴ The circuit court's granting of a commitment order under these circumstances was reversible error.

¶ 38 Although we have repeatedly stated the need for strict compliance with legislatively

³ See also *In re Luttrell*, 261 Ill. App. 3d 221, 227 (1994) ("[t]he requirement that the State prove hospitalization is the least restrictive treatment alternative is not met merely because the State's expert opines commitment is the least restrictive means"); *Daryll C.*, 401 Ill. App. 3d at 756; *Daniel M.*, 387 Ill. App. 3d at 423.

⁴ The State argues that Dr. Singh's "descriptions of the respondent's mental state, her disregard for her own safety, and her aggressive and promiscuous behavior toward police and hospital staff demonstrated the need for hospitalization as opposed to a less restrictive treatment option." 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.

established procedural safeguards for involuntary commitment proceedings, the State continues to disregard those procedural safeguards. See, e.g., *Alaka W.*, 379 Ill. App. 3d at 271–72; *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 (including the requirements of sections 3–810 and 3-811 of the Mental Health Code) to protect and balance the competing interests of society and individuals subject to involuntary commitment.

¶ 39 Because we reverse the circuit court's involuntary admission order on the grounds discussed above, we do not need to address the defendant's remaining arguments for reversal of that order.

¶ 40 4. The Involuntary Medication Order

¶ 41 We also reverse the circuit court's order regarding the involuntary administration of psychotropic medication. Pursuant to section 2-107.1 of the Mental Health Code, a court may authorize administration of involuntary treatment to a "recipient of services." 405 ILCS 5/2–107.1 (West 2012). Under the Mental Health Code, a "recipient of services" is defined as a person who has received or is receiving treatment or rehabilitation. 405 ILCS 5/1–123 (West 2012). Under the facts of the instant case, the circuit court's involuntary medication order was dependent upon the respondent currently receiving treatment as an inpatient at UnityPoint or the VA. The court's treatment order directed UnityPoint or VA staff to dispense psychotropic medication to the respondent during her inpatient hospitalization. Because we have reversed the order granting the respondent's involuntary admission, she will no longer be receiving such inpatient treatment and therefore no longer qualifies as a "recipient of services" for involuntary administration of medication. See *In re John N.*, 364 Ill. App. 3d 996, 998 (2006).

¶ 42

CONCLUSION

¶ 43

For the foregoing reasons, we reverse the Peoria County circuit court's orders to: (1) involuntarily admit the respondent; and (2) involuntarily administer psychotropic medication to the respondent.

¶ 44

Involuntary admission order reversed; involuntary administration of psychotropic medication order reversed.

¶ 45

JUSTICE WRIGHT, dissenting.

¶ 46

After careful review of the record, I respectfully disagree that any exception to the mootness doctrine applies in this case.

¶ 47

The record reveals Dr. Singh testified at respondent's involuntary admission hearing and stated he would "presume" the 51-year-old respondent had a 25-year history of bipolar disorder because respondent attempted suicide with an overdose of Haldol when she was 25 years old. Dr. Singh's testimony also indicated respondent had been hospitalized "once" at UnityPoint and observed that during respondent's last hospitalization she was "committed to VA, as well." However, Dr. Singh did not indicate whether respondent's prior treatment at either UnityPoint or elsewhere had been voluntary or involuntary. In my view, this span of 25 years without a well-documented history of repeated involuntary admissions is insufficient to satisfy the requirement that there is a "reasonable expectation that 'the same complaining party would be subjected to the same action again.'" *In re Alfred H.H.*, 233 Ill. 2d 345, 358 (2009); *In re Barbara H.*, 183 Ill. 2d 482, 491 (1998).

¶ 48

Consequently, I respectfully conclude the "capable of repetition" mootness exception is not present under the circumstances in this case. Further, since I believe neither the "public-

interest” exception nor the “collateral-consequences” exception applies, I would dismiss respondent’s appeal as moot.