FOURTH DIVISION
June 11, 2015

No. 1-13-3734

IN THE
APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

THE PEOPLE OF THE STATE OF ILLINOIS,	)	Appeal from the
	)	Circuit Court of
Plaintiff-Appellee,	)	Cook County.
	)	
v.	)	No. 88 CR 7354
	)	
BRIAN BLEDSOE,	)	Honorable
	)	Michael McHale,
Defendant-Appellant.	)	Judge Presiding.

JUSTICE HOWSE delivered the judgment of the court.
Justices Ellis and Cobbs concurred in the judgment.

O R D E R

¶ 1 *Held*: Trial court's denial of defendant's petition for conditional release was not against the manifest weight of the evidence. Statutory requirement of express findings of fact and conclusions of law is directory.

¶ 2 In 1991, defendant Brian Bledsoe, also known as Brian Childress, was found not guilty of first degree murder by reason of insanity (NGRI) and was committed to the custody of the

Department of Mental Health and Developmental Disabilities, now the Department of Human Services ("Department" for both). He now appeals from the 2013 denial of his petition for conditional release, contending that the denial was erroneous.

¶ 3 The record includes Department treatment plans or reports for defendant from September 1993 through August 2013.

¶ 4 In June 1993, defendant petitioned for discharge or conditional release, accompanied by his request for an independent psychiatric examination (IPE). *See* 730 ILCS 5/5-2-4 (West 2012). The circuit court did not grant the IPE nor was one held. The court denied the petition following a September 1993 hearing with testimony by defendant and a Department psychologist. Defendant unsuccessfully repeated his request for an IPE and then appealed.

¶ 5 On appeal, we held that the court must order an IPE if a defendant requests one; that is, section 5-2-4 does not give the court discretion to deny an IPE request. We remanded for a new hearing on the petition preceded by an IPE. *People v. Bledsoe*, 268 Ill. App. 3d 869 (1994).

¶ 6 In February 1996, following remand, the circuit court ordered its Forensic Clinical Services (FCS) to conduct a behavioral clinical examination (BCX) of defendant. In April 1996, FCS psychiatrist Dr. Roni Seltzberg reported that she conducted the BCX in late March and formed the opinion that defendant remain subject to involuntary admission rather than outpatient treatment due to his "chronic mental illness which is showing signs of acute exacerbation with loose and delusional thought processes" and refusal to take medication for his history of "agitated and potentially violent behavior." The court denied the petition in April 1996 after a hearing where Dr. Seltzberg testified.

¶ 7 Defendant filed another petition for discharge in September 1996 and a BCX was ordered. In October 1996, Dr. Seltzberg reported that she conducted the BCX in late October and formed the opinion that defendant remain subject to involuntary admission based on his refusal to take medication and his reported and directly-observed agitation, paranoia, and bizarre behavior. The record does not indicate the disposition of the petition after a November 1996 continuance "for hearing."

¶ 8 In January 2000, the court ordered another BCX and scheduled a hearing on a petition for discharge or conditional release. Late that month, Dr. Seltzberg reported that she conducted the BCX that month and formed the opinion that defendant remain subject to involuntary admission based on his "difficulty with medication compliance" and his history of psychosis and of "assaultive, psychotic, and unpredictable behaviors *** as recently as October of 1999." Dr. Seltzberg noted that defendant "has only recently shown some minor improvement in his behavior and psychosis." However, the petition was withdrawn in March 2000 on the day set for its hearing.

¶ 9 In April 2010, on Department recommendations for unsupervised on-grounds passes and supervised off-grounds passes, the court ordered an IPE of defendant by FCS. In May 2010, Dr. Seltzberg reported that she examined defendant that month and formed the opinion that he was unready for pass privileges, either on- or off-grounds. She found that he made considerable improvement but still had significant delusional beliefs and did not associate his mental illness with the NGRI incident so that he presented a "moderate risk of harm to others" requiring monitoring in a secure facility. In July 2010, the court granted unsupervised on-grounds passes and denied supervised off-grounds passes.

¶ 10 In November 2011, on the Department's recommendation for supervised off-grounds passes, the court ordered an IPE of defendant by FCS. In January 2012, Dr. Seltzberg reported that she examined defendant in December 2011 and formed the opinion that supervised off-grounds pass privileges were appropriate. He was compliant with medication and she noted no aggressive behavior for about five years but also found that he still had "delusional beliefs and other psychotic processes." She saw no increased risk of harm to defendant or the community from supervised off-grounds passes if he maintained medication and treatment compliance. In January 2012, the court granted supervised off-grounds passes at Department discretion.

¶ 11 In August 2013, pursuant to a petition for discharge or conditional release, the court ordered an IPE of defendant by BCS to determine whether (1) he is mentally ill and, if so, the nature of his illness, (2) due to the mental illness underlying his NGRI disposition, he is reasonably expected to inflict serious bodily harm on himself or another, (3) he requires inpatient care, and (4) may be released under conditions set by the court to reasonably assure safety and treatment progress and, if so, what conditions.

¶ 12 In September 2013, FCS psychiatrist Dr. Fidel Echeverria reported that, after examining defendant and reviewing his records, it was his opinion that defendant has a mental illness consistent with the diagnosis of schizoaffective disorder of a bipolar type, and that he "is not at the present time reasonably expected to inflict serious harm on himself or another." As defendant needed ongoing management of his psychotic and mood symptoms, Dr. Echeverria found him to be in need of inpatient care and opined that he was "not yet an appropriate candidate for conditional release."

¶ 13 At the hearing on the petition on November 8, 2013, Dr. Echevarria testified that he examined defendant in September and reviewed the records of his treatment by the jail hospital and the Department and his prior FCS examinations but did not personally consult anyone. Defendant has a criminal record including disorderly conduct, theft, retail theft, trespass, a battery, and an aggravated assault. Dr. Echevarria diagnosed defendant with schizoaffective disorder of a bipolar type; that is, with mood changes between depression and mania and "psychotic features" that "could" manifest even when neither depressed nor manic. Defendant's records reflected that he had an untreated and unmedicated mental illness – a psychosis – when he killed his uncle. Since then, his condition improved significantly with medication and other treatment. At the time of the hearing, he was taking mood stabilizer Divalproex, antipsychotics Olanzapine and Halperidol, and anti-anxiety Lorazepam. He was compliant with treatment and felt that he had improved. There was no record since 2011 that he had refused medication or expressed a desire to do so. Dr. Echevarria opined that he would deteriorate in about two weeks to a month if he stopped taking his medication. In addition to his mental illness, defendant has diabetes being treated with medication and an asymptomatic cardiac condition.

¶ 14 In defendant's examination, his hygiene was appropriate, he was oriented, responsive and engaged, and he showed an appropriate range of moods. He self-reported being in a good mood, and Dr. Echevarria concurred. There were no signs of anxiety, thought, or mood disorders, and he denied having any suicidal or homicidal ideations. Dr. Echevarria was not testing for intelligence or memory but observed defendant's intelligence to be at the low end of average and his memory appropriate. His insight and impulse control were good. He showed some ongoing signs of mental illness, in that he was preoccupied with a family probate issue and had ingrained

delusions. However, the delusions did not affect his everyday behavior and did not cause him to violate any rules or lose any passes. There was no record since 2011 of defendant injuring or threatening anyone, and he has both on-grounds unsupervised and off-grounds supervised passes with no record of failing to return on-time or attempting to escape. Defendant acknowledged that he was mentally ill at the time of his crime and appreciates the criminality of his actions.

¶ 15 Dr. Echevarria formed the opinion that defendant is not reasonably expected to inflict serious harm on himself or another but also that he requires inpatient care so his condition is closely monitored and he is provided a structured setting. He has not required any intervention for six years, and Dr. Echevarria was "unclear" why the Department had not recommended defendant's conditional release as nothing in his records explained the reluctance. Nonetheless, he considered the absence of such a recommendation by the team of Department personnel treating defendant as significant and key in forming his opinion that defendant is not ready for conditional release. However, Dr. Echevarria would not have changed his opinion if the treatment team had recommended conditional release; he prefers to see "a year of absolute stability of symptoms" before he concurs with a Department recommendation but defendant did not yet have such a year.

¶ 16 On cross-examination, Dr. Echevarria testified that defendant's *Thiem* date[1] is November 9, 2017. His treatment team documented concerns that he still showed psychotic symptoms including delusional preoccupations as late as May 2013, and his team was not recommending

[1]That is, "the maximum length of time that the defendant would have been required to serve, less credit for good behavior[,] before becoming eligible for release had he been convicted of and received the maximum sentence for the most serious crime" with an NGRI disposition. 730 ILCS 5/5-2-4(b) (West 2012); *People v. Thiem*, 82 Ill. App. 3d 956, 962 (1980).

conditional release. The Department facilities are overcrowded, and Dr. Echevarria believed that the Department tries "to get people out *** as fast as possible" including instances where FCS found defendants unfit who the Department had found fit. Dr. Echevarria considered it reasonable to rely in part on the recommendations of the Department treatment team, though he was directed to form his own opinion, because the team has "many more hours with" a defendant and "their tendency is to want a person to proceed and progress" so that the absence of a conditional-release recommendation is significant. That said, he also relied on the prior FCS examinations and his own examination in forming his opinion.

¶ 17 On redirect examination, Dr. Echevarria testified that defendant's treatment report for April 2012 stated that he is reasonably expected to inflict serious physical harm on himself or another while the February and August 2013 reports did not so state. Thus, the Department treatment team's opinion for at least a year was that defendant was not dangerous. Dr. Echevarria noted that his opinion was also that defendant is not reasonably expected to inflict serious physical harm on himself or another.

¶ 18 On re-cross examination, Dr. Echevarria testified that the February 2013 treatment report also found defendant to be in need of inpatient mental health services due to his psychosis and mood disorder and lack of understanding of his mental illness. The former was based on his "extensive history of grandiose and persecutory delusions, auditory hallucinations, grossly impaired judgment and aberrant behavior" and "history of significant mood and affective instability *** evidenced by pressured speech, irritability, impulse dyscontrol [*sic*], and episodes of unprovoked physical aggression." The latter was based on the observation that defendant admitted his crime "but expresses being justified in doing what he did," with no sign of remorse.

¶ 19 On redirect examination, Dr. Echevarria acknowledged that this report referred to a history of such symptoms and issues rather than matters observed at the time of the report.

¶ 20 Following closing arguments, the court denied the petition for discharge or conditional release. The court noted that the Department report from only months prior reflected concerns including ongoing delusional preoccupations. The court acknowledged that defendant's extensive history of unprovoked violence and aggression was a history but noted that "history often repeats itself" and that "nothing in the statute" stands for the proposition that "a year approximately is enough to say he's never going to act out like this again." The court found that the Department provides "a highly structured setting which provides for making sure he takes his medication" and concluded that "I think it's too early as well." The written order of denial includes no findings. This appeal timely followed.

¶ 21 On appeal, defendant contends that the court erred in denying his petition for conditional release, in that the court's decision was (1) against the manifest weight of the evidence, (2) based improperly on past behavior, current mental illness, and a requirement that defendant's future behavior be guaranteed, and (3) not supported by express findings of fact and conclusions of law.

¶ 22 We shall first address defendant's contention that the trial court erred by failing to make express findings of fact and conclusions of law as required by section 3-816 of the Mental Health and Developmental Disabilities Code.[2] That statute provides that "[e]very 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." 405 ILCS 5/3-816(a) (West 2012).

[2]The Mental Health and Developmental Disabilities Code governs proceedings under section 5-2-4 except when it conflicts with section 5-2-4. 730 ILCS 5/5-2-4(a), (k) (West 2012).

Our supreme court has determined that this provision is directory rather than mandatory. *In re Rita P.*, 2014 IL 115798, ¶ 68. Defendant argues that *Rita P.* stands for the limited proposition that "failure to comply with [section] 3-816(a) is no longer grounds for *automatic* reversal." (Emphasis in original.) However, the *Rita P.* court clearly stated that "the issue before the appellate court was not case-specific [but] one of general applicability to mental health cases, involving the proper construction of section 3-816(a) as either a mandatory or directory provision," thus "the only question before us is whether section 3-816(a) is mandatory, as the appellate court held, or directory, as the State argues," and this is a question of statutory construction evaluated under the presumption that a statute issuing procedural directives to a governmental official is directory. *Id.*, ¶¶ 36, 42-44. Noting that we review the judgment of the trial court rather than its reasoning, the *Rita P.* court found that section 3-816(a) is not mandatory in the absence of statutorily-prescribed consequences for non-compliance and because it saw "no reason to conclude that *a* respondent's appeal rights or liberty interests will generally be injured through a directory reading of section 3-816(a)." (Emphasis added.) *Id.*, ¶¶ 45-46, 50-51, 68. Our supreme court was not weighing compliance with section 3-816(a) in a particular case, rendering this case potentially distinguishable as defendant contends, but holding that the provision at issue is directory as a matter of law. Following *Rita P.*, we find no reversible error on this point.

¶ 23 Section 5-2-4 of the Code of Corrections provides that, when a defendant has been committed to the Department's custody upon a NGRI disposition and "is found to be in need of mental health services on an inpatient care basis, *** [t]he defendant shall be placed in a secure setting unless the Court determines that there are compelling reasons why such placement is not necessary." 730 ILCS 5/5-2-4(a) (West 2012). Thereafter,

> "[i]f the defendant is found to be in need of mental health services, but not on an inpatient care basis, the Court shall conditionally release the defendant, under such conditions as set forth in this Section as will reasonably assure the defendant's satisfactory progress and participation in treatment or rehabilitation and the safety of the defendant and others. If the Court finds the person not in need of mental health services, then the Court shall order the defendant discharged from custody." 730 ILCS 5/5-2-4(a) (West 2012).

A defendant is in need of mental health services on an inpatient basis if "due to mental illness [he] is reasonably expected to inflict serious physical harm upon himself or another and *** would benefit from inpatient care or is in need of inpatient care," while he is in need of mental health services on an outpatient basis if he is "not in need of mental health services on an inpatient basis, but is in need of outpatient care, drug and/or alcohol rehabilitation programs, community adjustment programs, individual, group, or family therapy, or chemotherapy." 730 ILCS 5/5-2-4(a) (West 2012).

¶ 24 A defendant in Department custody pursuant to section 5-2-4 may petition the court for discharge or conditional release, whereupon a hearing shall be held where the defendant shall have the benefit of counsel who can confront and cross-examine witnesses and may beforehand demand an IPE by a psychiatrist or clinical psychologist not employed by the Department. 730 ILCS 5/5-2-4(c), (e), (f), (g) (West 2012). Such a hearing must also be held on the Department's written recommendation for a defendant's conditional release. 730 ILCS 5/5-2-4(d) (West 2012). In such a hearing, the court's findings "shall be established by clear and convincing evidence" and the burden of proof is on the defendant when the petition is filed by or for the defendant. 730 ILCS 5/5-2-4(g) (West 2012). The evidence in such a hearing:

> "may include, but is not limited to: (1) whether the defendant appreciates the harm caused by the defendant to others and the community by his or her prior conduct that resulted in the finding of not guilty by reason of insanity; (2) whether the person appreciates the criminality of conduct similar to the conduct for which he or she was originally charged in this matter; (3) the current state of the defendant's illness; (4) what, if any, medications the defendant is taking to control his or her mental illness; (5) what, if any, adverse physical side effects the medication has on the defendant; (6) the length of time it would take for the defendant's mental health to deteriorate if the defendant stopped taking prescribed medication; (7) the defendant's history or potential for alcohol and drug abuse; (8) the defendant's past criminal history; (9) any specialized physical or medical needs of the defendant; (10) any family participation or involvement expected upon release and what is the willingness and ability of the family to participate or be involved; (11) the defendant's potential to be a danger to himself, herself, or others; and (12) any other factor or factors the Court deems appropriate." 730 ILCS 5/5-2-4(g) (West 2012).

¶ 25 A defendant committed upon an NGRI disposition may be held only so long as he is both mentally ill and dangerous, and it is improper to require a guarantee of future behavior or harmlessness. *People v. Bethke*, 2014 IL App (1st) 122502, ¶ 18. Under section 5-2-4, the court may consider the crimes for which he received the NGRI disposition, his treatment history, and his current mental status in making its determination. *Id*. We reverse the court's decision only if it is manifestly erroneous or against the manifest weight of the evidence; that is, when the conclusion opposite to the court's decision is clearly evident. *Id*., ¶ 17; *People v. Robin*, 312 Ill. App. 3d 710, 715 (2000). It is not the mental health professionals who treat or evaluate a

defendant but the court as trier of fact who weighs the evidence and witness credibility. *In re Commitment of Rendon,* 2014 IL App (1st) 123090, ¶ 32, citing *Robin*, 312 Ill. App. 3d at 715.

¶ 26 Here, the undisputed evidence was that defendant is still suffering from mental illness, and the Department treatment team and Dr. Echevarria concurred that defendant still required the structured environment of inpatient care. Defendant notes the implicit stance of the treatment team and Dr. Echevarria's express opinion that he was not "at the present time" reasonably expected to cause serious physical harm to himself or another. However, as of the last Department treatment plan a few months before the hearing being appealed, defendant was expressing no remorse for the crime for which he received an NGRI disposition and indeed maintaining that his actions were justified. Unlike many other matters referenced in the treatment plan, this was not a matter of history but a present and ongoing concern for defendant's treatment team, and it is relevant to whether he is dangerous because it concerns his misperception of his violent actions. We consider it eminently reasonable and proper – and not at all equivalent to insisting on a guarantee of harmlessness – for the ongoing denial of such a crucial and fundamental acknowledgement to weigh negatively in evaluating whether defendant is reasonably expected to present a risk of serious harm to himself or others. Under the circumstances, we cannot find that the court's decision was against the manifest weight of the evidence or manifestly erroneous.

¶ 27 Accordingly, the judgment of the circuit court is affirmed.

¶ 28 Affirmed.