2019 IL App (5th) 150123-U

NO. 5-15-0123

IN THE

APPELLATE COURT OF ILLINOIS

FIFTH DISTRICT

In re ANTHONY G.	)	Appeal from the
	)	Circuit Court of
(The People of the State of Illinois,	)	Madison County.
	)	
Petitioner-Appellee,	)	
	)	
v.	)	No. 15-MH-39
	)	
Anthony G.,	)	Honorable
	)	Ben L. Beyers II,
Respondent-Appellant).	)	Judge, presiding.

JUSTICE CHAPMAN delivered the judgment of the court.
Presiding Justice Overstreet and Justice Cates concurred in the judgment.

ORDER

¶ 1 *Held*: The evidence was sufficient to prove that the respondent was subject to the involuntary administration of psychotropic medication because he exhibited both a deterioration in his ability to function and threatening behavior. However, the evidence was not sufficient to prove that the benefits of the proposed treatment outweighed the risks where the respondent's treating psychologist did not testify about the potential side effects of one of the drugs she wanted to administer to the respondent.

¶ 2 The respondent, Anthony G., appeals an order authorizing the involuntary administration of psychotropic medication. He argues that (1) there was insufficient evidence of a deterioration in his functioning where there was no evidence that his behavior was harmful to his health; (2) there was insufficient evidence that he exhibited threatening behavior because there was no evidence that he acted violently or that he intended to harm others; and (3) the State failed to

prove that the benefits of treatment outweighed the risk of harm because its expert witness did not testify about the side effects of one of the medications she intended to administer. We reverse.

¶ 3 Anthony G. has a lengthy history of mental illness. In February 2014, he was admitted to Chester Mental Health Center (Chester) after being found unfit to stand trial on a burglary charge in Cook County. He was previously admitted to various facilities for mental health treatment at least four times between 1981 and 1997.

¶ 4 Dr. Sanghee Kim-Ansbro was Anthony's treating psychiatrist at Chester from the time he was admitted. On March 11, 2015, Dr. Kim-Ansbro filed a petition to involuntarily medicate Anthony. She alleged that he was diagnosed with schizophrenia, undifferentiated type. She further alleged that Anthony was subject to involuntary administration of psychotropic medication due to a deterioration in his ability to function (see 405 ILCS 5/2-107.1(a-5)(4)(B)(i) (West 2012)) and threatening behavior (see *id.* § 2-107.1(a-5)(4)(B)(iii)). Dr. Kim-Ansbro requested permission to administer olanzapine, lorazepam, diphenhydramine, and divalproex to Anthony. She also requested that the court approve a total of five medications as alternatives to olanzapine and divalproex in case those drugs proved to be ineffective or Anthony experienced adverse side effects.

¶ 5 The hearing on the petition took place on March 26, 2015. Dr. Kim-Ansbro testified that she had diagnosed Anthony as suffering from schizophrenia, undifferentiated type. She explained that one symptom of his illness was disorganized thinking, as a result of which, Anthony was unable to carry on coherent conversations. Dr. Kim-Ansbro testified that less intrusive alternatives to medication, such as counseling, were not effective for Anthony due to his disorganized thinking and inability to carry on coherent conversations.

¶ 6 Asked to describe Anthony's "symptoms of deterioration," Dr. Kim-Ansbro testified that, in addition to his inability to "have meaningful and coherent conversations with others," Anthony refused to shower more than once every 5 to 10 days because he was afraid that he would catch a cold if he showered more frequently. She noted that this caused him to have body odor. Dr. Kim-Ansbro further testified that Anthony "also neglects personal hygiene and grooming," but she did not offer any examples other than his refusal to shower more frequently.

¶ 7 Dr. Kim-Ansbro was then asked to describe any instances of "threatening or aggressive behavior" exhibited by Anthony. She described several specific incidents, all of which occurred between November 2014 and March 2015. In three of these incidents, Anthony became agitated and angry because he believed that another patient defecated on the bathroom floor. In one incident, he spit on the floor and expressed dismay that there was "shit all over" the bathroom floor even though there was nothing there. In another incident, he threatened to beat another patient for defecating on the bathroom floor and making too much noise. In a third incident, Anthony pointed to another patient and said that he was "going to kill the man who shits all over the place." He also said, "I might be in jail tonight for murder if he keeps shitting on the floor."

¶ 8 Dr. Kim-Ansbro also described four incidents in which Anthony became agitated because staff members urged him to eat meals or take showers. During one incident, he threw food and spilled juice on the floor. During another incident, he yelled that "something is going to happen" to the staff member urging him to eat his breakfast. He then said that "somebody is going to blow her brains out." When urged on another occasion to eat his lunch, Anthony became agitated and he slammed his tray and utensils into the garbage. On another occasion, he refused to shower because he believed he had a sore on his stomach because another patient had caused a toilet to

overflow. He threatened to "bust" any staff member "in the face" if they tried to make him take a shower.

¶ 9 Dr. Kim-Ansbro testified about incidents involving other patients. During one argument with another patient, Anthony rolled up a magazine and waved it in the other patient's face. Another argument ensued when a patient asked a staff member to ask Anthony not to stand over him. Anthony threatened to "bust" the patient in the face. Dr. Kim-Ansbro testified that on another occasion, Anthony slapped another patient during an argument. When asked by staff to stop slapping the other patient, he became agitated and said, "I don't have to." Dr. Kim-Ansbro testified that Anthony's records indicated that one other argument with another patient took place, but she did not offer any specifics about this incident.

¶ 10 Finally, Dr. Kim-Ansbro testified about three additional incidents involving Anthony's conduct towards staff members. On one occasion, Anthony said "hi" to Dr. Kim-Ansbro and tapped her on the shoulder. She explained to him that he should not touch her, but he continued to tap her shoulder. When she went into the documentation station, Anthony became agitated. He yelled at her and pounded on the document station window. He then mooned her. In addition, Dr. Kim-Ansbro noted that there were two incidents in which Anthony followed female staff members and glared at them.

¶ 11 Dr. Kim-Ansbro testified about the benefits of the medications she wanted to administer to Anthony. She wanted to administer olanzapine, lorazepam, diphenhydramine, and divalproex. She was also requesting permission to administer risperidone, aripiprazole, haloperidol, and/or haloperidol decanoate as alternatives to olanzapine, and permission to administer oxcarbazepine as an alternative to divalproex. Dr. Kim-Ansbro explained that olanzapine and all four of the alternative medications are "anti-psychotic medications" that would benefit Anthony by making

his thinking more organized and reducing his aggression. She further explained that divalproex and oxcarbazepine would lessen Anthony's physical aggression and threatening behavior. Finally, she explained that lorazepam and diphenhydramine were intended to treat Anthony's anxiety and agitation.

¶ 12 Dr. Kim-Ansbro also testified about the potential side effects of most of the medications she wanted to administer. She explained that "typical anti-psychotics like Lorazepam, Risperidone, and Aripiprazole" can cause changes in blood pressure or heart rate, sedation, blurred vision, constipation, and urinary retention. She noted that there is "a black box warning for all the eight anti-psychotic medications" due to the potential for these medications to increase a patient's blood sugar, cholesterol, and triglycerides. She did not specify which drugs are included in this warning. Dr. Kim-Ansbro testified that haloperidol and haloperidol decanoate can cause hand tremors, Parkinson's Syndrome, tardive dyskinesia, and restlessness or sedation. She stated that possible side effects of lorazepam and diphenhydramine include blurred vision, dry mouth, tachycardia, constipation, and urinary retention. She testified that divalproex and oxcarbazepine can cause elevated liver enzymes, sedation, and skin rashes. Notably, Dr. Kim-Ansbro did not specifically address any of the potential side effects of olanzapine.

¶ 13 On cross-examination, Dr. Kim-Ansbro testified that Anthony was getting enough sleep and, although he was a picky eater, he was eating enough food. She acknowledged that although his refusal to shower more frequently caused body odor, it did not cause any serious health problems. Counsel for Anthony asked Dr. Kim-Ansbro if she believed that Anthony was "currently dangerous." Dr. Kim-Ansbro responded, "I would say he's potentially dangerous."

¶ 14 Anthony testified that he did not want to take medication because a doctor told him that it was "too much for [his] heart" and would make his heart beat too fast. His attorney asked him

multiple times if he wanted to harm anyone. Each time he said he did not want to hurt anyone. He was specifically asked if he wanted to kill other patients. He replied, "No, I—I don't want to kill him. I say someone in here going to kill him and eventually going to get killed."

¶ 15 Counsel also asked Anthony about the incident in which he tapped Dr. Kim-Ansbro on the shoulder. He responded, "I just touched her because I was kind of scared that what—what he did, he made me kind of—made me kind of like I'm a little girl or something." Anthony did not explain who he was talking about. He went on to describe an incident in which he was told to take a shower. He testified that he did not want to do so because someone had urinated on the floor.

¶ 16 When asked about his reluctance to go into the bathroom to shower, Anthony stated that another patient "dropped turds all over the floor." He then testified that a staff member "came and say, 'Anthony, what's wrong with you.' I said, 'you're trying to stay together this time.' I say, 'I'm going to hurt him, I'm going to hurt him, it's him.' " Although his testimony was somewhat incoherent, he indicated that the staff member told him not to harm the other patient, to which Anthony said he replied, "I ain't going to hit her."

¶ 17 The court found that Anthony exhibited both a deterioration in his ability to function and threatening behavior. See 405 ILCS 5/2-107.1(a-5)(4)(B)(i) & (iii) (West 2012). It further found that the benefits of the proposed treatment outweighed the risks of harm from the treatment. See *id*. § 2-107.1(a-5)(4)(D). The court granted the petition. This appeal followed.

¶ 18 Before addressing the merits of Anthony's claims, we must consider our jurisdiction to hear them. We begin by observing that this appeal is technically moot. Because the order authorizing the involuntary administration of psychotropic medication to Anthony has expired, this court cannot grant effective relief. See *In re Christopher C.*, 2018 IL App (5th) 150301, ¶ 12.

Generally, we do not have jurisdiction to render opinions that are purely advisory or to consider issues where our decision will not provide effective relief to any party. *Id*. ¶ 13. However, we do have jurisdiction over technically moot appeals if they fall into a recognized exception to the mootness doctrine. *Id*. Although there is no *per se* exception to the mootness doctrine for mental health cases, most mental health cases fall into one or more of the recognized exceptions. *In re Alfred H.H.*, 233 Ill. 2d 345, 355 (2009).

¶ 19 There are three recognized exceptions to the mootness doctrine. They are: (1) the public-interest exception, (2) the capable-of-repetition-but-evading-review exception, and (3) the collateral consequences exception. *Christopher C.*, 2018 IL App (5th) 150301, ¶ 13. Anthony argues that this case falls within all three exceptions, and the State acknowledges that the case falls within the capable-of-repetition-but-evading-review exception. Because we agree with both parties that this exception applies, we need not address the other two exceptions.

¶ 20 Under the capable-of-repetition-but-evading-review exception, we may consider issues that are technically moot if (1) the challenged action is of such short duration that the questions raised cannot be fully litigated before they become moot and (2) it is reasonably likely that the complaining party will be subjected to the same action again in the future. *Alfred H.H.*, 233 Ill. 2d at 358. The likely future action does not need to be identical to the action involved in this case to satisfy the second requirement. However, the two actions "must have a substantial enough relation that the resolution of the issue in the present case would be likely to affect a future case involving [the] respondent." *Id.* at 359.

¶ 21 We find that both of these requirements are satisfied in this case. Orders for the involuntary administration of psychotropic medication expire after 90 days. 405 ILCS 5/2-107.1(a-5)(5) (West 2012). This is not enough time to fully litigate issues related to such orders

before they expire. Thus, the first requirement is satisfied. See *In re Joseph M.*, 405 Ill. App. 3d 1167, 1175 (2010).

¶ 22 In addition, Anthony has a lengthy history of mental illness, making it reasonably likely that he will be subjected to proceedings for the involuntary administration of psychotropic medication in the future. See *id.* As noted earlier, however, there must be a substantial enough relationship between the issues raised in this case and the issues likely to arise in future cases that our resolution of this case will affect the outcome of future cases involving Anthony. See *Alfred H.H.*, 233 Ill. 2d at 359. Our Illinois Supreme Court has emphasized that arguments concerning the sufficiency of the evidence "are inherently case-specific reviews." *Id.* at 356-57. As such, review of such claims usually will not "be of use to [the] respondent in future litigation." *Id.* at 360. Here, all three of Anthony's arguments relate to the sufficiency of the evidence. However, the focus of his arguments is on the type of evidence the State must present to meet its statutory burden, not the weight of the particular evidence presented. See *In re Debra B.*, 2016 IL App (5th) 130573, ¶ 22. We find that such questions are substantially likely to recur, thereby satisfying the second requirement for review under the capable-of-repetition-but-evading-review exception. Because both requirements are satisfied, we may consider Anthony's arguments under the capable-of-repetition-but-evading-review exception.

¶ 23 Courts have long recognized that medicating a patient against his will involves a " 'massive curtailment of liberty.' " *In re Barbara H.*, 183 Ill. 2d 482, 496 (1998) (quoting *Vitek v. Jones*, 445 U.S. 480, 491 (1980)). As such, both the United States Supreme Court and the Illinois Supreme Court have held that mentally ill patients have a constitutionally-protected liberty interest in refusing psychotropic medications. *In re C.E.*, 161 Ill. 2d 200, 213 (1994) (citing *Washington v. Harper*, 494 U.S. 210, 221 (1990)). "Two fundamental concerns" underlie

the recognition of this right. *Id.* at 214. The first of these concerns is "the substantially invasive nature of psychotropic substances" and their potential for "significant side effects." *Id*. The second concern is the potential for misuse of psychotropic medications. The concern is that medical personnel might use these medications to manage or control patients rather than to treat them. *Id*. at 215.

¶ 24 Courts have also recognized, however, "that the state has a legitimate *parens patriae* interest in furthering the treatment" of mentally ill patients who are incapable of making reasoned decisions regarding their own treatment. *Id.* at 217. The statute authorizing the involuntary administration of psychotropic medication balances these important interests. See *id*. at 217-19. It provides that before a patient may be medicated against his will, a court must find by clear and convincing evidence:

> "(A) That the recipient has a serious mental illness or developmental disability.
>
> (B) That because of said mental illness or developmental disability, the recipient currently exhibits any one of the following: (i) deterioration of his or her ability to function, as compared to the recipient's ability to function prior to the current onset of symptoms ***, (ii) suffering, or (iii) threatening behavior.
>
> (C) That the illness or disability has existed for a period marked by the continuing presence of the symptoms set forth in item (B) *** or the repeated episodic occurrence of these symptoms.
>
> (D) That the benefits of the treatment outweigh the harm.
>
> (E) That the recipient lacks the capacity to make a reasoned decision about the treatment.

(F) That other less restrictive services have been explored and found inappropriate." 405 ILCS 5/2-107.1(a-5)(4) (West 2012).

The court must find that all six of these factors are present before it can authorize the administration of medication to an unwilling patient. *In re Gail F.*, 365 Ill. App. 3d 439, 446 (2006). In addition, if the petition also requests authorization for tests or other procedures, the court must find that the tests or procedures requested are "essential for the safe and effective administration of the treatment." 405 ILCS 5/2-107.1(a-5)(4)(G) (West 2012).

¶ 25 As noted, the court must be convinced of each factor by clear and convincing evidence. *Debra B.*, 2016 IL App (5th) 130573, ¶ 37. Clear and convincing evidence is something "more than a preponderance" that does not "reach the degree of proof necessary to convict a person of a criminal offense." *In re M.T.*, 371 Ill. App. 3d 318, 323 (2007). On appeal from an order authorizing involuntary treatment, we review the trial court's factual findings to determine whether they are against the manifest weight of the evidence. *Debra B.*, 2016 IL App (5th) 130573, ¶ 24. However, we review *de novo* the question of whether the State has complied with these statutory requirements. *Christopher C.*, 2018 IL App (5th) 150301, ¶ 18.

¶ 26 Here, the petition alleged and the court found that Anthony exhibited two of the symptoms listed in section 2-107.1(a-5)(4)(B)—a deterioration in his ability to function and threatening behavior. See 405 ILCS 5/2-107.1(a-5)(4)(B) (West 2012). We note that the State was only required to prove that one of these symptoms was present. *Debra B.*, 2016 IL App (5th) 130573, ¶ 35; *In re Lisa P.*, 381 Ill. App. 3d 1087, 1095 (2008). Anthony argues that the evidence did not support a finding that either of these symptoms was present. We disagree.

¶ 27 Anthony argues that the evidence did not establish a deterioration in his ability to function sufficient to warrant involuntary medication because there was no evidence that any of

his behavior was harmful to his health. As he points out, Dr. Kim-Ansbro testified that he was eating and sleeping enough and that his refusal to shower more frequently did not pose a serious risk to his health. He contends that, absent clear and convincing evidence that a patient's "general health is at risk," we must reverse the court's finding that he exhibited a deterioration in his ability to function. We disagree.

¶ 28 In *Debra B.*, this court addressed the question of what type of evidence must be presented to show that a patient's ability to function has deteriorated. There, the respondent's treating psychiatrist testified that the respondent aggravated other patients. He explained that she frequently got "into the business" of other patients. She also accused other patients of engaging in phone sex and other unspecified misconduct. *Id*. ¶ 6. On appeal from an order authorizing the involuntary administration of psychotropic medications, Debra B. argued that this evidence was insufficient to prove that her ability to function had deteriorated. In particular, she argued that in order to show that a patient's ability to function has deteriorated, "the State must prove that the respondent's behavior endangers her own health or threatens others." *Id*. ¶ 50. That is precisely the argument Anthony makes here. Although we ultimately agreed with Debra B. that the evidence in that case did not support the court's finding, we expressly rejected this argument. We explained that we found this requirement "too constricted." *Id*. We held that in order to meet its burden, the State must demonstrate that the patient's "ability to function on a basic level" had deteriorated. *Id*. We emphasized that to do so, the State must show something more than the fact that the respondent suffers from a mental illness. *Id*. ¶ 36.

¶ 29 In reversing the trial court's finding that Debra B. exhibited a deterioration in her ability to function, we emphasized that much of her psychiatrist's testimony on this question focused on her interactions with other patients. *Id*. ¶ 49. We explained that "[i]f the main goal in

administering psychotropic medication is to modify nonthreatening behavior toward other patients, this raises serious questions concerning whether the medication is being used primarily as a means of managing her behavior rather than as a means of treating her illness." *Id.* We also found that the evidence showed that "Debra was able to function reasonably well, at least in the environment of the facility." *Id.* ¶ 52. For example, both Debra and her psychiatrist testified that Debra participated in therapy sessions. Debra testified that she forced herself to get up and take a shower even when she felt tired so that she would be permitted to use the facility's "comfort room," a room with a recliner, stereo, and puzzles. *Id.*

¶ 30 Here, by contrast, the evidence showed that Anthony was unable to communicate coherently, and that he was afraid to take regular showers—a basic function of self-care—due to an irrational fear that doing so would make him ill. This is precisely the type of deterioration in ability to function that supports an order for the involuntary medication of a mentally ill patient. See, *e.g.*, *In re Wendy T.*, 406 Ill. App. 3d 185, 194 (2010) (upholding a trial court's finding of a deterioration in the respondent's ability to function where there was evidence that she was unable to "carry on everyday conversations, accept and process what other people say, make decisions, or execute simple tasks"), *overruled on other grounds by In re Rita P.*, 2014 IL 115798, ¶¶ 33-34; *In re Perona*, 294 Ill. App. 3d 755, 766 (1998) (affirming the trial court's finding of a deterioration in ability to function where the evidence showed that the respondent was unwilling to keep his clothes on, that he was depressed, and that he was not eating regularly). We conclude that the evidence was sufficient to show a deterioration in Anthony's ability to function.

¶ 31 Anthony next argues that the evidence was insufficient to prove that he exhibited threatening behavior. We disagree.

¶ 32 In support of his contention, Anthony correctly notes that the State must provide evidence of something more than loud or disruptive behavior in order to demonstrate that a respondent exhibits threatening behavior. See, *e.g.*, *In re Jennifer H.*, 333 Ill. App. 3d 427, 431 (2002) (explaining that the pertinent statute was amended to remove language permitting patients to be involuntarily medicated if they exhibited "threatening or disruptive behavior"); *In re Jones*, 285 Ill. App. 3d 8, 11-13 (1996) (reversing an order for involuntary medication where there was evidence that the respondent was loud, disruptive, and delusional, but "no evidence of actual suffering, loss of ability to function, or threatening behavior"). He is also correct in pointing that *some* of the numerous incidents described by Dr. Kim-Ansbro involved conduct that was disruptive or inappropriate but not threatening. For example, she testified that Anthony glared at staff members, threw food, poured his juice on the floor, and spit on the floor, and he mooned her when she told him not to tap her shoulder. One of the arguments he had with another patient apparently did not involve any physical aggression or verbal threats. We agree with Anthony that evidence of these incidents, standing alone, would not support a finding that he exhibited threatening behavior.

¶ 33 Significantly, however, these incidents did *not* stand alone. Dr. Kim-Ansbro also described incidents in which Anthony explicitly threatened to beat another patient and threatened to "bust the faces" of a patient who angered him and the staff members who coaxed him to eat or told him to take a shower. She also described an incident in which he stated multiple times that he would kill a patient he believed was defecating on the bathroom floor. Anthony acknowledged during his testimony that he told a staff member that he wanted to hurt another patient who "dropped turds all over the [bathroom] floor." Dr. Kim-Ansbro also described one incident in which Anthony actually struck another patient and other incidents in which he

demonstrated physically intimidating behavior—for example, pounding on the window of the documentation station and waving a magazine in a patient's face.

¶ 34 Anthony acknowledges that courts have found evidence of acts of physical violence and/or specific verbal threats to be sufficient to support a finding of threatening behavior. See, *e.g.*, *In re Robert S.*, 213 Ill. 2d 30, 36, 40-41, 53-54 (2004) (evidence that a respondent threatened to kill another patient and made multiple telephone calls to an assistant state's attorney telling her that they were "supposed to be together" was sufficient to establish threatening behavior); *In re R.K.*, 338 Ill. App. 3d 514, 516-17, 521 (2003) (evidence that the respondent struck two staff members, threw a paper bag on the floor and kicked its contents across the floor, and experienced periodic episodes of agitated and aggressive behavior was sufficient to prove that she exhibited threatening behavior). He argues, however, that while the State may have proven that he has exhibited threatening behavior in the past, it failed to prove that he was currently exhibiting threatening behavior at the time of the hearing. We disagree.

¶ 35 In support of his claim, Anthony emphasizes Dr. Kim-Ansbro's opinion that he is "potentially dangerous" rather than "currently dangerous." He also points to the precise timing of the incidents she described. He notes that with one exception, none of the incidents occurred during the two weeks preceding the hearing. Dr. Kim-Ansbro acknowledged that no similar incidents occurred during that time period either. Anthony acknowledges that one of the incidents she described took place on March 19, 2015, one week before the hearing. In that incident, he followed a staff member and glared at her. He argues that evidence of that incident does not support a finding of threatening behavior. We are not persuaded.

¶ 36 The State is required to prove that the respondent "*currently* exhibits" any of the three symptoms necessary to support an order for involuntary medication. (Emphasis added.) 405

ILCS 5/2-107.1(a-5)(4)(B) (West 2012). It must also prove that the respondent's mental illness has been "marked by the continuing presence *** *or the repeated episodic occurrence* of these symptoms." (Emphasis added.) *Id.* § 2-107.1(a-5)(4)(C). The State's evidence, viewed in its entirety, was sufficient to prove that at the time of these proceedings, Anthony was exhibiting regular repeated episodes of threatening behavior. We conclude that the State met its burden of demonstrating that Anthony exhibited both a deterioration in his ability to function and threatening behavior.

¶ 37 Anthony next argues that the State failed to provide clear and convincing evidence that the benefits of the proposed treatment outweighed the harm. He argues that the State failed to meet its statutory burden because it did not provide specific evidence concerning the potential side effects of olanzapine, one of the medications Dr. Kim-Ansbro sought permission to administer. We agree.

¶ 38 As we have already discussed, the State was required to prove by clear and convincing evidence that the benefits of the proposed treatment outweighed the risk of harm. *In re Louis S.*, 361 Ill. App. 3d 774, 781 (2005) (citing 405 ILCS 5/2-107.1(a-5)(4)(D) (West 2004)). This requirement—like all of the statutory requirements for authorizing involuntary treatment—is not a technicality; it is "intended to safeguard the important liberty interests of the patient." *In re Larry B.*, 394 Ill. App. 3d 470, 475 (2009). The State cannot satisfy its statutory obligation by presenting an expert witness's bare opinion that the benefit of treatment outweighs the harm; the expert's opinion must be supported by specific facts and information. *In re Alaka W.*, 379 Ill. App. 3d 251, 263 (2008). This requires the State to provide evidence concerning the benefits and potential side effects of *each* medication sought to be administered. *Larry B.*, 394 Ill. App. 3d at

476; *Alaka W.*, 379 Ill. App. 3d at 263; *Gail F.*, 365 Ill. App. 3d at 446-47; *Louis S.*, 361 Ill. App. 3d at 781-82.

¶ 39 The State acknowledges that this is law. It argues, however, that even though Dr. Kim-Ansbro did not "specifically refer to Olanzapine" in her testimony about potential side effects, she nevertheless described its potential side effects when she discussed the side effects of "typical anti-psychotic" medications. We are not persuaded.

¶ 40 The State's argument would require the court to make two assumptions. First, the court would have to assume that olanzapine is, in fact, a "typical anti-psychotic" medication similar to as lorazepam, risperidone, and aripiprazole. Second, the court would have to assume that it has the same side effects as those drugs. Making such assumptions is problematic because, as our supreme court has recognized, the treatment of mental illness is a "highly specialized area of medicine." See *In re Mary Ann P.*, 202 Ill. 2d 393, 406 (2002); *C.E.*, 161 Ill. 2d at 229. Accepting the State's argument would allow a trial court to find that the benefit of the proposed treatment outweighs the harm in cases where it must fill in gaps in the testimony of a qualified expert by making assumptions and inferences it is not qualified to make.

¶ 41 Further, even if the court could properly infer from Dr. Kim-Ansbro's testimony that olanzapine has all of the side effects she described when discussing the side effects of "typical anti-psychotics like Lorazepam, Risperidone, and Aripiprazole," we do not believe it would be appropriate for the court to simply assume that olanzapine has no additional side effects. Indeed, the variance among individual drugs is one of the reasons psychiatrists request alternative medications. We therefore hold that, in order to meet its burden of proving by clear and convincing evidence that the benefit of the proposed treatment outweighs the risk of harm, the

State must provide express expert testimony concerning the risks and benefits of each medication it seeks permission to administer. In this case, the State failed to meet its burden.

¶ 42 Finally, we note that although the State did not present the court with all of the required information about the benefits and risks of olanzapine, it did present the requisite information about all of the other medications requested by Dr. Kim-Ansbro. We must nevertheless reverse the court's order in its entirety. Neither this court nor the trial court may selectively authorize fewer than all of the medications requested by a physician as part of the treatment she seeks to administer. *Mary Ann P.*, 202 Ill. 2d at 405-06. As our supreme court has explained, it is the role of the physician to determine an appropriate course of treatment. *Id*. at 406. The court's role is to determine whether the benefits of that treatment outweigh its harms. *Id*. at 405. Because the State did not provide the court with all of the information it needed to make this determination, the order authorizing the involuntary administration of all nine medications must be reversed.

¶ 43 For the foregoing reasons, we reverse the order of the trial court authorizing the involuntary administration of psychotropic medication to Anthony G.

¶ 44 Reversed.