2014 IL App (2d) 130985-U
No. 2-13-0985
Order filed May 20, 2014

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IN THE

APPELLATE COURT OF ILLINOIS

SECOND DISTRICT

In re MIGUEL G., Alleged to be a Person Subject to Involuntary Admission,	)	Appeal from the Circuit Court of Kane County.
	)	
	)	No. 13-MH-131
	)	
(The People of the State of Illinois, Petitioner-Appellee, v. Miguel G., Respondent-Appellant).	)	Honorable William Parkhurst, Judge, Presiding.

JUSTICE JORGENSEN delivered the judgment of the court.
Justices Hutchinson and Hudson concurred in the judgment.

ORDER

¶ 1 *Held*: The trial court properly found respondent subject to involuntary admission, but the cause is remanded with directions to correct a ministerial error in a notice to State police. Affirmed and remanded with directions.

¶ 2 Respondent, Miguel G., appeals from the trial court's order finding him subject to involuntary admission and hospitalization for up to 90 days. He argues that: (1) several exceptions to the mootness doctrine apply, allowing this court to review his appeal; (2) the State failed to prove that he was subject to involuntary admission on an inpatient basis due to mental illness-related dangerousness (405 ILCS 5/1-119(1) (West 2012)); (3) the legislative intent of section 3-810 of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/3-

810 (West 2012)) was not met where the predisposition report did not comply with the statute and was uncured by testimony and where no less restrictive treatment alternatives were sufficiently considered; and (4) a ministerial error warrants correction of the notification to the State police.

¶ 3 I. BACKGROUND

¶ 4 On August 15, 2013, Dawn Salveson, a mental health professional, filed a petition for emergency inpatient involuntary admission of respondent. (Respondent was admitted to Presence Mercy Behavioral Health (Mercy) that day.) Salveson asserted that respondent had paranoid thoughts and was suspicious of drinking water, believing it was contaminated. His mother reported that he had taken apart all electronics and lights in the home "due to being watched."

¶ 5 The petition was subsequently amended to proceed on allegations that, due to his mental illness, unless treated on an inpatient basis, respondent was reasonably expected to physically harm himself or another. The petition also alleged that respondent was unable to provide for his basic physical needs so as to guard himself from serious harm and asserted that he is in need of immediate hospitalization. Dr. Darrell C. Powe examined respondent and prepared an inpatient certificate. He stated that respondent exhibited paranoia and believed that family and hospital personnel are trying to poison him. He had been disruptive at home, experienced decreased sleep, was agitated, and had multiple recent arrests. Dr. Powe also wrote that respondent had been dismantling electronic devices at home, reportedly looking for monitoring devices.

¶ 6 The hearing was held on August 27, 2013.[1] Dr. Ramon Alvarez-Leonardo, a psychiatrist at Dreyer Medical Clinic, testified that he performed a psychiatric examination of respondent and

[1] The initial hearing date was set for August 20, 2013, but it was continued on

reviewed his medical records and spoke with hospital staff. Dr. Alvarez diagnosed respondent with psychosis not otherwise specified (NOS), which is considered a serious mental illness. He explained that a patient with the disorder does not meet the strict criteria of DSM-4TR of schizophrenia, schizoaffective disorder, "schizophphreniform." Thus, psychosis NOS is diagnosed "when they have psychotic symptoms but don't meet the criteria for the formal diagnosis of the other conditions." The characteristics of the disorder include hallucinations and delusions (typically paranoid delusions or delusions of grandeur). Persons with the disorder typically have no insight into their condition, feeling that there is nothing the matter with them. Dr. Alvarez explained that respondent's diagnosis is sort of a "catchall" disorder, which is used when there are psychotic symptoms but there is inadequate information to make a diagnosis. It is also used when there is contradictory information regarding the patient's symptoms. Dr. Alvarez testified that there was no evidence that respondent experienced auditory or visual hallucinations, nor has he observed respondent to be catatonic.

¶ 7 Respondent, in Dr. Alvarez's opinion, does not have insight into his condition and has displayed paranoid delusions and grandiosity. On admission, respondent's mother reported that, when she returned from vacation, respondent had ransacked the home. He had taken apart a lot of electronics, thinking they contained a listening device. Respondent also had turned off/unplugged the lights so that it would be dark because he believed he was being watched. Because of these paranoid delusions, he became quite agitated. Respondent climbed to the roof, fell off, and injured his leg.

¶ 8 Dr. Alvarez addressed his opinion that respondent, because of his mental illness, is likely, unless treated on an inpatient basis, to place himself or another in physical harm. He based his

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respondent's motion to August 27, 2013.

opinion on respondent's aggressive behavior and the need to be placed in restraints. Respondent's primary symptoms are his unpredictability and his violence toward others. On two occasions since his admission, he had been put in four-point restraints (August 23, and 26, 2013). Throughout his stay at Mercy, respondent had been quite aggressive and angry and irritable with staff. He had been doing a lot of posturing and "almost intimidating staff and peers."

¶ 9 Addressing the first incident, which occurred on August 23, 2013, Dr. Alvarez testified that respondent hit a staff member (presumably a nurse). He had slept only two hours and had been verbally threatening staff. One staff member contacted Dr. Alvarez and reported to him that respondent had struck her in the chest. The hospital security service was called, "but it was apparent that this would not be enough." Thus, the Aurora police department was contacted. In total, six people were required to restrain respondent, and he was involuntarily medicated.

¶ 10 Addressing August 26, 2013, Dr. Alvarez testified that respondent hurt a staff member by slamming a door on her. He had only about 3.8 hours of sleep that evening and was very verbally aggressive and "somewhat menacing towards the one-to-one sitter."[2] Respondent wanted his door shut, which is against policy. "The one-on-one sitter tried to keep it open, and the door was slammed, catching the sitter's arm." Respondent continued to be aggressive. He spit and was warned that he would receive an injection to calm him down. Security staff came, but it was not sufficient. Again, the Aurora police department was contacted. Respondent was given the "IM medication Geodon" (two milligrams) and then placed in four-point restraints.

¶ 11 Since admission on August 15, 2013, respondent was involuntarily medicated on only two occasions (August 23, and 26, 2013). Addressing the evening before his testimony, Dr.

[2] A one-to-one sitter is assigned to patients who are actively suicidal, actively homicidal, or are at risk of being aggressive toward others. They are watched at all times.

Alvarez explained that respondent had been somewhat better, but still did not get any sleep overnight; he was somewhat restless and pacing. Respondent's pacing and restlessness could be symptoms of the disorder. "He still remains very unpredictable and labile in his mood. At one point, when he was in a group, [he] was claiming that he could read the minds of some of his peers during group." This is an example of a delusion of grandeur.

¶ 12 Dr. Alvarez opined that respondent, who is at the facility involuntarily because he would not sign in, needs continued hospitalization for the prevention of harm. (Respondent has requested to be discharged.) The Department of Human Services is the least restrictive environment that is appropriate at this time. A less restrictive setting, such as a halfway house or group home, would not be appropriate because respondent's "behavior has been so unpredictable while he's been here. My concern is that he will harm others or harm himself." Dr. Alvarez further opined that respondent is not psychiatrically stable enough for a less restrictive setting.

¶ 13 Addressing respondent's treatment plan, Dr. Alvarez explained that it is "fairly standard" and includes medication (specifically, an antipsychotic, "Olanazpine at ten milligrams PO, QHS, at bedtime"). Respondent is expected to attend group sessions to be educated about his medication and condition. However, he has not been (presumably reliably) attending group sessions. Respondent is also assessed as to his interaction with staff "one to one, again he has not been engaging in that behavior." Dr. Alvarez estimated that it would take two to four weeks to attain the foregoing goals. He sought a commitment period of 90 days.

¶ 14 Addressing respondent's speech, Dr. Alvarez explained that, at times, respondent's thought process is tangential, circumstantial, and not easily re-directable. Respondent, at times, will talk about things other than what Dr. Alvarez is asking about or becomes fixated on topics that have already been covered, such as what he needs to do to be discharged. "But with time, if

he's allowed to continue speaking, again he becomes very circumstantial and really tangential and doesn't make a lot of sense." Respondent refused to give a urine sample for a drug screen, which could be related to his paranoia. Respondent is very guarded and does not provide a lot of information; he takes control of an interview, wanting to answer his own questions.

¶ 15 Addressing respondent's delusions, Dr. Alvarez testified that, at one point when respondent was in the emergency room, he was offered water. Respondent would take it only if it was sealed water because "he thought that maybe somebody would put something in it." At Mercy, however, respondent is taking the water and food that is offered to him. Addressing respondent's history, Dr. Alvarez testified that he was previously diagnosed at his first admission with schizoaffective disorder, which, in his view, was too specific a diagnosis. He referred to respondent's "behavior initially on admission back in November of 2012 in which he again came in in a very aggressive manner, again needed to be restrained[.]" Respondent claimed to have attention deficit disorder, and he was on Vyvanse (60 milligrams) prior to coming to Mercy.

¶ 16 Addressing substance abuse, Dr. Alvarez testified that respondent admitted to smoking synthetic marijuana prior to his admission. He did not self-report taking any other drugs. Dr. Alvarez stated that synthetic marijuana can cause psychotic symptoms. It binds to certain receptors and can case someone to present with auditory and visual hallucinations, aggression, paranoia, and catatonia. When asked if respondent's problems could have been caused by his use of synthetic marijuana or from a mental illness, Dr. Alvarez stated: "I don't know for certain. *** [I]n my professional opinion *** [respondent] does have underlying psychiatric issues and [ ] smoking synthetic marijuana will exacerbate his symptoms." He explained that he has seen a lot of patients who present as agitated and need to be restrained and then "suddenly, they clear up[.]" Respondent's symptoms have not improved and are still bad or worse. This could not be

consistent with someone who was simply acting out or because of synthetic marijuana use. Dr. Alvarez testified that he is unaware how long the intoxication from synthetic marijuana lasts. Besides intoxication, the synthetic marijuana can affect someone's psychiatry by inducing psychotic behavior, which can last longer than the intoxication.

¶ 17 Dr. Alvarez testified that he is concerned for his safety when he meets with respondent. He no longer meets with him in a private room, but sees him in a common area or in a room across from the cafeteria with the door open. Since his admission, respondent has become more threatening, harmful, and violent. Dr. Alvarez is unaware if this behavior is a product of smoking marijuana. Even if respondent's behavior is triggered by the use of drugs, Dr. Alvarez's treatment plan would not be different.

¶ 18 The State rested.

¶ 19 Cordelia G., respondent's mother, testified that she lives in Aurora with her husband, daughter, and respondent. Prior to his hospitalization, respondent worked at The Sunglass Hut in North Aurora. He knows how to handle money. Respondent was diagnosed with attention deficit disorder in middle school. Off and on, he received medication (Vyvanse and, previously, Adderall) to treat it. Also as to respondent's history, Cordelia stated: "[t]hey let him—once he got a shot, they let him out the next day, and the doctor never would call me back to—I would say he's a zombie, and you know, I don't like the way he's looking or acting; and, he did end up back in the emergency room because his throat was closing up or whatever, and he had to get some Benadryl pumped into him."

¶ 20 In the days leading up to his hospitalization at Mercy, Cordelia noticed that respondent was not himself; he had not slept and was despondent. She assumed he was taking his medication because she noticed that he had his prescription refilled on August 2, or 3, 2013. She

also suspected he used marijuana. When Cordelia, her husband, and their daughter returned from vacation on a Sunday night, they noticed unscrewed light bulbs in the house. (Respondent did not join the rest of the family on vacation because he works on weekends.) Respondent had also taken apart the motion detector in the alarm system. Cordelia testified that respondent believed there were recording devices in the electronics. However, he left his parents' and their daughter's rooms alone. Respondent stated that the lights were bothering him. When she returned from vacation, she did not want to be too confrontational with respondent because she did not want to agitate him. He was agitated and "hollering" and wanted things quiet. Respondent told his father to get rid of things that smelled. Cordelia attributed this behavior to the Vyvanse. Respondent did not become violent with Cordelia, but he became agitated and aggressive with the members of the household.

¶ 21 Cordelia further testified that, if respondent is released from Mercy, he would be allowed to stay in the family home. Cordelia does not fear any harm from him, nor does she believe anyone else in the home fears any harm from respondent. She would assist him in seeing a psychiatrist and receiving any outpatient services. Cordelia would also ensure he attends appointments and follows up with doctors. Cordelia is concerned about respondent being committed for 90 days.

¶ 22 Cordelia's husband does not work because he is disabled, and her daughter started college. When asked who would care for respondent if he was discharged, Cordelia stated that she does not feel that he needs daily care. She believes that he can go to work and the gym. If respondent needs to be taken to treatment, Cordelia's daughter could drive him or he could drive himself. Cordelia testified that, if needed, she could (and would) take off of work to assist respondent. "We would figure it out." However, she was unaware of his behavior since his

admission. Cordelia further testified that respondent has twice been arrested in the last two years, one of which involved a traffic ticket.

¶ 23 Respondent testified that he is 20 years old and has completed about two years of college. If he were discharged, he would be able to get his job back at The Sunglass Hut. When he was 10 years old, he was diagnosed with attention deficit disorder. He has taken various medications for the condition, including Strattera, Adderall, Vyvanse, Ridalin, and Concerta.

¶ 24 Prior to his hospitalization, he took Vyvanse. His prescribed dosage is 30 milligrams, but the pharmacy gave him 60 milligrams. He took the new pills on the Sunday (*i.e.*, August 11, 2013) before his hospitalization and the following two days. Vyvanse makes respondent feel focused. In this instance, however, he believes he took too much of the drug. He felt restless and less focused, but it relieved his pain and perked him up when he was down from the injury to his leg. When asked why he took the 60-milligram Vyvanse pill, respondent stated that he did not notice that it was the wrong dosage when he took the first pill. Respondent does not believe that he suffers from a mental illness other than attention deficit disorder, which he feels he has "somewhat grown out of." The Vyvanse helps him when he needs it.

¶ 25 Also, two days before his admission, respondent also went out with friends and consumed one cigar (about one gram) of synthetic marijuana.

¶ 26 Respondent denied that he believed people were watching him. He did, however, have "some indication" that people were watching him. He believes that he felt this way because he took more than the prescribed dosage of Vyvanse. Respondent testified that he has been consuming the food and drinking the water at Mercy. Respondent denied that he struck a nurse in the chest on August 23, 2013. He conceded, however, that he had an altercation with one. He had been taking Ativan, and it made him feel "somewhat not really myself" and he "did attempt

to swipe for her badge." Respondent denied resisting the Aurora police officers or hospital security personnel. Addressing August 26, 2013, respondent explained that he was again on Ativan and that hospital rules prohibited closed doors. When he awoke that day, there was a lot of noise and "I kind of got agitated" and restless. Respondent attempted to shut the door and the one-to-one sitter's "hand was in the door."

¶ 27 Since his admission, respondent has not feared that he is being watched. Respondent testified that no one has discussed any outpatient options with him or offered any group therapy sessions. However, respondent also testified that he was able to participate in the majority of the group therapy sessions that were offered at Mercy (up to three per day): "It went well. I felt like it was effective as far as therapy." There was no time during the therapy that he thought he was reading other people's minds, and he denied that he stated as such. If released, respondent is open to seeking psychiatric treatment, though he does not know where he would receive it.

¶ 28 Respondent explained that he injured his leg by falling 10 to 15 feet from a roof. Respondent had locked himself out of the house (on the Sunday that his family was to return from vacation) and attempted to enter by climbing onto the roof to access a window. He has not received treatment for it because he does not think it is broken; he ices it.

¶ 29 Dr. Alvarez was recalled by respondent and testified that respondent has taken Ativan since his admission, as needed, including on August 23, and 26, 2013. Also, "there's been other times where he has—he's requested Ativan for feeling a little bit anxious, a little bit irritable; he's asked for it, or they have offered it to him, and he's taken it." Dr. Alvarez has never observed respondent have an adverse reaction to the drug, nor has respondent reported one to him.

¶ 30 Describing attention deficit disorder, Dr. Alvarez testified that it is a psychiatric disorder and persons with the disorder can experience restlessness and disorganized thought processes. They can pace and have labile moods, which includes irritability ("be a little short fused"), but not aggression or lashing out.

¶ 31 When asked if it is common for people on Ativan, which is a benzodiazepine, to act out because of it, Dr. Alvarez testified that it can cause such a reaction, but generally in older patients (older than 60 years old) and patients with dementia.

¶ 32 The trial court found respondent subject to involuntary admission and ordered hospitalization at Mercy for a period not exceeding 90 days. The court found that the State had proved by clear and convincing evidence that respondent suffers from a psychological disorder—psychosis NOS. Finding Dr. Alvarez's testimony credible, the court further found that, because of the disorder, respondent has been violent toward others and "perhaps" placed himself at risk (noting the leg injury). The court noted that Dr. Alvarez specifically addressed that less restrictive alternative to involuntary admission, such as a group home, "is not a possibility at this time" and not appropriate given respondent's instability and psychiatric health. Finally, addressing respondent's use of synthetic marijuana, the court found, based on Dr. Alvarez's testimony, that it "could trigger the mental illness that [respondent] is suffering from; but regardless of what was the cause of the trigger of this illness becoming worse, the treatment according to the doctor is the same. And it's what's been outlined in the treatment plan that the doctor testified to." Respondent appeals.

¶ 33 II. ANALYSIS

¶ 34 A. Mootness

¶ 35 Initially, we note that, with the exception of the last issue in this appeal, this case is moot, because the August 27, 2013, order involuntarily committing respondent for a period of 90 days has expired. 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.

¶ 36 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: (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 order could have consequences for a party in some future proceedings. See *In re Alfred H.H.*, 233 Ill. 2d 345, 355-62 (2009); *In re J.T.*, 221 Ill. 2d at 350. The questions presented when considering whether an exception to mootness applies are purely legal and we review them *de novo*. *In re Alfred H.H.*, 233 Ill. 2d at 350.

¶ 37 Here, the State concedes that the collateral-consequences exception applies. We agree. The collateral-consequences exception allows a reviewing court to consider a case that is otherwise moot where an order for involuntary treatment "could return to plague the respondent in some future proceedings or could affect other aspects of the respondent's life." *In re Val Q.*, 396 Ill. App. 3d 155, 159 (2009); see also *In re Dawn H.*, 2012 IL App (2d) 111013, ¶ 13. Moreover, courts have applied the collateral-consequences exception because the fact that a respondent has a mental illness and is a danger to himself or herself means the respondent will

likely be subject to future proceedings that could be adversely affected by his or her first involuntary order. *In re Gloria C.*, 401 Ill. App. 3d 271, 276 (2010).

¶ 38 Here, the record reflects that respondent was previously hospitalized and diagnosed with a mental illness on at least one prior occasion, although it does not reflect whether or not the hospitalization was involuntary. During his testimony, Dr. Alvarez referred to respondent's "behavior initially on admission back in November of 2012 in which he again came in in a very aggressive manner, again needed to be restrained[.]" Furthermore, Cordelia stated: "They let him—once he got a shot, they let him out the next day, and the doctor never would call me back to—I would say he's a zombie, and you know, I don't like the way he's looking or acting; and, he did end up back in the emergency room because his throat was closing up or whatever, and he had to get some Benadryl pumped into him." Further, she stated that he had a prior traffic ticket, but related no felony convictions. Where an involuntary treatment order is the respondent's first, collateral consequences could plague him or her in the future. *In re Val Q.*, 396 Ill. App. 3d 155, 159 (2009). Because the evidence reflects that respondent has a long term mental illness and need for medication, he is likely to be subject to future proceedings and the involuntary admission order at issue in this case could adversely affect him at that time. *Id.* at 160. Thus, we conclude that the collateral-consequences exception applies.

¶ 39 In light of our determination, we need not address the public-interest exception to mootness or the exception for issues capable of repetition yet avoiding review. See *In re Vanessa K.*, 2011 IL App (3d) 100545, ¶ 16.

¶ 40 B. Sufficiency of the Evidence

¶ 41 Turning to the merits, respondent argues first that the evidence was insufficient to prove that he was subject to involuntary admission under section 1-119(1) of the Code (405 ILCS 5/1-

119(1) (West 2012)). Respondent specifically argues that: (1) Dr. Alvarez's testimony did not establish that his symptoms were attributable to mental illness rather than to his pre-admission use of synthetic marijuana and his doubled dose of Vyvanse, or his occasional use, during hospitalization, of Ativan, his anti-anxiety medication; (2) the evidence did not show that, as a result of his mental illness, there was a reasonable expectation that he would place himself or another in harm should he not be hospitalized; and (3) Dr. Alvarez's testimony did not establish that hospitalization was the least restrictive alternative. For the following reasons, we reject respondent's sufficiency arguments.

¶ 42 "A petition for involuntary admission must assert that the respondent is suffering from a condition that requires immediate hospitalization in order to protect himself or others from harm." *Robert F.*, 396 Ill. App. 3d 304, 312 (2009) (citing 405 ILCS 5/3-601(a) (West 2008)). "The State must prove the allegations in the petition by clear and convincing evidence." *Id.* (citing 405 ILCS 5/3-808 (West 2008)). Proof of a mental illness, by itself, is insufficient to warrant involuntary admission and, "[t]o meet its burden, the State must submit 'explicit medical testimony' that the respondent is reasonably expected to be a serious danger to herself [or himself] or others as a result of [the respondent's] mental illness." *In re Tommy B.*, 372 Ill. App. 3d 677, 686 (2007) (quoting *In re James*, 191 Ill. App. 3d 352, 355 (1989)). "The court need not wait until respondent actually hurts himself [or herself] or another before involuntarily committing [the individual]." *Tommy B.*, 372 Ill. App. 3d at 687.

¶ 43 "Involuntary admission procedures implicate substantial liberty interests." *In re Robinson*, 151 Ill. 2d 126, 130 (1992). However, these interests are balanced against the dual objectives of involuntary admissions generally—to provide care for those who are unable to care for themselves—and to protect society from the dangerously mentally ill. *Id.* at 130-31.

¶ 44 "Because the [trial] court is in a superior position to determine witness credibility and to weigh evidence, we give great deference to the court's findings" (*In re Lisa G.C.*, 373 Ill. App. 3d 586, 594 (2007)), and its decision will not be overturned unless it is manifestly erroneous (*In re Bert W.*, 313 Ill. App. 3d 788, 798 (2000)). "A judgment will be considered against the manifest weight of the evidence 'only when an opposite conclusion is apparent or when the findings appear to be unreasonable, arbitrary, or not based on evidence.' " *In re Elizabeth McN.*, 367 Ill. App. 3d 786, 789 (2006) (quoting *In re John R.*, 339 Ill. App. 3d 778, 781 (2003)).

¶ 45 Section 1-119(1) of the Code defines persons subject to involuntary admission on an inpatient basis as including: "[a] person with mental illness who because of his or her illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed." 405 ILCS 5/1-119(1) (West 2012). The amended petition here was based, in part, on this provision, and the parties address the propriety of the court's ruling only as to this provision.

¶ 46 An examining physician may properly consider the respondent's complete medical history in forming an opinion about the respondent's current and future dangerousness. *In re Todd K.*, 371 Ill. App. 3d 539, 543 (2007). Section 1-119 of the Code provides: "In determining whether a person meets the criteria specified in paragraph (1), (2), or (3), the court may consider evidence of the person's repeated past pattern of specific behavior and actions related to the person's illness." 405 ILCS 5/1-119 (West 2012).

¶ 47 Respondent's first contention is that Dr. Alvarez's testimony did not establish that respondent's symptoms were attributable to mental illness rather than to his pre-admission use of synthetic marijuana and his doubled dose of Vyvanse prior to his admission, or his occasional use of Ativan, his anti-anxiety medication, during his hospitalization. Respondent claims that

Dr. Alvarez was uncertain whether respondent's symptoms were attributable to his recent use of synthetic marijuana or mental illness, but thought that the use of synthetic marijuana would have exacerbated respondent's psychiatric issues. Respondent also contends that, prior to admission, he inadvertently took a doubled dose of Vyvanse, his attention deficit disorder medication, which caused him to feel restless rather than focused. He also took Ativan while at Mercy for his anxiety. Dr. Alvarez, respondent argues, did not analyze his symptoms to determine their cause and never opined that they were due to the diagnosed psychosis NOS, rather than the other "equally speculative" causes for his behavior. Respondent contends that the evidence, therefore, was insufficient to show mental illness-related dangerousness. We disagree.

¶ 48 Dr. Alvarez testified that he examined respondent and reviewed his medical records and spoke with hospital staff. He diagnosed psychosis NOS, which he testified is a serious mental illness, with symptoms that include hallucinations and delusions. Dr. Alvarez also stated that persons with the condition have no insight into it and feel that there is nothing the matter with them. He explained that respondent does not have insight into his condition and had displayed paranoid delusions and grandiosity, and his primary symptoms are his unpredictability and his violence toward others. He noted that respondent had to be placed in four-point restraints on two occasions since his admission and that the Aurora police department had to be called to assist hospital staff in restraining him. Dr. Alvarez further explained that respondent, unless treated on an inpatient basis, could place himself or another in physical harm. He based his opinion on respondent's aggressive behavior and the need to be placed in restraints because of it.

¶ 49 Dr. Alvarez's testimony also addressed the paranoia he listed as one of respondent's symptoms. He noted (and this was corroborated by Cordelia) that, shortly before admission, respondent had dismantled electronic devices in his home, believing that they contained listening

devices. He also unplugged or turned off various lights to avoid being watched or, as reported by Cordelia, because he wanted things quiet. Respondent himself testified that he had "some indication" that people were watching him (although he attributes it to the extra dosage of Vyvanse). Respondent refused to give a urine sample for a drug screen, which could be related to his paranoia. Further, just prior to his admission, respondent became agitated, climbed on a roof, and then fell and injured his leg. At the hospital after admission, he refused to drink the water unless it was sealed, fearing that it was contaminated.

¶ 50 Dr. Alvarez opined that respondent's paranoid delusions caused him to become agitated. Respondent denied resisting hospital security personnel or the Aurora police officers, but conceded that he had an altercation with a nurse on August 23, 2013, although he denied striking her in the chest. He explained that the Ativan made him not feel himself and that he "did attempt to swipe for her badge." As to August 26, 2013, he conceded that he became "agitated" and restless and attempted to shut the door when the one-on-one sitter's "hand was in the door." He explained that he was again on Ativan. Dr. Alvarez testified that he is concerned for his own safety when he meets with respondent and sees him in a common area or with the door open.

¶ 51 Addressing respondent's delusions of grandeur, Dr. Alvarez related that, during group therapy, respondent claimed that he could read his peers' minds. (Respondent denied that he stated as such and at one point testified that he had not been offered group therapy.) He also explained that respondent's restlessness and pacing could also be symptoms of his disorder. Further, respondent's speech is circumstantial, tangential, and often does not make sense. However, he has not experienced hallucinations or been observed to be catatonic.

¶ 52 Addressing respondent's use of synthetic marijuana prior to his involuntary admission, Dr. Alvarez initially stated that he was uncertain whether respondent's symptoms could have

been caused by his drug use, although they would have been exacerbated by it: "I don't know for certain. *** [I]n my professional opinion *** [respondent] does have underlying psychiatric issues and [ ] smoking synthetic marijuana will exacerbate his symptoms." He explained that he has seen a lot of patients who present agitated and need to be restrained and, then, "suddenly, they clear up[.]" He also stated that he is unaware how long intoxication from synthetic marijuana lasts. However, Dr. Alvarez explained that respondent's symptoms have not improved since his admission and are still bad or worse. In his view, this is *not* consistent with someone who was simply acting out or because of synthetic marijuana use. We also note that respondent testified that he used the synthetic marijuana two days before his involuntary admission, which would have been August 13, 2013 (a *Tuesday*). However, Cordelia testified that respondent was agitated and aggressive when she and her family returned from vacation on the preceding *Sunday* evening (*i.e.*, August 11, 2013) and that he had dismantled electronic devices (believing they contained listening devices) and unscrewed light bulbs.

¶ 53 Addressing respondent's attention deficit disorder, Dr. Alvarez explained that persons who suffer from the condition can experience restlessness and disorganized thought processes and can pace and have labile moods, which include irritability. However, they do not exhibit aggression or lash out. We reject respondent's argument that his (pre-admission) taking of a double dose of Vyvanse, his attention deficit disorder drug, caused him to act (post-admission) in a physically threatening manner. Dr. Alvarez testified that respondent would not submit to urine or blood tests. Thus, his claim that he consumed a double dosage could not be verified. Also, Dr. Alvarez did not testify that aggressive behavior *following* admission (and when he was no longer taking the drug) could be a possible reaction to an increased dosage of Vyvanse *prior* to hospitalization.

¶ 54 As to Ativan, Dr. Alvarez explained that, typically, only older patients and those with dementia act out because of the drug. Respondent is 20 years old, and there was no evidence that he has dementia. Accordingly, we reject respondent's claim that Ativan could have caused his aggressive behavior on August 23, and 26, 2013. We also reject respondent's argument that, during his testimony, he explained his behavior (including on August 23, and 26, 2013) (*i.e.*, attributed it to lack of sleep and adverse reaction to medication) and that no evidence was presented "to counteract his heartfelt explanations." As noted, Dr. Alvarez testified that Ativan does not cause aggression in patients such as respondent.

¶ 55 Next, respondent argues that the evidence did not show that, as a result of his mental illness, there was a reasonable expectation that he would place himself or others in harm should he not be hospitalized. We disagree. On two occasions and within 12 days of hospitalization, respondent needed to be physically restrained (by hospital staff and police officers) after being aggressive against hospital personnel. As discussed above, we cannot conclude that the trial court erred in rejecting respondent's explanations that he had insufficient sleep and was under the influence of his medication. Further, Dr. Alvarez testified that he feared for his safety while with respondent and made accommodations to ensure he would be safe, such as not closing the door or meeting respondent in a common area. The trial court's adoption of Dr. Alvarez's determination that there was reasonable expectation that respondent might harm himself or others if not hospitalized was not against the manifest weight of the evidence.

¶ 56 Finally, respondent argues that Dr. Alvarez's testimony did not establish that hospitalization was the least restrictive alternative. He contends that an unsupported conclusion is not clear and convincing evidence that less restrictive treatment alternatives were inappropriate. See 405 ILCS 5/3-811 (West 2012). Although we do not dispute this assertion,

here, the evidence was sufficient to support a finding that hospitalization was the least restrictive alternative. Dr. Alvarez opined that The Department of Human Services is the least restrictive environment that is appropriate at this time. A less restrictive setting, such as a halfway house or group home, would not be appropriate because respondent's "behavior has been so unpredictable while he's been here. My concern is that he will harm others or harm himself." Dr. Alvarez further opined that respondent is not psychiatrically stable enough for a less restrictive setting. The evidence further reflected that respondent's family, with whom he resided, could not provide the support he needed to obtain outpatient services. Cordelia testified that she works full-time, that her husband is disabled, and that her daughter recently started college. Her claim that the family "would figure it out" or that she could take off of work, could reasonably have been discounted by the trial court as, although possibly sufficient to meet respondent's short-term needs, insufficient to meet his medium- or long-term needs. In any event, respondent's aggressive behavior does not reflect that outpatient options were even an option. Again, Dr. Alvarez testified that respondent is not psychiatrically stable enough for a less restrictive setting.

¶ 57 In summary, the trial court's findings were not against the manifest weight of the evidence.

¶ 58 C. Statutory Compliance

¶ 59 1. Treatment Plan

¶ 60 Next, respondent argues that the pre-disposition report did not comply with the statute and was uncured by testimony. We disagree.

¶ 61 Section 3-810 of the Code addresses pre-disposition reports and 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 on an inpatient or outpatient basis, the court shall consider the report in determining an appropriate disposition." 405 ILCS 5/3-810 (West 2012).

¶ 62 The statute's purpose is to provide the trial court "information necessary for determining whether an individual is subject to involuntary admission to a mental health facility. 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).

¶ 63 Further, under section 3-811 of the Code, 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). Under sections 3-810 and 3-811, the court is required to consider information regarding alternatives to treatment in an inpatient facility. *Id.* Section 3-811 explicitly mandates that the court order "the least restrictive alternative for treatment which is appropriate." 405 ILCS 5/3-811 (West 2012).

¶ 64 Generally, the section 3-810 written predisposition report is mandatory. *In re Daryll C.*, 405 Ill. App. 3d 748, 755 (2010). However, "[w]here a respondent fails to object to the absence of a predispositional report, strict compliance with section 3-810 is required only when the

legislative intent cannot otherwise be achieved." *Robinson*, 151 Ill. 2d at 134. Oral testimony containing the statutorily-required information can be an adequate substitute for a formal written report prepared by an authorized person. *Id.*

¶ 65 Here, respondent did not object to the absence of a written predisposition report; therefore, we must determine whether the oral testimony and other evidence were adequate substitutes.[3] *In re Robert H.*, 302 Ill. App. 3d 980, 988 (1999). Section 3-810 calls for specific information, including information on the appropriateness and availability of alternative treatment settings, a social investigation of the respondent, and a preliminary treatment plan describing the respondent's problems and needs, the treatment goals, and the proposed treatment methods, and a projected timetable for their attainment. 405 ILCS 5/3-810 (West 2012).

¶ 66 "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). We conclude that the evidence presented at the hearing was an adequate substitute for a written predispositional report and that the statute's purpose was met. Although a predisposition report was not admitted into evidence in the trial court, an "Inpatient Initial Treatment Plan," dated August 15, 2013, was filed. A preprinted note on the first page of the plan states: "The treatment plan shall be based upon the assessment of the following needs: physical, emotional, behavioral, spiritual, social, recreational[,] and, when appropriate, educational, nutritional[,] and legal." The plan states that respondent's diagnosis was psychosis NOS and noted as precautions assaultive behavior and impulse control issues.

[3] Although we caution that compliance with a statutory mandate is an obligation, not merely a suggestion, we again note that, here, respondent did not object to the absence of a written predisposition report.

The plan also listed as specific problems that respondent was acting paranoid and was aggressive with his family. It also contained assessments of respondent's strengths, rating as "Good" his physical health; rating as "Fair" his social skills, ability for independence, family stability, work stability and verbal skills; and rating as "Poor" his ability for insight.[4] The plan also listed respondent's clinical problems, which included risk for self-harm and showing an altered thought process, and goals (including identification of his stressors, improved thought process and ability to independently meet basic needs, understanding of necessity to take medications, and ceasing to act out or harm self or others and to cooperate with assessments and medication routines) and their target date (August 29, 2013). The plan also included discharge criteria, target dates, interventions, and the staff assigned to each of those areas.

¶ 67 Again, section 3-810 requires that the predisposition report include a preliminary treatment plan and a social investigation of respondent. The foregoing plan (in addition to Dr. Alvarez's testimony) satisfies these statutory requirements: it contains a description of the respondent's problems and needs, including social history, the treatment goals, the proposed treatment methods, and a projected timetable for their attainment. See 405 ILCS 5/3-810 (West 2012). Dr. Alvarez's testimony addressed respondent's symptoms, including his aggressive actions and need to be placed in restraints on two occasions, his delusions, and his unpredictability. He also stated that respondent is psychiatrically unstable. Dr. Alvarez reviewed respondent's treatment plan, noting his prescribed medications and the fact that group sessions were ordered. He also testified as to the treatment goals, noting that it would take two to four weeks to attain the goals. Dr. Alvarez also described respondent's history, including his prior diagnosis and first admission. We conclude that the foregoing plan, which noted that it was

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[4] It is unclear if respondent's intellectual ability is rated as "Poor" or "Good."

based in part on a review of respondent's social needs, and Dr. Alvarez's testimony satisfied section 3-810's requirements. See *In re Robinson*, 151 Ill. 2d at 134-35 (psychiatrist's testimony sufficiently addressed the information that would typically be in a preliminary treatment plan, where the doctor addressed the respondent's diagnosis, symptoms, suicidal history, threats to his wife and altercations in taverns, his treatment goals, specific treatment recommendations, and the estimated time to meet the goals); *cf. In re Daryll C.*, 401 Ill. App. 3d 748, 756-57 (2010) (in the context of assessing an ineffective-assistance-of-counsel claim, holding that State's failure to file predisposition report was reversible error where the State did not present testimony providing the specific information required by statute; and psychiatrist did not testify regarding treatment alternatives to inpatient hospitalization or why he had rejected those options); *In re Alaka W.*, 379 Ill. App. 3d 251, 271 (2008) (conclusory testimony unsupported by factual bases not sufficient to satisfy statutory requirements and constituted reversible error; State did not present any testimony concerning alternative treatment settings and why they were inappropriate or "provide the court with the information necessary to balance the competing interests involved in involuntary commitment. The testimony did not provide information on the treatment goals or a projected timetable for their attainment.").

¶ 68 The remaining statutory requirement for a predisposition report is information on the appropriateness and availability of alternative treatment settings. 405 ILCS 5/3-810 (West 2012). We reject respondent's argument that he was prejudiced by the lack of a predisposition report that addressed possible alternative placements and that Dr. Alvarez's opinion that hospitalization was the least restrictive alternative was not supported by the evidence. As discussed, the evidence reasonably reflected that respondent was unpredictable and that he was aggressive and not psychiatrically stable for a less restrictive environment. Dr. Alvarez testified

that respondent made him fear for his own safety and that he took precautions when meeting with him. The evidence also reasonably reflected that respondent's family could not provide the support he needed to obtain outpatient services. Again, Cordelia's claim that the family "would figure it out" or that she could take off of work, could reasonably have been discounted by the trial court as insufficiently specific to reflect that the family could meet respondent's needs. In any event, respondent's aggressive behavior does not reflect that outpatient treatment was even an option. See *In re Tommy B.*, 372 Ill. App. 3d 677, 689 (2007) (finding that hospitalization was the least restrictive option was not against the manifest weight of the evidence; no evidence suggested that a relative or other persons could care for the respondent; evidence demonstrated that outpatient treatment was not an option, where the psychiatrist testified that the respondent threatened and assaulted others to the point of requiring restraints, concluded that the respondent, due to his behavior, could not receive his nonpsychiatric treatment outside of the psychiatric wing of the hospital, and, opined that, if he left the supervised setting, the respondent would quickly be dangerous to himself or others); see also *Robinson*, 151 Ill. 2d at 135 (evidence sufficient, where the psychiatrist testified that hospitalization would be the least restrictive alternative, ensuring that the respondent would not go out drinking when he became angry and frustrated with his wife and where information about his social situation was supplied by both the doctor and the respondent); *In re Lisa G.C.*, 373 Ill. App. 3d 586, 596 (2007) (evidence supported trial court's finding that commitment was the least-restrictive alternative, where the psychologist testified as such and where evaluation showed that the respondent made numerous delusional, violent statements concerning bombings, decapitations, and murder and where the doctor opined that it was very likely that the respondent might act aggressively and violently to protect herself or others); *In re Robert H.*, 302 Ill. App. 3d 980, 989 (1999) (oral testimony

contained sufficient information concerning appropriateness and availability of least restrictive alternatives, where the doctor explained that she originally intended to send the respondent home, but changed her opinion after the respondent's wife became very distraught and did not want him home; also, the respondent's strong interest in guns made him more of an imminent threat; admission would ensure that he did not have access to guns if the threat of harm was imminent); *cf. In re Alaka W.*, 379 Ill. App. 3d 251, 271 (2008); *In re Lawrence S.*, 319 Ill. App. 3d 476, 484 (2001) (oral testimony insufficient, where neither one of two doctors explained the bases for their opinions that commitment was the least restrictive alternative, nor mentioned that any other alternatives were considered; "[t]here was simply no testimony about the appropriateness and availability of alternative treatment settings or about a treatment plan for respondent.").

¶ 69 In summary, the evidence sufficiently showed that the requirements and legislative intent of section 3-810 of the Code were met.

¶ 70 2. State Police Notice

¶ 71 Respondent's final argument is that a notice to the State police needs to be corrected. The State agrees. The trial court found respondent subject to involuntary admission and ordered hospitalization for up to 90 days. With that order, respondent was "adjudicated a mentally disabled person" as provided in section 1.1 of the Firearm Owners Identification Card Act. 430 ILCS 65/1.1(10) (West 2012) (defined to include a person "subject to involuntary admission as an inpatient as defined in Section 1-119 of the Mental Health and Developmental Disabilities Code"); see also 430 ILCS 65/8.1(b) (West 2012) ("Upon adjudication of any individual as a mentally disabled person as defined in Section 1.1 of this Act or a finding that a person has been involuntarily admitted, the court shall direct the circuit court clerk to immediately notify the

Department of State Police, Firearm Owner's Identification (FOID) department, and shall forward a copy of the court order to the Department.").

¶ 72 The trial court entered an order directing the circuit court clerk to notify the State police of respondent's adjudication. Specifically, in the notice (entitled "ORDER TO NOTIFY THE ILLINOIS STATE POLICE") the court found (by checking a box on the form) that respondent was adjudicated as a mentally disabled person in that he "presents a clear and present danger to himself, herself, or to others." Further, the court (incorrectly) checked a box, reflecting a finding that respondent was also adjudicated disabled in that he or she is subject to "judicial admission as set forth in 405 ILCS 5/4-500." The boxes for two alternative options were not checked in this portion of the form: (1) "in-patient involuntary admission under 405 ILCS 5/1-110" and (2) out-patient involuntary admission under 405 ILCS 5/1-119.1."

¶ 73 We agree with the parties that the trial court marked the wrong box with an "x" on the order to notify the State police and that the court should have checked the box labeled "in-patient involuntary admission under 405 ILCS 5/1-110." Accordingly, pursuant to Illinois Supreme Court Rule 366(a)(5) (eff. Feb. 1, 1994) (reviewing court may "enter any judgment and make any order that ought to have been given or made, and make any other and further orders and grant any relief, including a remandment, ***, that the case may require"), we remand the cause and direct the trial court to correct the notice.

¶ 74 III. CONCLUSION

¶ 75 For the reasons stated, the judgment of the circuit court of Kane County is affirmed and the cause is remanded with directions to correct the notice to State police.

¶ 76 Affirmed and remanded with directions.