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Mental Health Matters

The newsletter of the Illinois State Bar Association's Section on Mental Health Law

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Top 10 Things Guardians and Their Attorneys Should Know About Mental Health Law

BY MARK B. EPSTEIN

10. A mentally ill person cannot "voluntarily" sign in to a mental health facility unless sufficiently "competent" to do so.

See *Zinermon v. Burch,* 494 U.S. 113 (1990).

On December 7, 1981, Darryl Burch was found wandering along a Florida highway, appearing to be hurt and disoriented. He was taken to a private mental health center in Tallahassee. Upon arrival, he was hallucinating, confused and psychotic and believed he was "in heaven." His

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European Congress Showcases Innovative Mental Health Treatments

Every autumn, the European College of Neuropsychopharmacology (ECNP) Congress brings together psychiatrists, neuroscientists, neurologists and psychologists from around the world to discuss the latest developments in the science and treatment of brain disorders. The ECNP Congress is Europe's premier showcase for new research, treatments and technologies in applied brain science.

The annual ECNP Congress attracts some 6,000 participants with an interest in:

- Treatment research in psychiatry, neurology and psychology
- Mental health care
- Discoveries in neuroscience and neurobiology
- The latest developments in industry innovation
- Public policy and regulation
- Patient issues

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face and chest were bruised and bloodied, suggesting that he had fallen or had been attacked. He was asked to sign forms giving his consent to admission and treatment, and he signed them. He remained for three days, was diagnosed as having paranoid schizophrenia, and was given psychotropic medication. He was then transferred to a public mental health facility where he again signed forms requesting admission and authorizing treatment. He remained there five months. Shortly after his release, he filed a complaint stating he did not remember having signed any forms and that he had been inappropriately admitted.

His complaint reached the Florida Human Rights Advocacy Committee. The Committee investigated and stated that there was "documentation that you were heavily medicated and disoriented on admission and ... you were probably not competent to be signing legal documents." The Committee also stated that "hospital administration ... were very likely asking medicated clients to make decisions at a time when they were not mentally competent."

Eventually, in 1985, Burch filed a 42 U.S.C. § 1983 lawsuit (denial of civil rights by a state entity) arguing that his constitutional rights had been violated when he was treated as a "voluntary" patient: because he was incapable of giving voluntary consent, he had been entitled to -- but failed to receive -- the procedural safeguards of an *involuntary* admission hearing.

In 1990, the US Supreme Court agreed that Burch was entitled to proceed with his suit. Writing for the majority, Justice Blackmun noted that Florida's law explicitly required the patient to give "express and informed consent" and that "the very nature of mental illness makes it foreseeable that a person needing mental health care will be unable to understand . . . the forms that person is asked to sign, and will be unable 'to make a knowing and willful decision' whether to consent to admission." Yet, wrote Justice Blackmun, Florida statutes "do not direct any member of the facility staff to determine whether a person is competent to give consent, nor to initiate the involuntary placement procedure for every incompetent patient." The state's violation of the duty to investigate the patient's competence to sign admission forms was therefore "fully predictable" and state officials could be found liable if it is shown that they had failed to make the required examination of Burch's capacity to give informed consent.

In a footnote, the Court observed: "*The characteristics of mental illness thus create special problems regarding informed consent. Even if the State usually might be justified in taking at face value a person's request for admission to a hospital for medical treatment, it may not be justified in doing so, without further inquiry, as to a mentally ill person's request for admission and treatment at a mental hospital.*" [Emphasis added.] In the body of the decision Judge Blackmun wrote: "Florida already has an established procedure for involuntary placement. The problem is only to enforce that this procedure is afforded to all patients who cannot be admitted voluntarily, both those who are unwilling and those who are unable to give consent." [1]

9. A guardian cannot admit a ward to a mental health facility except via the Mental Health Code.

See *Matter of Gardner,* 121 III.App.3d 7, 459 N.E.2d 17, 76 Ill.Dec. 608 (4th Dist. 1984).

In 1982, a petition for involuntary psychiatric admission was filed in Macon County, Illinois, alleging that Ronald Gardner was mentally ill and as a result was unable to provide for his basic needs so as to protect himself from serious harm. Dr. Radecki testified that, in his opinion, Gardner was mentally ill, having a chronic low-level psychosis. Although not immediately dangerous to himself or others, he was allegedly unable to fend for himself in society, totally lacking in judgment and understanding about the "outside" world, having no rational discharge plans and

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having not done well on home visits. Dr. Radecki also testified that Gardner suffered from delusions, making frequent paranoid statements that staff members were going to kill him and raise him from the dead; however, Gardner was not considered to be "acutely suicidal." The prognosis was not very good and Dr. Radecki was not optimistic that Gardner would return to a normal mental state in the near future.

The trial court was then advised that Office of State Guardian (OSG) had previously been appointed Gardner's guardian, but had refused, despite request from hospital staff, to sign Gardner in "voluntarily." The trial court, possibly believing that the State's case for civil commitment was weak but that Gardner still needed protection, ordered OSG to sign in Gardner "voluntarily." The Court likened the situation to the ability of the guardian to consent to medical treatment for the ward. OSG conceded that a guardian may order medical treatment for a disabled ward without the ward's consent, but argued that its authority to do so under the Probate Code did not extend to a work-around of the protections provided by the Mental Health Code.

In a case of first impression in Illinois, the appellate court agreed with OSG and reversed the trial court.

"The State argues that if a plenary guardian has the power to consent to open-heart surgery to save the ward's life and has the power to consent to the adoption of its wards, then it seems logical that a guardian should, subject to court approval, have the authority to seek psychiatric care and treatment for a mentally ill ward. The State argues that such power can easily be inferred from the broad language of [the Probate Code at 755 ILCS 5/11a-17] placing upon the guardian the duty of providing for the health and care of the ward and providing professional services where such services would be appropriate.

"Construing section 11a-17 in that manner would place it into conflict with the [Mental Health Code]. .. [which] provides that a person may be admitted as an in-patient to a mental health facility only as provided in the [Mental Health Code] .... *[T]he legislature has clearly provided that the [Mental Health Code] is to be the exclusive means by which a mentally ill person is admitted to a mental health facility*. The [Mental Health] Code contains an elaborate and complex system of procedures designed to protect the rights of the mentally ill. By bypassing the procedures for involuntary commitment set forth in the [Mental Health] Code, the trial court has denied respondent the rights guaranteed under those provisions ....

" .... Section lla-14.1 [of the Probate Code] prohibits placement of a ward in a "residential facility" without prior authorization by the trial court. To expand the definition of "residential facility" to include mental health facilities ... would bring the Probate Act into conflict with ... the [Mental Health] Code." [Emphasis added.]

8. Under the Mental Health Code, a nursing home or unit operated for treatment of persons with mental illness qualifies as a "mental health facility," so that admission of an unwilling person—even a ward under guardianship—is prohibited except by civil commitment under the Mental Health Code.

See *Guardianship of Muellner v. Blessing Hospital,* 335 Ill.App.3d 1079, 782 N.E.2d 799, 270 Ill.Dec. 240 (4th Dist. 2002).

In September 2001, Sandra Muellner was 55 years old and resided in Hotel Quincy Apartments. The manager noticed Muellner holding a towel in her arms and acting like she had a baby. A maid convinced Muellner to go to Blessing Hospital, where she was voluntarily admitted as an inpatient to an adult psychiatric unit. In October 2001, a social worker at Blessing Hospital, filed a petition for temporary and plenary guardianship. The social worker alleged that Muellner was a disabled person because she was unable to care for herself and she suffered from chronic paranoid schizophrenia with delusions. The petitions sought to appoint the State Guardian (OSG) as guardian of Muellner's person with authority to make residential placement. OSG was appointed temporary guardian with residential placement authority and OSG placed Muellner with New Horizons in Sycamore Health Care, a 24-hour skilled nursing facility. New Horizons is a behavioral unit that works to stabilize psychiatric patients. The facility is not locked, but access to other areas of Sycamore or the outside community is restricted until the resident gains levels of trust.

After the plenary hearing, the trial court appointed OSG limited guardian with authority to place Muellner in a group home, shelter-care facility, or in the community. The court also granted OSG authority to residentially place Muellner in a nursing facility but only if placement in a less restrictive environment would cause substantial harm to her.

The appellate court reversed. It held that *a nursing facility or section of a nursing facility for the treatment of persons with mental illness is equivalent to a "mental health facility" under the Mental Health Code[2], requiring the same protections - in particular, the right to a civil commitment hearing for an unwilling resident - as provided by an inpatient psychiatric facility.*

***7.* No recipient of mental health services may be administered psychotropic medications[3] without their informed consent, except:**

(a) in emergency pursuant to 2-107 of the Mental Health Code (MHC)

(b) by petition and order pursuant to 2-107.1 of the MHC

(c) by consent of a guardian for a non-objecting ward

(d) by consent of an authorized agent pursuant to an unrevoked, or revocation delayed, Health Care Power of Attorney

(e) by consent of an authorized attorney-in-fact pursuant to the principal's Declaration for Mental Health Treatment

405 ILCS 5/2-107 .1: "Administration of psychotropic medication ... upon application to a court ....

(a-5) [Notwithstanding the right to refuse non-emergency psychotropic medication set forth in 405 ILCS 5/2-107] psychotropic medication ... may be administered to an adult recipient of services without the informed consent of the recipient under the following standards: . . .

(4) … (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 of the mental illness or disability for which treatment is presently sought, (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) of this subdivision (4) 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 .... [4]

(b) A guardian may be authorized to consent to the administration of psychotropic medication ... to an *objecting* recipient only under the standards and procedures of subsection (a-5).

(c) Notwithstanding any other provision of this Section, a guardian may consent to the administration of psychotropic medication ... to a *non-objecting* recipient under Article XIa of the Probate Act of 1975.

(d) Nothing in this Section shall prevent the administration of psychotropic medication ... to recipients in an emergency under Section 2-107 of this Act.

(e) Notwithstanding any of the provisions of this Section, psychotropic medication ... may be administered pursuant to a power of attorney for health care under the Powers of Attorney for Health Care Law[5] or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act[6]."

6. The Nursing Home Care Act appears to trump the Mental Health Code regarding psychotropic medications. Possibly authorizing administration of psychotropic medications for an "objecting" ward based solely on the guardian's informed consent.

In #7 we saw that while a guardian may consent to psychotropic medications for a "non-objecting" ward[7], a guardian may not consent for an "objecting" ward except by petition and order obtained under the Mental Health Code[8].

Ironically, however, the same limitation on the authority of the guardian does not seem to apply if the "objecting" ward is a resident of a nursing home.

Regarding "drug treatment," the Nursing Home Care Act provides that: "Except in the case of an emergency, psychotropic medication shall not be administered without the informed consent of the resident or the resident's surrogate decision maker. . . '[S]urrogate decision maker' means an individual representing the resident's interests as permitted by this Section. Informed consent shall be sought by the resident's guardian of the person if one has been named by a court of competent jurisdiction. In the absence of a court-appointed guardian, informed consent shall be sought from a health care agent under the Illinois Power of Attorney Act who has authority to give consent. If neither a court-ordered guardian of the person nor a health care agent under the Illinois Power of Attorney Act is available and the attending physician determines that the resident lacks capacity to make decisions, informed consent shall be sought from the resident's attorney-in-fact designated under the Mental Health Treatment Preference Declaration Act, if applicable, or the resident's representative." 210 ILCS 45/2-106.1(b)

"'Resident's representative' means a person other than the owner not related to the representative, or an agent or employee of a facility not related to the resident, designated in writing by a resident to be his representative, or the resident's guardian." 210 ILCS 45/1-123.

By not restricting the guardian's consent authority to "non-objecting" wards, the Nursing Home Care Act seems to imply that a guardian may consent to psychotropic medication for an "objecting" ward as long as the ward happens to be in a nursing home. As if the drafters of the Nursing Home Care Act anticipated that this might be controversial, the Nursing Home Care Act appears to explicitly trump the stricter standards and procedures of the Mental Health Code in this respect. The Nursing Home Care Act provides: "The requirements of this Section are intended to control in a conflict with the requirements of Sections 2-102 and 2- 107.2 of the Mental Health and Developmental Disabilities Code with respect to the administration of psychotropic medication." 210 ILCS 45/2-106.1(c).

However, 210 ILCS 45/2-106.1 fails to state that the Nursing Home Care Act trumps 405 ILCS 5/2-107.1. And in the absence of an explicit trump of 405 ILCS 5/2-107.1, the Mental Health Code should govern, and guardians should not have the authority to give substituted informed consent to psychotropic medications for an "objecting" ward. The legislature should clarify its meaning. Regarding psychotropic medications – and whether guardians can give substituted informed consent to psychotropic medications for their "objecting" wards – does it want the stricter standards of the Mental Health Code to govern or the much more relaxed standards of the Nursing Home Care Act?

5. For the purposes of the Mental Health Code, dementia and Alzheimer's disease—absent psychosis—are not "mental illnesses."

Mental Health Code 405 ILCS 5/1-129: "'*Mental illness'* means a mental, or emotional disorder that substantially impairs a person's thought, perception of reality, emotional process, judgment, behavior, or ability to cope with the ordinary demands of life, but *does not include* a developmental disability, *dementia or Alzheimer's disease absent psychosis*, a substance abuse disorder, or an abnormality manifested only by repeated criminal or otherwise antisocial conduct."

"Mental illness" is a precondition for civil commitment and for court-authorized psychotropic medications and electroconvulsive therapy under the Mental Health Code. Accordingly, in the absence of psychosis a person with *only dementia* or *only Alzheimer's disease* is not subject to civil commitment or to court-authorized psychotropic medications or

electroconvulsive therapy under the Mental Health Code.

Query: Where does that leave a person with non-psychotic dementia who lacks the capacity to consent voluntarily to a mental health facility (see *Zinermon v. Burch*) and yet is in need of the services of a mental health facility? Is such person denied services because of this definition?

4. It's important to know the standard for civil commitment that no longer exists.

Until August 21, 2003, the substantive standard for involuntary admission was:

Mental Health Code 405 ILCS 5/1-119:

" '***Person subject to involuntary admission' means:***

(l) A person with *mental illness* and who because of his or her illness is reasonably expected to inflict ***serious*** *physical harm* upon himself or herself or another **in the *near* future**; or

(2) A person with mental illness and who because of his or her illness is unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm. [Emphasis added.] . . ."[9]

Here is a summary of the amendments that repeatedly lowered the standard:

- 2003: Broadens the standard for involuntary admission for prong (1) to include "threatening behavior or conduct" that places another individual in reasonable expectation of being harmed; and, for prong (2) provides that an individual may qualify for involuntary admission even if his or her needs are actually being met by family or others as long the individual is unable to provide his or her own basic physical needs **independent** of that support.[10]
- 2008: For prong (1) the phrase "serious physical harm" was deleted entirely in favor of "dangerous conduct" defined, as in the 2003 amendment, as "threatening behavior or conduct." Prong (2) stayed the same, but a prong (3) was added: "A person with mental illness who, because of the nature of his or her illness, is *unable to understand his or her need for treatment* and who, if not treated, is reasonably expected to suffer or continue to suffer mental deterioration or emotional deterioration, or both, to the point that the person is reasonably expected to engage in dangerous conduct." [Emphasis added.][11]

***3.* Because the current standard for inpatient civil commitment is dramatically lower.**

Since 2010,[12] the standard for involuntary inpatient admission has been, and remains:

Mental Health Code 405 ILCS 5/1-119:

'"Person subject to involuntary admission on an inpatient basis' means:

(1) 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;

(2) A person with mental illness who because of his or her illness is *unable to provide for his or her basic physical needs so as to guard* himself or he*rself from serious harm without the assistance of family or others*, unless treated on an inpatient basis; ***or***

(3) A person with mental illness who:

(i) *refuses treatment* or is not adhering adequately to prescribed treatment;

(ii) because of the nature of his or her illness, is *unable to understand his or her need for treatment*; and

(iii) if not treated on an inpatient basis, is *reasonably expected*, based on his or her behavioral history, *to suffer mental or emotional deterioration* and is reasonably expected, after such deterioration, *to meet the criteria of either paragraph (1) or paragraph (2)* of this Section.

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." [Emphasis added.]

2. And the new standard for *out*patient civil commitment is lower still.

Since 2010,[13] the standard for ***outpatient*** involuntary admission is:

Mental Health Code 405 ILCS 5/1-119.1:

'"Person subject to involuntary admission on an outpatient basis' means:

(1) A person who *would meet the criteria for* admission on an *inpatient* basis as specified in Section 1-119 *in the absence of treatment on an outpatient basis and* for whom treatment on an *outpatient* basis *can only be reasonably ensured by a court order mandating such treatment*; *or*

(2) A person with a mental illness which, *if left untreated*, is reasonably *expected to result in an increase in the symptoms* caused by the illness *to the point that the person would meet the criteria for commitment* under Section 1-119, *and* whose mental illness has, *on more than one occasion* in the past, caused that person to *refuse needed and appropriate mental health services in the community*." [Emphasis added.]

***1.* Though inherently limited, guardianship may be the missing piece of the treatment plan puzzle—the piece that makes it whole.**

An overall treatment plan for a mentally ill adult may involve multiple areas of the law: inpatient civil commitment, outpatient civil commitment, and involuntary psychotropic medication or ECT. While guardianship is not necessarily a short-cut through these legal areas, in the absence of a patient that is willing and able to sign releases of information, and in the absence of applicable advance directives, or in the absence of a "custodian" appointed pursuant to an outpatient commitment order[14] or an outpatient agreed "care and custody"[15] order, guardianship can make navigating these areas much easier and more effective, because of one particular provision of the Mental Health and Developmental Disabilities Confidentiality Act: for the duration of the guardianship, guardians have unchallengeable access to otherwise confidential mental health information:

Mental Health and Developmental Disabilities Confidentiality Act 740 ILCS 110/4(a):

"The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof: ... (4) the guardian of a recipient who is 18 years or

older ... “

This provision gives the guardian the right to access the ward’s mental health records and to talk to the ward’s treatment team, and, thereby, to organize the ward’s mental health treatment and recovery.■

This article was prepared by Mark B. Epstein for IICLE Guardianships Institute, Intersection Between Mental Health and Guardianships, August 2023. He may be contacted at Mark@EpsteinLawOffice.com or (312)782-3193.

1. For the Illinois implementation of *Zinermon*, see 405 ILCS 5/3-400(a) and (b).
2. For the very broad definition of “mental health facility” under the Mental Health Code, see 405 ILCS 5/1-114.
3. The law applying to psychotropic medications applies equivalently to electroconvulsive therapy.
4. For a deeper understanding of 405 ILCS 5/2-107.1, see *In re Israel* 278 Ill.App.3d 24 (2nd Dist. 1996), *cert*. den. 167 Ill.2d 554 (Ill. 1996).
5. 755 ILCS 45/4-1 ff.
6. 755 ILCS 43/1 ff.
7. 405 ILCS 5/2-107.1 (e)
8. 405 ILCS 5/2-107.1 (b)
9. See PA 91-726, eff. 06-02-00.
10. See PA 93-573, eff. 08-21-03.
11. See PA 95-602, eff. 06-01-08.
12. See PA 96-1399, eff. 07-29-10; and PA 96-1453, eff. 08-20-10.
13. See PA 96-1399, eff. 7-29-10 and PA 96-1453, eff. 8-20-10.
14. See 405 ILCS 5/3-750 ff.
15. See 405 ILCS 5/3-801.5

European Congress Showcases Innovative Mental Health Treatments

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The ECNP Congress brings participants the best in clinical neuroscience innovation. Two such innovations captured the attention of medical reporters following the 2023 Congress.

Wearable devices can track all sorts of physical health metrics, and now scientists say they have found a way to monitor mental health, specifically bipolar disorder. A bipolar bracelet detects changing electrical signals in the skin linked to manic or depressed moods. By constantly tracking physiological biomarkers associated with mood changes, researchers say they hope the wearable bracelet may one day be able to diagnose patients, determine potential triggers and provide more rapid and personalized treatments.

It may be possible to run away from depression. Researchers wanted to see if exercise could rival anti-depressants or relieving symptoms in those suffering with depression and anxiety. They found that not only did exercise relieve depression, it provided physical benefits and did not cause the same side effects as medication therapy. After 16 weeks, study participants who ran had better mood and felt better overall, but the dropout rate was much higher for the exercise group. This suggests that for prolonged depression management, patients find taking a pill to be easier, even when the medication may cause side effects.

The next ECNP Congress is slated for September 21-24, 2024, in Milan, Italy.■