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Capacity, Competency, and Courts: The Illinois Experience

Wenona Y. Whitfield*

When mental health patients refuse to accept voluntary administration of psychotropic medicine, Illinois is one of several states that provides for a judicial hearing to determine whether the patient's wishes should be overruled.¹ One of the principal issues in

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1. I begin with the assumption that psychotropic medication works. The terms psychotropic and antipsychotic are used synonymously in this Article. "Psychotropic medication" means medication whose use for antipsychotic, antidepressant, antimanic, antianxiety, behavioral modification or behavioral management purposes is listed in AMA Drug Evaluations, latest edition, or Physician's Desk Reference, latest edition, or which are administered for any of these purposes." 405 ILL. COMP. STAT. 5/1-121.1. *See also* 53 AM. JUR. 2D *Mentally Impaired Persons* § 113 (1996) (providing a comprehensive discussion of psychotropic medication); Catherine E. Blackburn, *The "Therapeutic Orgy" and the "Right to Rot" Collide: The Right to Refuse Antipsychotic Drugs Under State Law*, 27 HOUS. L. REV. 447 (1990) (providing a brief description of the side effects associated with psychotropic medications). The overwhelming view of the medical community is that psychotropic drugs are very effective. *See, e.g.*, Paul Appelbaum & Thomas Gutheil, *Rotting With Their Rights On: Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 BULL. AM. ACAD. PSYCHIATRY & L. 306 (1979); William M. Greenberg et al., *Patients' Attitudes Toward Having Been Forcibly Medicated*, 24 BULL. AM. ACAD. PSYCHIATRY & L. 513 (1996); E. Fuller Torrey, *Protecting the Rights, the Person, and the Public: A Biological Basis for Responsible Action*, 11 GEO. MASON U. CIV. RTS. L.J. 17 (2000). According to medical professionals, adherence to a prescribed regimen of psychotropic medication allows patients to function normally. "Compared with psychotic patients who take medications, unmedicated psychotic patients have longer hospital stays, are more likely to require seclusion or restraint during hospitalization, and have higher rates of actual or threatened assaults. Unmedicated depressed patients are more likely than their medicated counterparts to commit suicide." Malini Patel & Daniel W. Hardy, *Encouraging Pursuit of Court-Ordered Treatment in a State Hospital*, 52 PSYCHIATRIC SERVICES 1656 (2001). I also begin with the assumption that persons subject to involuntary commitment are capable of deciding to refuse psychotropic medication, despite of physicians' and psychiatrists' firm belief that medication can significantly reduce mental illness symptoms and improve quality of life. In Illinois, involuntary commitment does *not* include authority to administer medication against a patient's wishes. *In re Phyllis P.*, 695 N.E.2d 851, 853 (Ill. 1998) (expressly prohibiting administration of psychotropic medications without the patient's consent). "[A]n adjudication of mental illness is not an adjudication of

the judicial hearing is whether the patient has the capacity to make an informed choice to refuse the medication. Physicians and psychiatrists view judicial hearings as problematic for several reasons. One obvious problem is that declining staff resources are diverted from treatment to litigation. Psychiatrists also dislike testifying “against” their patients and believe such testimony is damaging to the therapist/patient relationship. Finally, psychiatrists question judges’ ability to understand the underlying pharmacology involved in administering appropriate psychotropic medications.²

Those in favor of courts deciding involuntary medication cases point to past abuses of medication and the underlying liberty interests at stake when forcing any type of medical treatment on an unwilling patient.³ Neither the proponents nor the opponents of judicial hearings for involuntary medication cases are likely to be satisfied with the record under the Illinois involuntary medication statute

incompetence to direct one’s legal affairs.” Moreover, the refusal to take medication is not a ground for involuntary commitment. *In re Schumaker*, 633 N.E.2d 169, 174 (Ill. App. Ct. 1994). *See also In re Orr*, 531 N.E.2d 65, 74 (Ill. App. Ct. 1988) (citations omitted) (“A variety of courts have recognized that informed consent and the right to refuse medical treatment are concepts grounded in the common law right to be free from nonconsensual bodily invasions, the individual liberty interest in personal autonomy and bodily integrity, and the right to privacy protected by the United States and Illinois Constitutions.”).

The focus of this Article is on those patients who are receiving treatment on a voluntary or involuntary basis in a civil rather than a criminal context. The State has a far greater interest in seeking involuntary medication of patients who are in the criminal justice system. *See, e.g., Washington v. Harper*, 494 U.S. 210 (1990); *U.S. v. Sell*, 282 F.3d 560 (8th Cir. 2002), *cert. granted in part*, 537 U.S. 999 (2002); Jami Floyd, *The Administration of Psychotropic Drugs to Prisoners: State of the Law and Beyond*, 78 CAL. L. REV. 1243 (1990).

2. For an excellent treatment of the medical/legal debate involving involuntary medication issues, see Dennis E. Cichon, *The Right to “Just Say No:” A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 LA. L. REV. 283 (1992); Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. MIAMI L. REV. 1 (1989).

3. Numerous articles have been written about the benefits and problems of conducting judicial hearings when a mental health patient refuses to take psychotropic medications voluntarily. Not surprisingly, treatment providers overwhelmingly favor non-judicial decision-makers. *See, e.g.,* Thomas G. Gutheil, *In Search of True Freedom: Drug Refusal, Involuntary Medication and “Rotting with Your Rights On”*, 137 AM. J. PSYCHIATRY 327 (1980); Torrey, *supra* note 1. Lawyers and patient advocates, on the other hand, believe that judicial involvement is essential since involuntary medication raises constitutional issues. *See* Michael L. Perlin & Deborah A. Dorfman, *Is It More Than “Dodging Lions and Wastin’ Time?” Adequacy of Counsel, Questions of Competence, and the Judicial Process in Individual Right to Refuse Treatment Cases*, 2 PSYCHOL. PUB. POL’Y & L. 114 (1996).

because, in the author's view, the statute has proven unworkable for patients, physicians, and the courts.

This Article examines decisions involving involuntary medication in Illinois over the past decade, with a particular emphasis on how judges decide whether the patient has the capacity to refuse medication. The author concludes that Illinois courts have demonstrated an inability to decide questions of competency, and that a more efficient system that protects the rights of mental health patients is needed.

Part I briefly surveys the present statutory scheme in Illinois and in other states that have chosen a judicial model for deciding questions of a patient's competency to refuse psychotropic medication. Part II analyzes appellate decisions from Illinois, emphasizing the inability of judges to articulate a standard for competency. Part III concludes with a proposal for amending the legislative standard for determining competency and suggests an alternative model for determining competency of patients refusing psychotropic medication.

I. THE STATUTORY FRAMEWORK FOR DECIDING A PATIENT'S RIGHT TO REFUSE MEDICATION

In non-emergency situations,⁴ a number of states provide for judicial hearings for involuntary administration of psychotropic drugs.⁵ Within this group, the procedures for approving involuntary medication vary.

4. All states that require judicial approval for administration of psychotropic medication over a patient's objections have procedures to override the patient's objections when the patient or others may be in imminent danger or in some other emergency situation. *See, e.g.*, CONN. GEN. STAT. ANN. § 17a-543(b) (2003).

5. The states include: Alaska, ALASKA STAT. §§ 47.30.839 (LexisNexis 2003); California, CAL. WELF. & INST. CODE §§ 5332, 5334 (West 2003); Colorado, COL. REV. STAT. ANN. § 27-10-111 (West 2002); Delaware, 16 DEL. CODE ANN. tit. 16 §§ 5006, 5161 (1995); Florida, FLA. STAT. ANN. § 394.4598 (West 2002); Hawaii, HAW. REV. STAT. ANN. § 334E-2 (Michie 2000) and HAW. CODE RULES § 11-175-45 (a); Indiana, IND. CODE ANN. § 12-27-5-2 (West 2002); Illinois, 405 ILLINOIS COMP. STAT. 5/2-107.1 (2003); Kentucky, KY. REV. STAT. ANN. § 202A.196(3); Maryland, MD. CODE ANN., Health Gen. I § 10-708 (2000); Massachusetts, MASS. GEN. LAWS ANN. ch. 123, § 8B (West 1986); Minnesota, MINN. STAT. ANN. § 253B.092 (West 2002); Mississippi, MISS. CODE ANN. §§ 41-21-81, 41-21-99 (2001); Montana, MONT. CODE ANN. § 53-21-127 (2001); New Mexico, N.M. STAT. ANN. § 43-1-15

A few states have a treatment plan that incorporates involuntary medication into the initial commitment hearing.⁶ In Connecticut, the statute gives a treatment facility the option to establish an internal procedure for involuntary medication or to request a medication order from the court.⁷ In Maryland and Indiana, the state is allowed to forcibly medicate a patient unless the patient initiates a formal process for judicial intervention.⁸ A substantial number of states require the therapist or treatment facility to seek court authorization *before* a patient can be involuntarily medicated.⁹

(Michie 2000); New York, N.Y. COMP. CODES R. & REGS. tit. 14, § 527.8 (1995); North Dakota, N.D. CENT. CODE, § 25-03.1-18.1 (2002); Ohio, OHIO REV. CODE ANN. § 5122.15 (Anderson 2000); Pennsylvania, 50 PA. CONS. STAT. ANN. § 7304 (West 2003); Texas, TEX. HEALTH & SAFETY CODE ANN. §§ 574.106, 576.025 (Vernon 2003); Vermont, VT. STAT. ANN. tit. 18, §§ 7625, 7627 (2000); Virginia, VA. CODE ANN. § 37.1-134.21 (Michie 2003); Washington, WASH. REV. CODE ANN. § 71.05.370 (West 2003); Wisconsin, WIS. STAT. ANN. §§ 51.61, 51.20 (West 2003).

6. States within this group include: Arizona, ARIZ. REV. STAT. ANN. § 36-530 (West 2003); Idaho, IDAHO CODE § 66-322 (Michie 2000); Maine, ME. REV. STAT. ANN. tit. 34-B (West 1988); Oklahoma, OKLA. STAT. ANN. tit. 43A (West 2002); and Wyoming, WYO. STAT. ANN. § 25-10-110 (LexisNexis 2003).

7. CONN. GEN. STAT. ANN. § 17a-543 (West 2003).

8. In Maryland, the initial decision to medicate may be appealed to an in-house clinical review panel. Panel decisions can be appealed to an administrative board and then to the Circuit Court. MD. CODE ANN., HEALTH-GEN. I § 10-708. In Indiana, the involuntarily committed patient who wants to refuse treatment may petition the committing court. IND. CODE ANN. § 12-27-5-2.

9. In addition to Illinois, 405 ILL. COMP. STAT. § 5/2-107.1, states within this group include: Alaska, ALASKA STAT. §§ 47.30.836, 47.30.839 (LexisNexis 2003) (facility may seek court approval); California, CAL WELF. & INST CODE §§ 5332, 5334 (hearing required to determine person's incapacity to refuse treatment); Colorado, COL. REV. STAT. ANN. § 27-10-111 (committing court has jurisdiction to require involuntary medication); Delaware, 16 DEL. CO. ANN. tit. 16 §§ 5161, 5006 (medication only as authorized by applicable law or court order); Florida, FLA STAT. ANN. § 394.4598 (facility administrator may petition court for appointment of a guardian advocate with power to consent to medication); Hawaii, HAW. REV. STAT. ANN. § 334E-2 and HAW. ADMIN. R. § 11-175-45 A (patients have a right to refuse medication except where a court order exists); Kentucky, KY. REV. STAT. ANN. § 202A.196(3) (hospital may petition court to determine the appropriateness of proposed treatment, following an in-house treatment committee's renewal); Massachusetts, MASS. GEN. LAWS. ANN. ch. 123, § 8B (judicial petition for involuntary medication required); Minnesota, MINN. STAT. ANN. § 253B.092 (upon a showing of lack of capacity and propriety of medication, "the court shall appoint a substitute decision maker with authority to consent to administration of neuroleptic medication"); Mississippi, MISS. CODE ANN. §§ 41-21-81, 41-21-99 (medication proceeding to be similar to commitment proceeding); Montana, MONT. CODE ANN. § 53-21-127(6) (2001) (court may authorize appropriate medication); New Mexico, N.M. STAT. ANN. § 43-1-15 (treatment professional may petition the court for appointment of a guardian to make a substitute decision that is advisory to the court); New York, N.Y. COMP. CODES R. & REGS. tit.

A. *The Illinois Statutory Scheme for Involuntary Medication*

The Illinois statute for involuntary medication has a number of mandatory procedural requirements.¹⁰ The statute includes a “notice of rights” provision requiring that every recipient of services be notified of their rights, including the right to receive written notice of the side effects, risks, and benefits of proposed treatment¹¹ and the right to refuse treatment.¹² The Illinois statute also requires that medication hearings be conducted separate from commitment hearings¹³ and that persons opposing involuntary medication be

14, § 527.8 (clinical director may apply for court authorization of treatment); North Dakota, N.D. CENT. CODE, § 25-03.1-18.1 (2002) (treating psychiatrist may request authorization to treat person under a “mental health treatment order”); Ohio, OHIO REV. CODE ANN. § 5122.15 (petition to court for involuntary medication required); Pennsylvania, 50 PA. CONS. STAT. ANN. § 7304 (court-ordered involuntary treatment allowed for persons already subject to involuntary treatment); Texas, TEX. HEALTH & SAFETY CODE ANN. §§ 574.106, 576.025 (court order for psychoactive medications required); Vermont, VT. STAT. ANN. tit. 18, § 7627 (court may order appropriate medication); Virginia, VA. CODE ANN. § 37.1-134.21.A (court may authorize withholding or withdrawal of specific treatment); Washington, WASH. REV. CODE ANN. § 71.05.370(7) (West 2003) (court may authorize treatment); and Wisconsin, WIS. STAT. ANN. §§ 51.20(7)(d), 51.61(9)(g)(2) (court may determine after a hearing that the individual is not competent to refuse medication).

10. 405 ILL. COMP. STAT. § 5/2-107.1. The Illinois statute governing involuntary medication for mental health patients is a result of a commission appointed by the Governor in 1989 to revise the Mental Health Code. That commission found “serious flaws in the failure to provide adequate guidelines for the involuntary administration of psychotropic substances” and numerous shortcomings in the use of guardianship proceedings to determine if involuntary administration of psychotropic medication should be ordered. COMM’N TO REVISE THE MENTAL HEALTH CODE OF ILL., REPORT OF THE GOVERNOR’S COMM’N TO REVISE THE MENTAL HEALTH CODE OF ILL. 44-47 (1989). “The Commission recommended that the Mental Health Code be amended to specifically provide for the involuntary administration of psychotropic medication in nonemergency settings.” *In re C.E.*, 641 N.E.2d 345, 349 (Ill. 1994). The Illinois statute is an example of what noted authority Michael Perlin refers to as an “expanded due process model.” See Perlin & Dorfman, *supra* note 3, at 122-23.

11. 405 ILL. COMP. STAT. § 5/2-102(a-5) (2002).

12. Several statutory provisions refer to the right to refuse treatment and general rights of mental health service recipients: 405 ILL. COMP. STAT. §§ 5/2-107(a), 5-200(d), 5/3 (2003).

13. 405 ILL. COMP. STAT. § 5/3-107.1(a-5)(2) (2002). As a practical matter, the involuntary medication hearing is often held immediately following the civil commitment hearing, usually with the same witnesses and participants. See *In re Emmert J.*, 775 N.E.2d 193 (Ill. App. Ct. 2002). Even though the involuntary commitment hearing and the involuntary administration of medication hearing are to be heard separately, it seems overly formalistic to require, as one court has, that the court hold two hearings. *In re Miller*, 705 N.E.2d 144, 151 (Ill. App. Ct. 1998) (holding a trial judge cannot “conduct ‘separate hearings’ during the same hearing and enter separate findings on each petition.”).

provided with counsel.¹⁴ Illinois statutes also provide that the person subject to involuntary medication has the right to be present at the hearing,¹⁵ the right to have the involuntary medication issue tried before a jury,¹⁶ and the right to an independent examination.¹⁷

Substantively, the statute requires that the trial court find by clear and convincing evidence that *all* of the following factors are present before it can issue an order for involuntary medication:

(A) That the recipient has a serious mental illness or developmental disability.

(B) That because of said mental illness or developmental disability, the recipient exhibits any one of the following: (i) deterioration of his ability to function, (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 . . . or the repeated episodic occurrence of these symptoms.

14. 405 ILL. COMP. STAT. § 5/2-805 (2003). Although the statute refers to involuntary commitment proceedings, it is equally applicable to proceedings with respect to the involuntary administration of psychotropic medication pursuant to 405 ILL. COMP. STAT. § 5/2-107.1. *See also In re Jones*, 743 N.E.2d 1090 (Ill. App. Ct. 2001); *In re Barbara H.*, 702 N.E.2d 555 (Ill. 1998). The court, in *Jones*, expressly held that a guardian *ad litem* could not be substituted for an attorney:

A guardian *ad litem* and an attorney serve two distinct functions. A guardian *ad litem* is responsible for representing the respondent's best interests as opposed to serving as an advocate for the respondent's possibly ill-advised desires. While a guardian *ad litem* may properly determine that psychotropic medication is in the respondent's best interest, an attorney is necessary to advocate on the respondent's behalf. The roles necessarily conflict with one another.

Jones, 743 N.E.2d at 1093 (citations omitted).

The following jurisdictions also mandate appointment of counsel for involuntary medication: Oklahoma, OKLA. STAT. ANN. tit. 43A, § 5-415(A)(1) (West 2002); Florida, FLA. STAT. ANN. § 394.4598(1) (West 2002); Idaho, IDAHO CODE § 66-329(g) (Michie 2002); Wisconsin, WIS. STAT. ANN. § 51.20(3) (West 2002). Of course, the right to be represented by counsel does not ensure good or effective representation. *See generally* Perlin & Dorfman, *supra* note 3.

15. 405 ILL. COMP. STAT. § 5/3-806 (2002). *See also Barbara H.*, 702 N.E.2d at 558.

16. 405 ILL. COMP. STAT. § 5/3-802-803 (2002).

17. *Id.* § 5/3-804. *See also In re R.C.*, 788 N.E.2d 99 (Ill. App. Ct. 2003).

(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.¹⁸

II. ILLINOIS DECISIONS REGARDING THE RIGHT TO REFUSE MEDICATION

Advocates for mental health patients and the drafters of the Illinois involuntary medication statutes likely assumed that detailed procedural requirements and substantive rights would lead to transparency in treatment decisions and overall improvement in care.¹⁹ Unfortunately, decisions rendered by the courts within the last ten years have largely demonstrated confusion and indifference in regards to procedural matters. The cases also reveal a lack of a uniform analytical framework for deciding substantive capacity issues.

A. Procedural Confusion

The Illinois involuntary medication statute contains a straightforward provision for the contents of a court order authorizing involuntary treatment. The court order must: (1) designate the persons authorized to administer the treatment, and (2) specify the medications and the anticipated range of authorized dosages.²⁰ Physicians and psychiatrists can complain legitimately that the statutory provisions are, at best, unnecessary. Apparently, these requirements are meant to “prevent abuses of involuntary administration”²¹ and ensure that the medication will not be used for “the patient’s therapy, but for the purposes of managing and

18. 405 ILL. COMP. STAT. § 5/2-107.1(4)(A-E) (2002).

19. See generally COMM’N TO REVISE THE MENTAL HEALTH CODE OF ILL., *supra* note 10.

20. 405 ILL. COMP. STAT. § 5/2-107.1(a-5)(6) (2002).

21. *In re Emmett J.*, 775 N.E.2d 193 (Ill. App. Ct. 2002).

disciplining the patient.”²² According to one court, requiring the order to specifically identify the person who is authorized to provide the medication also ensures that a professional who is familiar with the patient’s specific needs and health history is involved.²³

It is difficult to see how identifying the person authorized to administer medication or treatment provides any additional safeguard for patients,²⁴ since Illinois statutes²⁵ and administrative regulations²⁶ provide sufficient safeguards against unlicensed professionals distributing medications. Moreover, given the acute shortage of professional staff at most state hospitals,²⁷ the patient, likely, will know well the few professionals involved with his or her actual diagnosis and treatment.

Requiring the court order to specify the anticipated range of authorized dosages is even more inappropriate because judges usually have little expertise in evaluating the drug regimen and dosage the physician proposes, and the specific dosages and medications required to stabilize a mental health patient are often a matter of trial and error, which may not be stated with certainty at the time of the hearing.²⁸ *In re Williams* provides an example of the legislation’s

22. *In re C.E.*, 641 N.E.2d 345, 352 (Ill. 1994).

23. *In re Cynthia S.*, 759 N.E.2d 1020, 1024 (Ill. App. Ct. 2001).

24. In a case that was decided before the statute required the court order to include specific medications, the appellate court stated: “[I]mplicit in the authority to administer . . . medication is the authority and responsibility to do so safely and correctly.” *In re Schaap*, 654 N.E.2d 1084, 1088 (Ill. App. Ct. 1995).

25. “All medications administered to recipients shall be administered only by those persons who are legally qualified to do so by the laws of the State of Illinois.” 20 ILL. COMP. STAT. § 1705/7 (2002). *See also* 20 ILL. COMP. STAT. § 1705 (2002); 225 ILL. COMP. STAT. § 65/15-20 (2002); 225 ILL. COMP. STAT. § 95/7.5 (2002).

26. Several administrative regulations directly address the issue of authorization to provide medications in mental health facilities. The Illinois Administrative Code provides for the establishment of a Pharmacy and Therapeutics Committee within the Mental Health and Developmental Disability Services. This committee is charged with establishing a list of all medications that may be used within departmental facilities. 59 ILL. ADMIN. CODE § 112.80(b). Psychotropic medication may only be prescribed for a recipient after a physical examination. *Id.* § 112.90. *See also* Saul J. Morse & Robert John Kane, *Nurses Lack Medical Diagnosis and Prescriptive Authority Under Illinois Law*, 83 ILL. BAR J. 130 (1995).

27. *See, e.g.*, Laurie Berclay, *Short on Shrinks*, WEBMD MEDICAL NEWS ARCHIVE, March 29, 2001, at http://my.webmd.com/content/article/31/1728_75846. (reporting that in 2001, nearly 80% of Illinois counties had one or fewer psychiatrists) (on file with the Washington University Journal of Law and Policy).

28. *See, e.g.*, *In re Gwendolyn N.*, 760 N.E.2d 575, 577-78 (Ill. App. Ct. 2001) (rejecting an argument that the psychiatrist should have latitude “to exercise her medical judgment in

arguably unintended result.²⁹ Williams was a patient at Chester Mental Health Center who had been charged with attempted murder and found unfit to stand trial.³⁰ When he refused to be treated with psychotropic medications, a staff psychiatrist petitioned for and obtained a court order to administer certain drugs.³¹ Williams's medications included: up to 100 milligrams of Prolixin per day, up to 100 milligrams of Prolixin Deconate every two weeks, up to 100 milligrams of Haldol per day, and 300 milligrams of Haldol Dec IM every month "if Prolixin and Prolixin Dec [do] not seem to be efficacious in reducing delusions."³² The trial court found that the State proved the factors necessary for involuntary medication and completed a standard form stating,

James Williams shall receive psychotropic medication to be administered by members of the clinical staff at Chester Mental Health, whose licenses allow them to administer psychotropic medications pursuant to Illinois Law. The above-named staff is authorized to administer psychotropic medications to the above[-]named recipient for a period not to exceed 90 days.³³

The appellate court reversed the trial court's decision, reasoning that, "[t]he lack of an order specifying the medications and dosages precludes, as a practical matter, appellate review of a determination that the State has met its burden to prove that the benefits of particular medications outweigh the harm to [the patient]."³⁴ Common sense tells us that few judges would rule that up to 100 milligrams of Prolixin per day, up to 100 milligrams of Prolixin Deconate every two weeks, and up to 100 milligrams of Haldol per day represent inappropriate dosage levels, and that a patient would be better served by dosages of up to fifty milligrams of Haldol per day

determining which combination of the antipsychotic medications worked best for [the patient].").

29. 712 N.E.2d 350 (Ill. App. Ct. 1999).

30. *Id.* at 351.

31. *Id.*

32. *Id.*

33. *Id.* at 352.

34. *Id.* at 353-54.

or up to 200 milligrams of Prolixin Deconate every two weeks. In other words, with rare exception, judges are incapable of knowing the specific medication and dosage required to stabilize a patient.

Since most trial judges lack any training in pharmacology, it is inconceivable that the legislature intended trial judges to “parse” the treatment and choose among various medications.³⁵ In what is clearly an argument in favor of form over substance, one appellate court, while acknowledging that judges have no expertise regarding medication, stated that specific medications must be named in the order to educate the court, so that it may make an informed judgment in its capacity as *parens patriae*.³⁶

The transcript of a recent court hearing in Cook County, Illinois, keenly demonstrates the difficulty in educating judges on a proposed treatment regimen.³⁷ At the conclusion of a trial for involuntary medication, following extensive testimony from the treating physician and an independent examiner, the trial court offered the

35. Curiously, requiring the order to specify the exact recommended medications and dosages was incorporated in an amendment to the statute in 1997. See 405 ILL. COMP. STAT. § 5/2-107.1(a)(6) (2002); Pub. Act. 90-538. Even before the amendment, however, some courts required witnesses to specifically identify the proposed medication. In one such case, the appellate court reversed an order granting involuntary medication even though it acknowledged that physicians should not be limited to the use of a particular drug, but should be able to switch medications based upon the patient’s reactions. *In re Kness*, 661 N.E.2d 394, 400 (Ill. App. Ct. 1996). The court stated:

[W]hile such argument has some practical appeal, nevertheless, we believe that the requirements of section 2-107.1(d)(4) cannot be satisfied without the identification of the medication proposed to be involuntarily administered to a respondent. Otherwise, there can be no meaningful comparison of the benefits of the medication to the side effects the recipient might experience. The very general nature of [the psychiatrist’s testimony, to wit, that respondent would be monitored for side effects, indicates that he had no idea as to what side effects respondent might experience upon the administration of such medication. Without such testimony, there is no evidence from which the trial court could determine that the benefits outweighed the harm of the medication.

Id. at 400.

36. *In re Gwendolyn N.*, 760 N.E.2d 575, 579 (Ill. App. Ct. 2001). Even if judges find a discrepancy in medication descriptions, their lack of knowledge about medications render them without the analytical resources to pursue any inquiry as to the appropriateness of the dosage. See, e.g., *In re Floyd*, 655 N.E.2d 10 (Ill. App. Ct. 1995) (noting a discrepancy in the medical records and the testimony of the treating physician).

37. *In re R.K.*, 786 N.E.2d 212, 215-16 (Ill. App. Ct. 2003).

following insights regarding her understanding of the medication being proposed:

Now, I have a problem here. I might have to ask the doctor a couple more questions because, first of all, I believe that all the testimony is clear and convincing that, and the State has, basically proved that she should have, she—I should authorize involuntary treatment.

...

What I'm not comfortable with *and I'm not a doctor so I don't know about this*, but I don't feel comfortable at all authorizing the use of Haldol for her. Now he mentioned a couple of other medications, Zyprexa or Olanzapine and I don't know what the, I don't know if they have the same side effects.

Now I understand his estimation of the difference between the dystonic reaction and the tardive dyskinesia, but I still—I still don't feel comfortable asking her to take Haldol again.³⁸

Following more testimony by the physician, the court continued:

Then what I'm going to propose then is that the Haldol be the alternative medication and that they start off trying her with the other medicines that don't have the same side effects. And if not, she then refuses those others, then if you need to, then the Haldol. But the Haldol as the medicines [sic] last resort.³⁹

In an apparent attempt to satisfy the statutory requirement, the trial judge's candid admission in the earlier part of the transcript that she "didn't know about" medications did not prevent her from second-guessing the recommendation of the treating physician.⁴⁰ Interestingly, the trial court's decision was reversed on appeal, despite the trial judge's efforts to formulate an opinion regarding the proposed medication.⁴¹

38. *Id.* (emphasis added).

39. *Id.* at 216.

40. *Id.*

41. *Id.*

In *In re Kness*, the court rejected the argument that a physician should have some flexibility in providing for treatment, stating that to do so would hamper the trial court's ability to undertake a meaningful comparison of the benefits of the medication and the side effects the patient might suffer.⁴² A meaningful comparison is highly unlikely when judges have no experience upon which to make the comparison. Since one reviewing court has suggested that courts who handle these cases should develop a checklist or a boiler-plate form order in which, presumably, medications would be listed in an easy-to-use format for routine treatment orders,⁴³ any notion that trial judges are likely to become better educated is illusory at best.

The Illinois Supreme Court has acknowledged that juries are incapable of deciding specific medication and dosage ranges.⁴⁴ In reversing the appellate court and reinstating a trial court order authorizing involuntary medication, the Supreme Court of Illinois recently stated:

[n]othing in the language of section 2-107.1 indicates that where the treatment involves more than one medication, the legislature intended the *jury* to parse the treatment and choose among the various medications. Similarly, nothing in the language of section 2-107.1 indicates that the legislature intended treatment orders to authorize something less than what the treating physician has prescribed. Accordingly, where, as here, the recommended treatment consists of multiple medications—some to be administered alternatively, some to be administered in combination, and some to be administered only as needed to counter side effects—it is only this treatment, in its entirety, that may be authorized.”⁴⁵

Although the court's language addressed whether the jury was capable of selecting a specific medication remedy, the court's opinion that the legislature intended that treatment orders reflect “what the

42. *In re Kness*, 661 N.E.2d 394, 400 (Ill. App. Ct. 1996).

43. *In re Miller*, 705 N.E.2d 144, 152 (Ill. App. Ct. 1998).

44. *In re Mary Ann P.*, 781 N.E.2d 237, 245 (Ill. 2003), *rev'd In re Nancy M.*, 739 N.E.2d 607 (Ill. App. Ct. 2000).

45. *Id.*

treating physician has prescribed”⁴⁶ ought to be applied in non-jury cases. Nevertheless, the current state of the law in Illinois is that trial judges, but not juries, are capable of deciding that patients should receive specific medications. However, given the difficulty in educating trial judges, juror education would likely be equally difficult.

While a number of Illinois trial courts have been seemingly unable or unwilling to comply with the statutory mandate to identify persons authorized to distribute specific medications,⁴⁷ trial courts have also had difficulty complying with other procedural requirements in the involuntary medication statute,⁴⁸ despite pleas

46. *Id.*

47. An alarming number of trial courts have ignored the requirement for specific medication and dosage orders. Cases reversing orders for involuntary medication because the order failed to specify the medication or the range of dosages include: *In re Emmet J.*, 775 N.E.2d 193 (Ill. App. Ct. 2002); *In re Gloria B.*, 776 N.E.2d 853 (Ill. App. Ct. 2002); *In re Jennifer H.*, 775 N.E.2d 616 (Ill. App. Ct. 2002), *In re Gwendolyn N.*, 760 N.E.2d 575 (Ill. App. Ct. 2001), *In re Richard C.*, 769 N.E.2d 1071 (Ill. App. Ct. 2002); *In re Len P.*, 706 N.E.2d 104 (Ill. App. Ct. 1999); *In re Cynthia S.*, 759 N.E.2d 1020 (Ill. App. Ct. 2001); *In re Williams*, 712 N.E.2d 350 (Ill. App. Ct. 1999). Fortunately, not all courts have adhered to this view. *In re Perona*, 690 N.E.2d 1058 (Ill. App. Ct. 1998) the court stated:

It is not necessary for a respondent to have tried a particular regimen of medicine before in order for his doctor to make a valid determination its benefits would outweigh the harm it imposed. *The expert's opinion alone is prima facie proof the benefits of a medication plan outweigh the harm.*

Id. at 1966 (emphasis added). See also *Miller*, 705 N.E.2d 144.

48. See, e.g., *In re Barbara H.*, 702 N.E.2d 555 (Ill. 1998); *In re Evelyn S.*, 788 N.E.2d 310 (Ill. App. Ct. 2003); *In re O.C.*, 788 N.E.2d 1163 (Ill. App. Ct. 2003) (failure to provide notice of medication hearing); *In re R.C.*, 788 N.E.2d 99 (Ill. App. Ct. 2003) (failure to appoint independent expert at patient's request); *In re Richard C.*, 769 N.E.2d 1071; *In re Cathy M.*, 760 N.E.2d 579 (Ill. App. Ct. 2001) (denial of the right to counsel); *In re Jones*, 743 N.E.2d 1090 (Ill. App. Ct. 2001) (appointment of a guardian ad litem is not a substitute for the right to counsel); *In re E.L.*, 736 N.E.2d 1189 (Ill. App. Ct. 2000) (dispositional report requirement was not met by psychiatrist's notes and failure to consider evidence that patient took medication on the morning of the hearing); *In re Janet S.*, 712 N.E.2d 422 (Ill. App. Ct. 1999) (failure to allege and prove that a good-faith effort had been made to determine whether the patient had executed a power of attorney for health care treatment); *Miller*, 705 N.E.2d 144; *In re Timothy H.*, 704 N.E.2d 943 (Ill. App. Ct. 1998) (failure to give meaning of "clear and convincing" instruction); *In re Barry B.*, 693 N.E.2d 882 (Ill. App. Ct. 1998); *In re Edward S.*, 698 N.E.2d 186 (Ill. App. Ct. 1998); *In re M.A.*, 689 N.E.2d 138 (Ill. App. Ct. 1997) (denial of the right to a jury); *In re Carmody*, 653 N.E.2d 977 (Ill. App. Ct. 1997) (failure to file formal petition for involuntary medication); *In re Bontrager*, 676 N.E.2d 4 (Ill. App. Ct. 1997) (failure to provide written information to the patient regarding the proposed treatment); *In re Robinson*, 679 N.E.2d 818 (Ill. App. Ct. 1997); *In re DeLong*, 682 N.E.2d 1189 (Ill. App. Ct. 1997) (failure to hold separate hearing for commitment and involuntary administration of medication); *In re Jones*,

and admonitions from reviewing courts.⁴⁹ The failure of trial courts to follow the basic procedural requirements of the involuntary medication statute suggests that change is needed.

B. Capacity to Make a Reasoned Decision

Determining when a patient has the capacity to make a reasoned decision to refuse medication is a more complex and serious problem than failure to follow procedural requirements. Assuming procedural errors can be reduced or eliminated, Illinois courts must articulate a framework for deciding this important issue.⁵⁰ To determine whether to grant an order for involuntary medications, the trial court must find the presence of six factors.⁵¹ Five of these six factors may be evaluated objectively, thus few appellate courts address these factors.⁵² Psychiatrists or physicians routinely testify objectively to establish the presence of a mental illness, the length of time the illness has existed, any deteriorating behavior, whether less restrictive services have been examined and found inappropriate, and whether

673 N.E.2d 703 (Ill. App. Ct. 1996) (failure to submit evidence regarding actual suffering, loss of ability to function or threatening behavior); *People v. Williford*, 649 N.E.2d 941 (Ill. App. Ct. 1995) (failure to allow patient to request interrogatories); *People v. DeJesus*, 636 N.E.2d 112 (Ill. App. Ct. 1994).

49. The court in *Miller* stated, "We urge strict compliance with all procedural safeguards set forth in the Code and caution that failure to follow those procedures creates the likelihood of reversal." 705 N.E.2d at 151.

Rejecting a claim by the State that procedural errors resulted in a "no-harm-no-foul" situation, the court, in *DeLong* stated:

[T]he procedural safeguards enacted by the legislature for mental health cases are not mere technicalities which may be routinely disregarded by the State. Rather, they are essential tools to protect the liberty interests of persons alleged to be mentally ill. We believe a harmless error finding would send the wrong signal and suggest that we condone the ignoring of clearly established procedural protections.

682 N.E.2d at 1190-91 (1997) (citations omitted).

50. In fairness to the reviewing courts, the number of procedural and other errors that trial courts commit usually precludes the reviewing court from addressing the patient's capacity to make a reasoned decision regarding medication. *See, e.g., O.C.*, 788 N.E.2d at 1163; *In re Nancy M.*, 739 N.E.2d 607 (Ill. App. Ct. 2000).

51. *See supra* note 16 and accompanying text.

52. Only a small number of the reported Illinois cases reference these objective factors. *See O.C.*, 788 N.E.2d 1163; *Jones*, 673 N.E.2d 703 (reversing trial court order for involuntary medication because the testimony failed to state that the patient exhibited deterioration of ability to function, suffering, or threatening behavior).

the benefits of the medication outweigh the harm.⁵³ However, determining whether a patient lacks the capacity to make a reasoned decision requires a *subjective* analysis of the patient's competency. Even though clinical researchers have difficulty defining competency or capacity to make a reasoned decision,⁵⁴ it is important for reviewing courts to offer some guidance on this important factor.

Courts in New York⁵⁵ and Wisconsin⁵⁶ have attempted to articulate standards for judicial determination of a patient's legal

53. See *In re Perona*, 690 N.E.2d 1058 (Ill. App. Ct. 1998) (testimony of psychiatrist that the benefits of the medication outweighed the harm is sufficient); *In re Kness*, 661 N.E.2d 394 (Ill. App. Ct. 1996) (testimony of physician regarding deterioration is sufficient).

54. See generally Torrey, *supra* note 1; Jessica Wilen Berg et al., *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345 (1996).

55. In *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986), the New York Court of Appeals, citing Michaels, *Competence to Refuse Treatment*, in REFUSING TREATMENT IN MENTAL HEALTH INSTITUTIONS-VALUES IN CONFLICT (A. Edward Dondera & Judith P. Swazey eds., 1982), mentioned the following criteria for evaluating capability to consent or refuse treatment:

- (1) the person's knowledge that he has a choice to make; (2) the patient's ability to understand the available options, their advantages and disadvantages; (3) the patient's cognitive capacity to consider the relevant factors; (4) the absence of any interfering pathologic perception or belief, such as a delusion concerning the decision; (5) the absence of any interfering emotional state, such as severe manic depression, euphoria or emotional disability; (6) the absence of any interfering pathologic motivational pressure; (7) the absence of any interfering pathologic relationship, such as the conviction of helpless dependency on another person; (8) an awareness of how others view the decision, the general social attitude toward the choices and an understanding of his reason for deviating from that attitude if he does.

Id. at 344 n.7 (noting the Court of Appeals does not expressly adopt the list of factors, but acknowledges one commentator has suggested the factors).

56. In *In re Virgil D.*, 524 N.W.2d 894 (Wis. 1994), the Supreme Court of Wisconsin stated that the Wisconsin statute for involuntary medication firmly established only one standard for determining if a patient is competent to refuse medication. The person seeking an order for involuntary medication "must establish that the patient is unable to express an understanding of the advantages and disadvantages of the medication or treatment, and the alternatives to accepting the particular medication or treatment offered, after the advantages, disadvantages and alternatives have been explained to him or her." *Id.* at 899.

The court held that the following factors should be considered in reaching its decision:

- (a) Whether the patient is able to identify the type of recommended medication or treatment;
- (b) whether patient has previously received the type of medication or treatment at issue;
- (c) if the patient has received similar treatment in the past, whether he or she can describe what happened as a result and how the effects were beneficial or harmful;

competence to refuse psychotropic medication. In deciding whether a recipient lacks the capacity to make a reasoned decision, most Illinois courts simply adopt the analysis and testimony of the expert physician witness, without any analytical discussion.⁵⁷ A few cases seem to merge the inquiry into the patient's capacity to make a reasoned decision with an inquiry as to whether the physician or the lower court followed all of the procedural guidelines for involuntary medication or whether the physician's testimony was specific enough to offer a justification for recommending medication.⁵⁸ Still other courts view "capacity to make a reasoned decision" as a test of whether the patient offers a sufficiently rational objection to the proposed medication or whether, in the court's view, the patient seems to be functioning at a "high level."⁵⁹ For example, in *In re*

(d) if the patient has not been similarly treated in the past, whether he or she can identify the risks and benefits associated with the recommended medication or treatment; and

(e) whether the patient holds any patently false beliefs about the recommended medication or treatment which would prevent an understanding of legitimate risks and benefits.

Id. at 899-900.

57. See, e.g., *In re Jill R.*, 785 N.E.2d 46, 52 (Ill. App. Ct. 2003); *In re Dorothy W.*, 692 N.E.2d 388 (Ill. App. Ct. 1998); *In re Jeffers*, 606 N.E.2d 727 (Ill. App. Ct. 1992) (agreeing with the physician's testimony and the trial court's finding that the patient lacked the capacity to make a reasoned decision about medication). *In re Floyd*, 655 N.E.2d 10 (Ill. App. Ct. 1995), is an example of the appellate court merely reciting the testimony of the physician: "The record, as well as Dr. Eisaman's testimony, shows that respondent lacks the capacity to make a reasoned decision about the medication. Sometimes respondent takes his medication; other times he does not." *Id.* at 18.

58. See *In re Edward S.*, 698 N.E.2d 186 (Ill. App. Ct. 1998); *In re Bontrager*, 676 N.E.2d 4 (Ill. App. Ct. 1997).

59. See, e.g., *In re R.K.*, 786 N.E.2d 212, 218 (Ill. App. Ct. 2003) ("[T]he record shows that while hospitalized, respondent functioned at a high level, was alert, polite, and oriented to time and place . . . [H]er alleged lack of insight did not alone prove that she was incapable of making a reasoned decision about her treatment"). See also *In re Jones*, 673 N.E.2d 703 (Ill. App. Ct. 1996). In *Jones*, the patient testified that her reasons for refusing the medication were that "she did not want to take this medication because she had doctor's orders not to because it would kill her. She stated that she experienced seven hours of trauma at Danville when medication was forced upon her." *Id.* at 705. Without commenting on how the court reached its decision, the appellate court simply stated that it agreed the patient lacked the capacity to make a reasoned decision, because the "objections concerning the medications were not rational. While Jones offered specific reasons for refusing the medical treatment, we find that such evidence does not render her testimony 'clear' evidence of her competent wishes concerning the administration of medication." *Id.* (citations omitted).

Jeffers the appellate court affirmed the trial court decision that the patient lacked the ability to make a reasoned decision by suggesting that the physician's testimony of the patient's need for medication outweighed the patient's rational views for refusing the medication.⁶⁰

In re Israel represents one of only two Illinois cases in which a trial court attempted to articulate a standard for determining whether a patient has the capacity to make a reasoned decision regarding medication.⁶¹ In *Israel*, after acknowledging the list of factors the cases from Wisconsin and New York used, the court declined to adopt either list in its entirety and instead borrowed several factors from each jurisdiction, including:

- (1) The person's knowledge that he has a choice to make;
- (2) The person's ability to understand the available options, their advantages and disadvantages;
- (3) Whether the commitment is voluntary or involuntary;
- (4) Whether the person has previously received the type of medication or treatment at issue;
- (5) If the person has received similar treatment in the past, whether he can describe what happened as a result and how the effects were beneficial or harmful; and
- (6) The absence of any interfering pathologic perceptions or beliefs or interfering emotional states which might prevent an understanding of legitimate risks and benefits.⁶²

60. 606 N.E.2d 727, 732. The court stated:

[A]lthough . . . merely disagreeing with the treating psychiatrist does not show an inability to make a reasoned decision, we disagree that merely presenting a purportedly nondeluded reason for refusing the medication shows that [the patient] has the ability to make a reasoned decision . . . [T]he mere fact that [the patient] understood the options available does not mean that she has the ability to appropriately balance those options and make a reasoned decision . . . Based on our review of the testimony considered by the trial court, we conclude that sufficient evidence was presented to support the trial court's finding that respondent lacked the ability to make a reasoned decision.

Id.

61. 664 N.E.2d 1032 (Ill. App. Ct. 1996).

62. *Id.* at 1040.

The court, however, held that “[n]one of these enumerated factors should be considered dispositive, and a court should consider any other relevant factors which it deems might be present.” Although the court’s attempt at analysis is encouraging, this court decided that involuntary medication was not warranted primarily because the patient had “rationally explained the basis for his refusal to take the medications.”⁶³ The dissenting judge actually used the factors and noted that the patient exhibited “interfering pathological perceptions or beliefs which might prevent an understanding of legitimate risks and benefits. (Factor No. 6 in majority’s discussion.) This factor appears to directly complement factor No. 2, the person’s ability to understand the available options, their advantages and disadvantages.”⁶⁴

Two years later, in *In re Barry B.*, the appellate court, using the *Israel* factors, held that an involuntary medication order was appropriate.⁶⁵ The court explained:

[T]he record contained evidence of interfering pathologic perceptions or beliefs or emotional states that undoubtedly prevented respondent from understanding the legitimate risks and benefits. It was not unreasonable to conclude that respondent’s pathologic perceptions prevented him from being able to understand the risks and benefits of medication. Respondent testified that he saw the benefit of medications, but not for himself. Respondent’s failure to perceive any benefit whatsoever from the medications flew in the face of . . . expert testimony concerning the benefits of such medications and of the testimony of both respondent’s mother and friend that such medications helped to stabilize his behavior. Likewise, it was not unreasonable to conclude that respondent’s emotional state also prevented him from being able to understand the risks and benefits of medication.⁶⁶

63. *Id.* at 1041.

64. *Id.*

65. 693 N.E.2d 882 (Ill. App. Ct. 1998).

66. *Id.* at 886.

One might argue that in reaching opposite results, the *Barry* and *Israel* courts simply used the factors as a way to guide the analysis and discussion. Because none of the factors are dispositive, a court is free to choose which of the factors it thinks is most important in justifying its decision. I will not suggest that one list of factors is more appropriate than another since “[t]here are several available options ranging from identifying general characteristics of acceptable decisions (e.g., ‘sufficient capacity to make or communicate responsible decisions’) to identifying the components of a competence standard (e.g., evidencing a choice, understanding and appreciation).”⁶⁷ Different decision-makers can always reach opposite conclusions so long as there is an articulated method or process for reaching that conclusion. The point is that decision-makers need to articulate a method or process for deciding whether the patient has the capacity to make a reasoned decision regarding medication. In most of the cases decided in Illinois, no attempt has been made at such an articulation.

III. A PROPOSAL FOR DECIDING INVOLUNTARY MEDICATION DISPUTES

The actual number of involuntary medication petitions in Illinois is relatively small.⁶⁸ Given the relatively small number of petitions

67. Berg et al., *supra* note 54, at 389.

68. In a study done by researchers at Choate Mental Health Center, the number of petitions for court ordered medications in Illinois in calendar years 2001 and 2002 were reported as follows:

Alton Mental Health Center	2000	2001
Number of Petitions	61	73
Patients Treated	642	488
Number Granted	52	51
Number Denied	0	3
Chester Mental Health Center	2000	2001
Number of Petitions	39	49
Patients Treated	460	451
Number Granted	36	48
Number Denied	0	1
Choate Mental Health Center	2000	2001
Number of Petitions	22	23
Patients Treated	620	617
Number Granted	16	15

for involuntary medication, a legitimate question is raised as to whether the judicial model for making involuntary medication decisions is warranted. This is especially true given the experience in Illinois trial courts over the past ten years. Many of the cases involving involuntary medication are decided by associate judges⁶⁹ who generally have little judicial experience and little incentive to develop expertise in this area. Compounding this problem, many of the involuntary medication cases are likely to be assigned to assistant

Number Denied	0	0
Elgin Mental Health Center	2000	2001
Number of Petitions	131	51
Patients Treated	1889	1958
Number Granted	50	17
Number Denied	16	8
Madden Mental Health Center	2000	2001
Number of Petitions	10	1
Patients Treated	2152	2505
Number Granted	7	1
Number Denied	1	0
McFarland Mental Health Center	2000	2001
Number of Petitions	12	10
Patients Treated	792	896
Number Granted	7	4
Number Denied	1	1
Read Mental Health Center	2000	2001
Number of Petitions	27	10
Patients Treated	1942	2162
Number Granted	21	7
Number Denied	1	1
Tinley Park Mental Health Center	2000	2001
Number of Petitions	5	9
Patients Treated	2101	2222
Number Granted	4	5
Number Denied	0	0
Zeller Mental Health Center	2000	2001
Number of Petitions	87	67
Patients Treated	533	605
Number Granted	51	42
Number Denied	14	9

69. There are two types of trial judges in Illinois. Circuit judges may hear any case assigned to them by the Chief Judge. Associate judges may not preside over criminal cases in which the defendant is charged with an offense punishable by imprisonment for one year or more (felonies), unless approval is received from the Illinois Supreme Court. Circuit judges are elected for a term of six years; associate judges are appointed by the circuit judges in accordance with the Illinois Supreme Court's rules for a four-year term. *See* 705 ILL. COMP. STAT. § 35/2; 705 ILL. COMP. STAT. § 45/2; ILL. SUP. CT. RULE 39.

state's attorneys and assistant public defenders, who also have little incentive or interest in making this area of the law their specialty.⁷⁰ Since Illinois trial judges lack expertise and have demonstrated an inability to consistently follow the statutory procedural requirements, strong consideration should be given for a statutory amendment that would assign involuntary medication cases to Department of Human Services administrative law judges.

If petitions for involuntary medication were heard by administrative law judges rather than by trial court judges, there would be several immediate benefits, including: (1) development of judges with special expertise in this evolving field; (2) consistency in opinions rendered; (3) and reduction in the number of appellate decisions.

Hearings conducted by administrative law judges would provide the same basic procedural rights presently accorded to mental health patients. Administrative hearings would allow parties to be present, to be represented by counsel, to have pre-hearing conferences and to have all of the other procedural and substantive rights associated with hearings before the circuit court.⁷¹ Specialized administrative judges could be expected to receive training regarding psychotropic medications and general psychiatry, which would allow them to make

70. As one author stated, "[e]mpirical surveys consistently demonstrate that the quality of counsel 'remains the single most important factor in the disposition of involuntary civil commitment cases.'" Perlin & Dorfman, *supra* note 3, at 120. "Few jurisdictions currently have in place a statewide system of independent, vigorous effective counsel whose job is to provide across-the-board representation for institutionalized patients in individual cases." *Id.* at 121. Quality of counsel is likely to be the most important factor in involuntary medication cases as well. Admittedly, my proposal to present involuntary medication hearings before an administrative law judge would not address the problem of poorly trained and poorly motivated counsel.

71. *See generally* ILL. ADM. CODE tit. 8, 9, § 508.110 (1996). Persons subject to a petition for involuntary medication would not be afforded the right to a jury trial if the cases were assigned to an administrative law judge, however, jury trials in involuntary medication cases are a rarity. Moreover, the benefits of having the petition heard by a trained administrative law judge may lessen the need for patients to seek a trial by jury. Illinois Administrative Law Judges currently adjudicate a variety of matters. *See* 225 ILL. COMP. STAT. 50/22 (discipline of physicians under the Medical Practice act); 115 ILL. COMP. STAT. 5/15 (labor disputes); Chand v. Patla, 795 N.E.2d 403 (Ill. App. Ct. 2003) (termination of physician's ability to participate in medical assistance program). The large number of administrative agencies functioning in a "judicial" role serves to relieve the court of hearing numerous cases while preserving the complete authority of the court to insure the proper application of the law. *See generally* Crowell v. Benson, 285 U.S. 22 (1932).

informed decisions regarding medication regimens.⁷² Although such training could be made available to judges in the circuit court, most Illinois counties rotate assignments so that a judge would not normally hear mental health or involuntary medication cases on a permanent basis.⁷³

VI. CONCLUSION

Involuntary medication cases in Illinois have proven to be an embarrassment for the State. The procedural and substantive errors revealed by appellate case warrants an overwhelming need for improvements to the system. Assigning cases to administrative law judges does not remove the judiciary from the process, as appellate courts would still maintain supervision over the substantive law and would insure that administrative courts follow the procedural requirements of the Illinois statute. It is time to try another system.

72. There is a growing body of literature that suggests, for instance, that minorities, particularly black males, receive higher dosages of psychotropic medications than whites, and that they are more likely to develop tardive dyskinesia and other unwanted side effects. In addition, research shows that members of different races receive differential dosages of psychotropic medications, and specifically that blacks receive higher dosages of psychotropic medication than whites. Judges with training may be able to recognize this disparity and make decisions accordingly.

73. As an example, between 1996 and 2002, six different judges heard involuntary medication cases in Peoria County. Between 1995 and 2001, no fewer than seven judges heard involuntary medication cases in Kane County.