No. 125203

IN THE

SUPREME COURT OF ILLINOIS

PEOPLE OF THE STATE OF ILLINOIS, Plaintiff-Appellant, -vs- SHAWN MARLON BROWN Defendant-Appellee	))))))))))	Appeal from the Appellate Court of Illinois, No. 3-17-0119. There on appeal from the Circuit Court of the Tenth Judicial Circuit, Peoria County, Illinois, No. 16 CF 315. Honorable John P. Vespa, Judge Presiding.

BRIEF AND ARGUMENT FOR DEFENDANT-APPELLEE

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POINTS AND AUTHORITIES

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I. The totality of the circumstances indicate a finding of *bona fide* doubt as to Brown's fitness, and thus that Brown was entitled to a fitness hearing, and the State has waived any argument to the contrary.

II. Judge Hoos failed to exercise independent judicial discretion in finding Brown fit, and instead merely adopted the opinion provided in the fitness evaluation report.

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III. A new trial is the proper remedy here.

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ISSUES PRESENTED FOR REVIEW

I. Whether the State has waived any argument that Brown was not entitled to a fitness hearing, and, in the alternative, whether the totality of the circumstances indicate a finding of *bona fide* doubt as to Brown's fitness, and thus that Brown was entitled to a fitness hearing.

II. Whether Judge Hoos failed to exercise independent judicial discretion in finding Brown fit, and instead merely adopted the opinion provided in the fitness evaluation report.

III. Whether a new trial is the appropriate remedy.

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STATUTES INVOLVED

725 ILCS 5/104-11 (2018)

§ 5-104-11. Raising Issue; Burden; Fitness Motions

(a) The issue of a defendant's fitness for trial, to plead, or to be sentenced may be raised by the defense, the State, or the Court at any appropriate time before a plea is entered or before, during or after trial. When a bona fide doubt of the defendant's fitness is raised, the court shall order a determination of the issue before proceeding further.

(b) Upon request of the defendant that a qualified expert be appointed to examine him or her to determine prior to trial if a bona fide doubt as to his or her fitness may be raised, the court, in its discretion, may order an appropriate examination. However, no order entered pursuant to this subsection shall prevent further proceedings in the case. An expert so appointed shall examine the defendant and make a report as provided in Section 104-15. Upon the filing with the court of a verified statement of services rendered, the court shall enter an order on the county board to pay such expert a reasonable fee stated in the order.

* * *

725 ILCS 5/104-21 (1992)

§ 5-104-21. Medication

(a) A defendant who is receiving psychotropic drugs or other medications under medical direction is entitled to a hearing on the issue of his fitness while under medication.

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STATEMENT OF FACTS

Shawn Brown was charged by indictment on April 26, 2016, with one count of armed robbery and one count of aggravated robbery for the April 2016 robbery of a Family Dollar Store in Peoria (C1-2). Brown's jury trial was subsequently scheduled for September 6, 2016 (C36).

On August 29, 2016, the parties appeared before Judge Kouri for a pre-trial conference (R20). On that date, defense counsel informed Judge Kouri that Brown revealed to him that his "mental problem" had resurfaced and, despite being on medication, Brown was again starting to hear voices and was having difficulty communicating with counsel (R21). Counsel indicated that he had previously been aware of Brown's condition, but that this was the first time Brown had revealed he was actively experiencing symptoms (R21). Counsel indicated that, based on Brown's statements, he believed it was "necessary to do an evaluation to determine whether or not [Brown was] fit to stand trial" (R22). Counsel stated that although it seemed to him that Brown understood "most" of what counsel was telling him, he could not determine that Brown was fit just by talking to him (R22). Judge Kouri ordered a fitness evaluation, vacated the September 6 trial date, and continued the case to September 29, 2016 (R22-23).

Brown's fitness evaluation was completed by Dr. Jean Clore, an Illinois State licensed clinical psychologist (SC4). In preparing the report, Dr. Clore personally met with Brown on one occasion and reviewed a number of documents (SC1). Dr. Clore found that Brown met the Diagnostic and Statistical Manual of Mental Disorders ("DSM–5") criteria for three psychiatric diagnoses: schizoaffective disorder - bipolar type; post-traumatic stress disorder; and mild intellectual disability (SC1-2). The report indicates that schizoaffective disorder - bipolar type is a combination of a mood disorder

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and symptoms of schizophrenia. The report further indicates that, at the time of Dr. Clore's interview, Brown's symptoms included, *inter alia*, trouble concentrating and auditory hallucinations (SC1-2). In relation to Brown's intellectual disability, Dr. Clore reported that Brown "exhibited memory problems and mild difficulty in abstract thinking" (SC2). Dr. Clore indicated that Brown was "mostly oriented, but was unsure of the date" and that his short-term memory skills were "poor" (SC3). Dr. Clore ultimately concluded that Brown had the ability to understand the proceedings against him and to assist in his defense, but recommended that counsel "periodically provide reminders and education" (SC4).

On September 29, 2016, the parties appeared before Judge Hoos for the first and only time (R26). Defense counsel told Judge Hoos that the fitness evaluation had been completed and that the report found no reason to believe that Brown was unfit to stand trial and requested the court put the case "back on the calendar for jury trial" (R27). Judge Hoos acknowledged "receipt of the report with the findings contained therein" and "the stipulation if called to testify the doctor would testify consistent to that report" (R27). Judge Hoos further entered a written order which provided that "by agreement - Defendant is fit to stand trial" (C54). The case proceeded to a jury trial in November 2016. The evidence tended to show that on April 6, 2016, Brown entered the Family Dollar store in Peoria and attempted to purchase a piece of candy (R135, 137). When the employee opened the register, Brown pulled out what looked like a gun and stole money out of the cash register (R135, 137). Brown then left the store (R139). In his testimony, Brown admitted that he committed the robbery because his younger brother had passed away and he needed money to pay for transportation to the funeral (R188-89). Brown testified that committed the robbery using a pellet gun

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(R188).

The jury found Brown guilty of both counts, and Brown was subsequently sentenced to 21 years' incarceration on the armed robbery count (C116-18)(R221-23; 235).

On appeal, Brown argued that the fitness hearing conducted by Judge Hoos was constitutionally deficient because Judge Hoos failed to independently determine Brown's fitness, and instead adopted the conclusion in Dr. Clore's report. Reviewing the issue under the second prong of the plain-error doctrine, the appellate majority agreed. *People v. Brown*, 2019 IL App (3d) 170119-U, ¶¶ 12, 15. The majority noted that while Judge Hoos acknowledged receipt of the report and stated the parties stipulated Clore would testify consistently with the report, Judge Hoos did not indicate she had actually viewed the report or was basing her finding of fitness on the stipulated testimony. Instead, Judge Hoos' written order indicated that Brown was fit by agreement of the parties. *Id.*, ¶ 15. The majority further noted that Judge Hoos had not previously presided over Brown's case, and thus, could not rely on her past observations of Brown in determining his fitness. *Id.* Having found that Brown's fitness hearing was constitutionally deficient, the majority reversed Brown's conviction and remanded for a new trial. *Id.*, ¶ 17. In doing so, the majority rejected the State's argument that a retrospective fitness hearing was the appropriate remedy, finding Brown's case did not present "an exceptional situation" where Brown's fitness could be determined long after the fact. *Id.*, ¶17-19.

In her dissent, Justice Wright disagreed with the majority's finding that Judge Hoos failed to independently exercise her discretion before finding Brown fit to stand trial. *Id.*, ¶ 26 (Wright, J., dissenting). Justice Wright's dissent did not address Judge Hoos' written order indicating Brown was fit by agreement of the parties. Instead, Justice Wright concluded that, because she acknowledged receipt of Dr. Clore's report and the findings therein, Judge Hoos had exercised her discretion. *Id.*, ¶ 27.

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ARGUMENT

I. The totality of the circumstances indicate a finding of *bona fide* doubt as to Brown's fitness, and thus that Brown was entitled to a fitness hearing, and the State has waived any argument to the contrary.

The State initially posits that no fitness hearing was required because the trial court never found a *bona fide* doubt as to Brown's fitness (St. Br. at 9). In a footnote, the State argues that its "omission" of this threshold argument in the appellate court does not prevent the State from raising it before this Court. In support, the State cites the following language from this Court's opinion in *People v. Artis*: "where the appellate court reverses the judgment of the of the trial court, and the appellee in that court brings the case to this court as appellant, that party may raise any issues properly presented in the record to sustain the judgment of the trial court, even if the issues were not raised before the appellate court." 232 Ill. 2d 156, 164 (2009) (St. Br. at 10).

While the waiver rule is generally enforced against the State only when the State seeks to overturn the trial court's ruling, "the principal underlying the application of the waiver rule to the State is that it should be estopped from arguing a theory inconsistent with the one in which it acquiesced below." *People v. Colley*, 173 Ill. App. 3d 798, 806 (1st Dist. 1988) (internal citations omitted). Thus, the government may lose its right on appeal to raise factual issues, "when (1) it has made contrary assertions in the courts below, (2) when it has acquiesced in contrary findings by those courts, or (3) when it has failed to raise such questions in a timely fashion during the litigation." *People v. Keller*, 93 Ill. 2d 432, 438 (1982) (citing *Steagald v. United States*, 451 U.S. 204, 211 (1981). *People v. Carter*, 208 Ill. 2d 309 (2003) is instructive here.

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In *Carter*, the defendant argued in the appellate court that the trial court erred in failing to give a lesser-included instruction *sua sponte* after determining that such an instruction was warranted by the evidence. *Carter*, 208 Ill. 2d at 317. The appellate court agreed, and reversed the defendant's conviction. *Id.* The State appealed to this Court and, in its brief, argued for the first time that the facts did not warrant the lesser-included instruction. *Id.* In finding the State waived its argument on this issue, this Court noted that, in the appellate court, the State did not respond to the defendant's argument that the evidence supported the lesser-included offense. *Id.* at 318. Further, in its petition for leave to appeal, the State did not challenge the appellate court's finding that the evidence warranted the lesser-included instruction. *Id.* Thus, "[d]espite several opportunities," the State "repeatedly failed to raise or address this argument," and, accordingly, it was waived. *Id.* at 318-19.

The same holds true in the case at bar. In the appellate court, Brown argued that his fitness hearing, to which he was constitutionally entitled, was inadequate because Judge Hoos merely adopted the opinion provided in the fitness evaluation report. And, as in *Carter*, the State failed to raise any issue in the appellate court regarding Brown's entitlement to a fitness hearing. In the appellate court, the State never challenged that there was a *bona fide* doubt as to Brown's fitness, and never alleged that Brown was not entitled to a fitness hearing. Nor did the State, in its petition for leave to appeal, challenge the appellate court's finding that Brown was entitled to a fitness hearing. As in *Carter*, the State had multiple opportunities to address this argument and it failed to do so. By failing to make this crucial, threshold argument, the State tacitly acknowledged that a *bona fide* doubt existed. Accordingly, as in *Carter*, this Court should find that the State has waived any argument to the contrary. *Carter*, 208 Ill. 2d at 319.

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This is not a situation, as in *Artis*, where the State was essentially precluded from raising the issue before the appellate court. See *Artis*, 232 Ill. 2d at 164 (rejecting the defendant's estoppel argument on the grounds that it would have been futile for the State to argue abandonment of the one-act, one crime doctrine before the appellate court, as that doctrine had been established by this Court, and the appellate court lacked the authority to overturn it). The State, having agreed below that Brown was constitutionally entitled to a fitness hearing, should be estopped from arguing differently here. Regardless, this Court should reject the State's argument.

The State argues that the appellate court's decision should be reversed because it was based on the mistaken assumption that Brown was entitled to a fitness hearing (St. Br. at 9). According to the State, there was no finding of a *bona fide* doubt as to Brown's fitness; thus, the failure to hold a proper fitness hearing was not error (St. Br. at 9-10). The State relies primarily on this Court's decision in *People v. Hanson*, 212 Ill. 2d 212 (2004). In *Hanson*, this Court held that the trial court's ordering of a fitness evaluation did not, by itself, establish a finding of *bona fide* doubt as to defendant's fitness, such that the defendant was entitled to a fitness hearing. *Id.* at 221-22. This Court reasoned that such a bright-line rule would conflict with the notion that "there are 'no fixed or immutable signs which invariably indicate the need for further inquiry to determine fitness to proceed; the question is often a difficult one in which a wide range of manifestations and subtle nuances are implicated.'" *Id*. at 222 (quoting *People v. Eddmonds*, 143 Ill. 2d 501, 518 (1991)). And, because there was insufficient evidence finding a *bona fide* doubt, this Court refused to presume that the trial court believed doubt was raised. *Hanson*, 212 Ill. 2d at 225. Specifically, this Court noted that, while defense counsel's motion indicated counsel believed there was a *bona fide* as to the

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defendant's fitness, the motion "failed to provide any facts to substantiate counsel's 'feeling' that doubt existed." *Id.* at 224. Additionally, while counsel's motion alleged the defendant had a history of mental instability and disability that could potentially affect his fitness to stand trial, "any connection these problems may have had to defendant's fitness at the time the motion was filed" remained unexplained. *Id.* at 225.

In contrast to *Hanson*, here, in requesting a determination as to Brown's fitness, defense counsel referred to specific facts temporally related his request. Brown had a documented history of mental illness. Counsel was aware of this history, but did not bring it to the Court's attention until Brown told counsel that he was experiencing symptoms, despite being on medication, and that he was having difficulty communicating. That counsel believed Brown's difficulties in communicating had more to do with an intellectual impairment than mental illness is of little import, as either condition had the potential to interfere with Brown's ability to understand the nature and purpose of the proceedings. Further, given that counsel was ready to proceed with trial, the timing of counsel's request suggests that counsel was not, as the State suggests, merely seeking a fitness evaluation to determine whether a *bona fide* doubt as to Brown's fitness could be raised (St. Br. at 12). By bringing Brown's statements to the Court's attention, counsel was, in effect, alerting the Court that he believed Brown's fitness to stand trial was in question.

The State argues that "counsel never requested a hearing, nor did the court order one" (St. Br. at 13). True, counsel did not specifically say the words "fitness hearing" when addressing the trial court. Counsel did, however, twice request "an evaluation to determine whether or not [Brown] was fit to stand trial" (R22). This suggests that counsel equated a fitness evaluation with a legal determination of fitness. Thus, in asking

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for an evaluation, counsel was seeking a determination of Brown's fitness to stand trial – a legal determination that could only be made at a fitness hearing. Further, it was Judge Kouri who vacated the scheduled trial date – an act that was only necessary if he believed a *bona fide* doubt of fitness had been raised. See 725 ILCS 5/104–11(a)(West 2016) ("When a *bona fide* doubt of the defendant's fitness is raised, the court shall order a determination of the issue before proceeding further"). *Cf.* 725 ILCS 5/104-11(b) (West 2016) (allowing the court, in its discretion, to appoint an expert to determine whether a *bona fide* doubt of defendant's fitness can be raised, but stating that "no order entered pursuant to this subsection shall prevent further proceedings in this case").

The totality of the circumstances here demonstrate that the trial court found a *bona fide* doubt as to Brown's fitness and, accordingly that Brown was entitled to a fitness hearing.

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II. Judge Hoos failed to exercise independent judicial discretion in finding Brown fit, and instead merely adopted the opinion provided in the fitness evaluation report.

The State argues in the alternative that the record establishes Judge Hoos[1] exercised independent judicial discretion in finding Brown was fit to stand trial (St. Br. at 15). The State acknowledges that, while Brown did not object to the deficient fitness proceedings below, this Court may nevertheless consider his claim under the plain-error doctrine (St. Br. at 15, fn.4). The plain-error doctrine allows a reviewing court to consider unpreserved error "when (1) a clear or obvious error occurred and the evidence is so closely balanced that the error alone threatened to tip the scales of justice against the defendant, or (2) a clear or obvious error occurred and that error is so serious that it affected the fairness of the defendant's trial and challenged the integrity of the judicial process, regardless of the closeness of the evidence." *People v. Piatowski*, 225 Ill. 2d 551 (2007); Ill. S. Ct. Rule 615(a). The right to be fit for trial is fundamental. *People v. Sandham*, 174 Ill. 2d 379, 382 (1996). Accordingly this issue is reviewable under the second prong of the plain-error doctrine. See *People v. Esang*, 396 Ill. App. 3d 833, 840 (1st Dist. 2009) (finding that a trial court's failure to independently analyze and weigh expert testimony in making a fitness finding is a constitutional error, and reversing under the second plain-error prong).

The State takes issue with what it characterizes as the appellate majority's sole and selective reliance on the portion of Judge Hoos' written order stating "by agreement, Defendant is fit to stand trial" (C54) as support for its conclusion that Judge Hoos failed to exercise independent judgment in determining Brown was fit (St. Br. at 16). According

[1]The State's brief implies that Judge Hoos was the trial judge. She was not. Brown's fitness hearing on September 29, 2016, was the first and only time the parties appeared before Judge Hoos.

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to the State, the appellate court overlooked the preceding portion of Judge Hoos' order, which indicated the parties stipulated to the contents of the report (C54), as well as Judge Hoos' oral statement that she "acknowledge[d] the stipulation [that] if called to testify, the doctor would testify consistent to that report" (R27) (St. Br. at 16). Quoting Justice Wright's dissent, the State posits that Judge Hoos "recognized the existence of the report and its contents" rather than adopting the report's conclusion as dispositive (St. Br. at 17). Additionally, the State argues that the parties did not stipulate to Dr. Clore's conclusions, but only that she would testify consistently with her report (St. Br. at 17).

First, the portion of the written order which indicates the parties stipulated to the contents of the report, supports Brown's argument here. The report contained the conclusion that, "[d]espite meeting criteria for schizoaffective disorder, PTSD, and a mild intellectual disability, Mr. Brown had the ability to understand the nature and purpose of the proceedings against him and to assist in his defense" (SC4). Fitness to stand trial requires that a defendant understand the nature and purpose of the proceedings against him and be able to assist in his defense. 725 ILCS 5/104-10 (West 2016). If the parties stipulated to the contents of the report, then they stipulated to the conclusion that Brown was fit. Thus, this portion of the order is consistent with the latter portion: that Brown was found fit "by agreement." And while Judge Hoos stated that she "acknowledge[d] the stipulation [that] if called to testify the doctor would testify consistent to" her report, no such stipulation was ever made. Instead, defense counsel stated that the "report [found] there [was] no reason to believe" Brown was "unfit to stand trial in any way" (R27). And when Judge Hoos asked the prosecutor if that was his understanding as well, the prosecutor indicated that it was (R27). Thus, contrary to

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the State's claim and Judge Hoos' oral remarks, the record demonstrates that the parties stipulated to the report's finding – that Brown was fit – and that this stipulation is what is reflected in Judge Hoos' written order.

Judge Hoos made no reference to the specific content of the expert's report (other than its conclusion), her personal observations of Brown that day, or any other evidence. A trial judge's determination of fitness "may not be based solely upon a stipulation to the existence of psychiatric conclusions or findings." *People v. Cook*, 2014 IL App (2d) 130545, ¶14; *People v. Contorno*, 322 Ill. App. 3d 177, 179 (2d Dist. 2001). When the parties stipulate to what an expert would testify, the judge may consider the stipulated testimony in exercising his discretion. *Cook*, ¶14 (quoting *Contorno*, 322 Ill. App. 3d at 179). However, "the ultimate decision as to a defendant's fitness must be made" by the trial judge, "not the experts," because the judge "must analyze and evaluate the basis for an expert's opinion instead of merely relying upon the expert's ultimate opinion." *Cook*, ¶14 (quoting *Contorno*, 322 Ill. App. 3d at 179). The judge must be "active, not passive, in making the fitness determination." *Cook*, ¶ 15. Such was not the case here.

Further, as the appellate majority noted, there is no indication that Judge Hoos even read the report that was submitted. *People v. Brown*, 2019 IL App (3d) 170119-U, ¶ 15. And given that Judge Hoos was not the judge assigned to Brown's case, it is reasonable to infer that she was relying on counsel's interpretation of Dr. Clore's findings, rather than the report itself. This is problematic where the report was not nearly as unequivocal as counsel made it seem.

While Dr. Clore ultimately concluded Brown was fit, the report was not entirely consistent. For instance, the report indicated that Brown "exhibited memory problems and mild difficulty in abstract thinking" and that his short-term memory skills were

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"poor" (SC2-3). However, the report also claimed that after being educated about certain legal concepts, Brown was able to understand the material and retain the information "some time" later (SC4). The report further recommended that, due to Brown's intellectual disability, counsel "periodically provide reminders and education" throughout the proceedings but fell short of indicating whether Brown's understanding of the proceedings would be dependent upon these reminders. In addition, the evaluation noted that "Brown's medications included" three psychotropic medications: Zyprexa, Depakote, and Remeron (SC2). See *In re Gloria B.*, 333 Ill. App. 3d 903, 904 (3d Dist. 2002) (designating Zyprexa as a psychotropic medication); *People v. Mitchell*, 189 Ill. 2d 312, 324 (2000) (designating Depakote as a psychotropic medication); *In re Carol B.*, 2017 IL App (4th) 160604 (referring to Remeron as a psychotropic medication). According to the report, Brown received medication management from his primary care physician, but frequently "went off" the medications at the advice of others (SC2). Presumably, Brown's arrest interrupted any regular medication management because he was unable to regularly see his personal physician. However, during the August 29 hearing, counsel implied that Brown was taking some sort of medication. The report failed to address a number of important concerns regarding the psychotropic medications:

- How the psychotropic medications impacted Brown's schizoaffective disorder symptoms, specifically his hallucinations and delusions;
- Whether, and to what extent, the psychotropic medications would affect Brown's ability to communicate and assist his counsel leading up to and during trial;
- Wheter Brown would receive the medications during trial proceedings;
- The prescribed frequency and dosage of the psychotropic medications;

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- Whether the medications were still effective as prescribed;
- Whether Brown was taking the psychotropic medications at the time of the assessment;
- Whether Brown had been regularly taking his medication prior to his arrest;
- Whether the jail staff was aware of Brown's prescriptions; and
- Whether Brown was regularly receiving the medications while incarcerated.

The record in this case provides no basis to conclude that Judge Hoos' fitness determination was based upon anything more than the parties' stipulation that defendant was fit. Neither the court nor either party asked any questions of Brown during the fitness hearing, and no discussion took place regarding the psychologist's findings. This "was in effect no fitness hearing at all." *People v. Greene*, 102 Ill. App. 3d 639, 643 (1st Dist. 1981) (reversing trial court's order finding defendant fit to stand trial where the trial court's decision rested solely upon stipulation to unsworn expert testimony). Accordingly, the appellate court properly concluded Judge Hoos erred in failing to independently exercise her discretion in finding Brown fit to stand trial. *Brown*, 2019 IL App (3d)170119-U, ¶ 15. This Court should affirm.

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III. A new trial is the proper remedy here.

The State argues that the appellate court erred in determining Brown was entitled to a new trial, and posits that the proper remedy is a retrospective fitness hearing (St. Br. at 17-18).Contrary to the State's claim, a retrospective fitness hearing is inappropriate, not only because of the amount of time that has elapsed since the initial fitness assessment and the problems with the fitness evaluation report, but because the remedy of a retrospective fitness hearing would be fundamentally incongruent with a finding of plain error.

The State's argument that a retrospective hearing is the proper remedy rests on its claim that retrospective hearings are not "per se impermissible." As support, the State relies on this Court's approval of retrospective hearings in both *People v. Burgess*, 176 Ill. 2d 289 (1997) and *People v. Neal*, 179 Ill. 2d 541 (1997), as well as this Court's observation in *People v. Mitchell* that the automatic reversal rule had "been replaced by the 'case-by-case' approach" and that "retrospective fitness hearings are now the norm." *Mitchell*, 189 Ill. 2d 312, 338-39 (2000) (St. Br. at 18-19). But the State ignores entirely the context in which this Court decided those cases. Indeed, this is demonstrated by the State's claim that the fact that *Neal* "concerned a defendant's statutory right to a fitness hearing (due to his use of psychotropic medications) rather than a due process right is of no moment" (St. Br. at 19). Simply put, the State's argument is belied by the history of this Court's psychotropic medication jurisprudence.

The door for retrospective fitness hearings was opened by *People v. Burgess*, 176 Ill. 2d 289 (1997), which this Court decided shortly before *Neal*. Prior to *Burgess*, this Court had consistently held that, where the defendant had ingested psychotropic medications at or near the time of trial, the failure to hold a fitness hearing pursuant

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to section 104-21(a)[2] required automatic reversal. *People v. Brandon*, 162 Ill. 2d 450 (1994); *People v. Gevas*, 166 Ill. 2d 461 (1995); *People v. Birdsall*, 172 Ill. 2d 464 (1996); *People v. Nitz*, 173 Ill. 2d 151 (1996). The determination that reversal was required in these cases was based on the notion that, in enacting section 104-21(a), the legislature had "equated the administering of psychotropic medication to a defendant with a *bona fide* doubt as to fitness to stand trial." *Gevas*, 166 Ill. 2d at 469 (1995). Thus, for a period of time, this Court did not distinguish between the failure to hold a fitness hearing pursuant to section 104-21(a) and the failure to hold a fitness hearing under section 104-11(a). See *Nitz*, 173 Ill. 2d at 164 (noting that an "automatic reversal" had always been the appropriate remedy where the requisite statutory fitness hearing was not provided, and concluding that the defendant was entitled to a new trial). See also *Birdsall*, 172 Ill. 2d at 476 ("Consistent with principles of due process, if an accused who is entitled to a fitness hearing is not accorded such a hearing before being criminally prosecuted or sentenced, the conviction ordinarily must be reversed and the cause remanded for further proceedings") (internal citations omitted). That changed with *Burgess*.

In *Burgess*, the parties participated in a limited supplemental hearing for the purpose of determining whether the defendant was taking psychotropic medication at the time of trial. *Burgess*, 176 Ill. 2d at 298-99. Evidence presented at the hearing demonstrated that the defendant had been prescribed three different psychotropic medications to assist him in sleeping. *Id.* at 299. The prescribing psychiatrist testified at the hearing that, given their dosages and the time of night at which they were taken,

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[2]In 1979, the General Assembly amended the Code of Criminal Procedure to address the issue of psychotropic drugs, enacting a provision which provided that: "a defendant who is receiving psychotropic drugs or other medications under medical direction is entitled to a hearing on the issue of his fitness while under medication." 725 ILCS 5/104-21(a) (West 1992).

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the drugs would not have had any effect on the defendant's mental condition the following day. *Id.* at 300. The defendant, relying on *Brandon* and its progeny, argued that he was entitled to a new trial. *Id.* at 299. The State argued against automatic reversal, contending that the evidence at the hearing demonstrated that the psychotropic drugs ingested by the defendant had no effect on his mental condition at his trial.

This Court agreed with the State that "a rule of automatic reversal" was "not always appropriate" because "there will be some circumstances in which it can be said that the use of psychotropic medication did not affect the defendant's mental functioning in such a way that relief would be appropriate." *Id.* at 303. This Court reiterated its position that retrospective hearings are not favored because of "the difficulty in determining, long after the conclusion of the underlying proceedings, the degree of mental functioning then enjoyed by the defendant" but found that automatic reversal was not necessary where there was a case-specific inquiry into the psychotropic drugs administered to the defendant which demonstrated that the medications did not impair the defendant's functioning. *Id.* Thus, in *Burgess*, this Court carved out a limited exception allowing a retrospective fitness hearing where the right to a fitness hearing was based on section 104-21(a), *i.e.*, on the defendant's ingestion of psychotropic medication.

Subsequently, in *People v. Neal*, this Court reiterated the principle it established in *Burgess*: while normally inadequate to protect a defendant's due process rights, retrospective fitness hearings are appropriate in the "exceptional cases" where the issue to be determined is the effect of a defendant's psychotropic medication on his mental functioning. 179 Ill. 2d 541, 552-54. This Court determined that, because "the chemical properties of medication are such that their effects could accurately be assessed in light of defendant's known medical history," the passage of several years was of no

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consequence: the results of a retrospective or new fitness determination would be the same as if it had been made at the time in question. *Neal*, 179 Ill. 2d at 554.

Finally, in *People v. Mitchell*, this Court explicitly overruled its previous determination that the legislature intended to equate the ingestion of psychtropic medication with a *bona fide* doubt of defendant's fitness to stand trial. *Mitchell*, 189 Ill. 2d at 331. Thus, beginning in *Burgess* and culminating in *Mitchell*, this Court drew a distinction between situations where the defendant's right to a fitness hearing was the result of a *bona fide* doubt of defendant's fitness being raised, and situations where the defendant's right to a fitness hearing was based solely on his ingestion of psychotropic medication. See *People v. Kinkead*, 182 Ill. 2d 316, 339-40 (1998) (recognizing that, until *Burgess*, a defendant who had been deprived of a fitness hearing was entitled to a new trial because retrospective hearings were improper, but that, in *Burgess*, this Court abandoned that view and held that, where a defendant was denied his right to a section 104-21(a) fitness hearing, the defendant would not be entitled to a new trial if evidence subsequently established that the defendant did not, in fact, suffer any impairment as a result of his ingestion of psychotropic medication).

The statement in *Mitchell*, noting the appearance "that retrospective fitness hearings are the norm," arose within the context of discussing what this Court referred to as its "erratic and confused jurisprudence" in the section 104-21(a) fitness hearing cases. By way of example, this Court wrote:

> "In 1998, we held that the automatic reversal rule of *Brandon* had been replaced by the 'case-by-case' approach and that a defendant could no longer prevail on a request for a new trial simply by showing that he had been taking psychotropic medications at the relevant time. Although not clearly stated in [*People v. Kinkead*, 182 Ill. 2d 316 (1998)] it appears that retrospective fitness hearings are now the norm. What was constitutionally forbidden three years ago is now compelled. This is not a principled and intelligible development of the law."

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Mitchell, 189 Ill. 2d at 339 (emphasis added). See also *Neal*, 179 Ill. 2d at 547 (noting that "the interpretation and application of section 104-21(a)" had been addressed now fewer than eight times over the previous three years).

Given its context, the statement in *Mitchell* cannot be fairly interpreted as a pronouncement by this Court that retrospective fitness hearings are the preferred remedy for inadequate fitness hearings, especially where this Court has clearly explained that "retrospective fitness determinations will normally be inadequate to protect a defendant's due process rights when more than a year has passed since the original trial and sentencing." *Neal*, 179 Ill. 2d at 554. This Court reached that conclusion on the basis of three United States Supreme Court cases that similarly held that where the delay in conducting a fitness hearing was over a year, retrospective fitness hearings violated the defendants' due process rights. *Neal*, 179 Ill. 2d at 553 (citing *Drope v. Missouri*, 420 U.S. 162, 182-83 (1975); *Pate v. Robinson*, 383 U.S. 375, 387 (1966); *Dusky v. United States*, 362 U.S. 402, 403 (1960)). It is therefore well-established, by the United States Supreme Court, that retrospective fitness hearings do not adequately protect a defendant's due process rights when over a year has passed since the defendant was tried and sentenced.

The State, relying on *People v. Cook*, 2014 IL App (2d) 130545, argues that the instant case is one of the "exceptional cases" as mentioned in *Neal* (St. Br. at 21). In *Cook*, the appellate court determined that, because the parties had stipulated to the fitness report, which was the only evidence presented at the defendant's deficient fitness hearing, the case presented the "exceptional" circumstances discussed in *Neal. Cook*, 2014 IL App 130545, ¶22. The court reasoned that the trial court was capable of reviewing

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the report and making a determination as to whether the defendant was fit when he pleaded guilty. *Id.*

But, like the State here, the appellate court in *Cook* ignored that *Neal* found its support for a retrospective fitness hearing in *Burgess* – a case in which this Court concluded that it should "not automatically assume that every psychotropic drug will inevitably render the person taking it unfit for the purposes of trial or sentencing" and thus, "retrospective hearings are sometimes proper." *Burgess*, 176 Ill. 2d at 304. Thus, what made *Burgess* and *Neal* "exceptional cases" allowing for a retrospective fitness hearing was the fact that the question of defendant's fitness involved a single issue: whether the medication caused the defendant to be unable to understand the nature and purpose of the proceedings against him or to assist in his defense. As noted in *Esang*, this is a "single, easily identified and readily assessed factor." *People v. Esang*, 396 Ill. App. 3d 833, 841 (1st Dist. 2009). See also *Kinkead*, 182 Ill. 2d at 349 (Harrison, J., specially concurring) (explaining that the "exceptional circumstances" in *Neal,* allowing for a retrospective fitness determination despite the passage of significant time, were situations "where it [could] still be shown that the psychotropic medication could not possibly have had any effect on the defendant's fitness"; otherwise, the defendant was entitled to a new trial).

The State argues that the question "is not whether the defendant's condition was alleged to have been caused by 'a single, readily assessed factor,' but instead whether the defendant's fitness at the time of trial may be fairly and accurately determined after the fact" (St. Br. at 22). Again, the State ignores that, in *Neal*, the reason this Court determined the defendant's fitness at the time of trial could be fairly and accurately assessed in retrospect was because such an assessment was based on a single, easily-

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answered inquiry: the effect of psychotropic medication on the defendant's mental functioning. *Neal*, 179 Ill. 2d at 554. And because "the nature of the proof" (*i.e.*, the chemical properties of the medication, along with the defendant's medical history) was constant, the results of a retrospective or new fitness determination would be the same as if it had been made at the time in question. *Id.* Such is not the case here.

And while the State cites cases in addition to *Cook* in which the appellate court has found a retrospective fitness hearing to be the appropriate remedy, these cases either involve the single issue of defendant's use of psychotropic medication (*People v. Melka*, 319 Ill. App. 3d 431 (1st Dist. 2009); *People v. Moore*, 408 Ill. App. 3d 706), or rely on the statement from *Mitchell* regarding retrospective hearings being the norm (*People v. Payne*, 2018 IL App (3d) 160105, ¶ 14; *People v. Gipson* 2015 IL App (1st) 122451, ¶ 38) (St. Br. at 19, 22). Again, given *Mitchell's* context within this Court's psychotropic medication jurisprudence, that statement cannot be fairly interpreted as this Court's broad approval of retrospective fitness hearings outside of that narrow class of cases.

The determination of Brown's fitness is more complex than simply looking at the fitness evaluation. While the fitness report was the only evidence offered at the hearing, it was not the only evidence available. "The question of fitness may be fluid." *People v. Weeks*, 393 Ill. App. 3d 1004, 1010 (4th Dist. 2009). In her report, Dr. Clore noted that Brown suffered from auditory hallucinations and delusions, including the belief that God was sending him messages through people (SC2). Accordingly, she found Brown met the Diagnostic and Statistical Manual of Mental Disorders ("DSM–V")

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criteria for schizoaffective disorder - bipolar type (SC1-2). See appendix.[3] However, despite reporting that Brown suffered from hallucinations up to the day of her personal assessment, Clore did not explain whether the hallucinations and delusions would continue during trial or how they would impact Brown's ability to work with his attorney. This is especially troubling given that the trial court originally ordered the fitness evaluation because defense counsel reported Brown was suffering from hallucinations that made communication difficult (R21). And, while the report indicated that Brown "exhibited memory problems and mild difficulty in abstract thinking," and that his short-term memory skills were "poor," the report also claimed that after being educated about certain legal concepts, Brown was able to understand the material and retain the information "some time" later (SC2-4). Had Judge Hoos questioned Brown, Brown's answers to those questions would have provided relevant information regarding his mental condition at that time. But such evidence would be impossible to obtain through a retrospective hearing conducted nearly four years after the fact.

Finally, the remedy of a retrospective fitness hearing is inherently antithetical to any finding of plain error here, because if this Court agrees that Brown's claim is not procedurally defaulted, this Court will have found that a "clear or obvious error occurred and that error is so serious that it affected the fairness of the defendant's trial and challenged the integrity of the judicial process." *Piatowski*, 225 Ill. 2d at 565. This Court has explained that "under plain-error analysis, a defendant's conviction and sentence will stand unless the defendant shows the error was prejudicial." *People v. Crespo*,

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[3]This Court may take judicial notice of the DSM-V. See, *e.g.*, *People v. Lee*, 256 Ill. App. 3d 856, 863 (1st Dist. 1993) ("Judicial notice may be taken of scientific principles and authoritative treatises that are generally known and accepted or 'readily verifiable from sources of indisputable accuracy.' ") (quoting *Murdy v. Edgar*, 103 Ill. 2d 384, 394 (1984)).

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203 Ill. 2d 335, 347-48 (2001) (emphasis added). If a defendant establishes second-prong plain error, "prejudice is presumed because of the importance of the right involved." *People v. Sebby*, 2017 IL 119445, ¶ 50 (internal citations omitted). In other words, second-prong plain error is akin to structural error, which requires automatic reversal. See *People v. Glasper*, 234 Ill. 2d 173, 197-98 (2009) (equating the second prong of plain-error review with structural error, asserting that "automatic reversal is only required where an error is deemed 'structural,' *i.e.*, a systemic error which serves to 'erode the integrity of the judicial process and undermine the fairness of the defendant's trial'") (quoting *People v. Herron*, 215 Ill. 167, 186 (2005)).

Thus, plain error is, by definition, reversible error. See *People v Keene*, 169 Ill. 2d 1, 17 (1995) ("[A]ll plain errors are reversible ones[.]"); *People v. Naylor*, 229 Ill. 2d 584, 602 (2008) ("We must next determine, under our plain-error rule, whether reversible error occurred. Absent reversible error, there can be no plain error.") (emphasis added). See also *People v. Piatowski*, 225 Ill. 2d 551, 566 (2007) (noting that jury instruction error could not be reviewed for second-prong plain error because it "was not an error so serious that reversal was required regardless of the closeness of the evidence") (emphasis added).

The appellate court correctly determined that the proper remedy was to reverse the defendant's conviction and remand for further proceedings. This Court should affirm.

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CONCLUSION

For the foregoing reasons, Shawn M. Brown, defendant-appellee, respectfully requests that this Court affirm the appellate court's judgment finding that a new trial is warranted because the trial court committed second-prong plain error in failing to affirmatively exercise its discretion at Brown's fitness hearing.

In the alternative, should this Court reverse the judgment of the appellate court, Brown respectfully requests that this Court remand his case to the appellate court so that it may consider the additional claim Brown raised in his appeal that the appellate court declined to address in light of its decision to grant relief on the fitness issue.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that this brief conforms to the requirements of Rules 341(a) and (b). The length of this brief, excluding the pages or words contained in the Rule 341(d) cover, the Rule 341(h)(1) statement of points and authorities, the Rule 341(c) certificate of compliance, the certificate of service, and those matters to be appended to the brief under Rule 342, is 25 pages.

/s/Emily A. Brandon
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APPENDIX TO THE BRIEF

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matic event and characteristic symptom features relating to reliving or reacting to the event are required to make the diagnosis.

Autism spectrum disorder or communication disorders. These disorders may also have symptoms resembling a psychotic episode but are distinguished by their respective deficits in social interaction with repetitive and restricted behaviors and other cognitive and communication deficits. An individual with autism spectrum disorder or communication disorder must have symptoms that meet full criteria for schizophrenia, with prominent hallucinations or delusions for at least 1 month, in order to be diagnosed with schizophrenia as a comorbid condition.

Other mental disorders associated with a psychotic episode. The diagnosis of schizophrenia is made only when the psychotic episode is persistent and not attributable to the physiological effects of a substance or another medical condition. Individuals with a delirium or major or minor neurocognitive disorder may present with psychotic symptoms, but these would have a temporal relationship to the onset of cognitive changes consistent with those disorders. Individuals with substance/medication-induced psychotic disorder may present with symptoms characteristic of Criterion A for schizophrenia, but the substance/medication-induced psychotic disorder can usually be distinguished by the chronological relationship of substance use to the onset and remission of the psychosis in the absence of substance use.

Comorbidity

Rates of comorbidity with substance-related disorders are high in schizophrenia. Over half of individuals with schizophrenia have tobacco use disorder and smoke cigarettes regularly. Comorbidity with anxiety disorders is increasingly recognized in schizophrenia. Rates of obsessive-compulsive disorder and panic disorder are elevated in individuals with schizophrenia compared with the general population. Schizotypal or paranoid personality disorder may sometimes precede the onset of schizophrenia.

Life expectancy is reduced in individuals with schizophrenia because of associated medical conditions. Weight gain, diabetes, metabolic syndrome, and cardiovascular and pulmonary disease are more common in schizophrenia than in the general population. Poor engagement in health maintenance behaviors (e.g., cancer screening, exercise) increases the risk of chronic disease, but other disorder factors, including medications, lifestyle, cigarette smoking, and diet, may also play a role. A shared vulnerability for psychosis and medical disorders may explain some of the medical comorbidity of schizophrenia.

Schizoaffective Disorder

Diagnostic Criteria

A. An uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia.

Note: The major depressive episode must include Criterion A1: Depressed mood.

B. Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness.

C. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness.

D. The disturbance is not attributable to the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

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Specify whether:

295.70 (F25.0) Bipolar type: This subtype applies if a manic episode is part of the presentation. Major depressive episodes may also occur.

295.70 (F25.1) Depressive type: This subtype applies if only major depressive episodes are part of the presentation.

Specify if:

With catatonia (refer to the criteria for catatonia associated with another mental disorder, pp. 119–120, for definition).

Coding note: Use additional code 293.89 (F06.1) catatonia associated with schizoaffective disorder to indicate the presence of the comorbid catatonia.

Specify if:

The following course specifiers are only to be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria.

First episode, currently in acute episode: First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An *acute episode* is a time period in which the symptom criteria are fulfilled.

First episode, currently in partial remission: *Partial remission* is a time period during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.

First episode, currently in full remission: *Full remission* is a period of time after a previous episode during which no disorder-specific symptoms are present.

Multiple episodes, currently in acute episode: Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission and a minimum of one relapse).

Multiple episodes, currently in partial remission

Multiple episodes, currently in full remission

Continuous: Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course.

Unspecified

Specify current severity:

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter "Assessment Measures.")

Note: Diagnosis of schizoaffective disorder can be made without using this severity specifier.

Note: For additional information on Development and Course (age-related factors), Risk and Prognostic Factors (environmental risk factors), Culture-Related Diagnostic Issues, and Gender-Related Diagnostic Issues, see the corresponding sections in schizophrenia, bipolar I and II disorders, and major depressive disorder in their respective chapters.

Diagnostic Features

The diagnosis of schizoaffective disorder is based on the assessment of an uninterrupted period of illness during which the individual continues to display active or residual symptoms of psychotic illness. The diagnosis is usually, but not necessarily, made during the period of psychotic illness. At some time during the period, Criterion A for schizophrenia

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has to be met. Criteria B (social dysfunction) and F (exclusion of autism spectrum disorder or other communication disorder of childhood onset) for schizophrenia do not have to be met. In addition to meeting Criterion A for schizophrenia, there is a major mood episode (major depressive or manic) (Criterion A for schizoaffective disorder). Because loss of interest or pleasure is common in schizophrenia, to meet Criterion A for schizoaffective disorder, the major depressive episode must include pervasive depressed mood (i.e., the presence of markedly diminished interest or pleasure is not sufficient). Episodes of depression or mania are present for the majority of the total duration of the illness (i.e., after Criterion A has been met) (Criterion C for schizoaffective disorder). To separate schizoaffective disorder from a depressive or bipolar disorder with psychotic features, delusions or hallucinations must be present for at least 2 weeks in the absence of a major mood episode (depressive or manic) at some point during the lifetime duration of the illness (Criterion B for schizoaffective disorder). The symptoms must not be attributable to the effects of a substance or another medical condition (Criterion D for schizoaffective disorder).

Criterion C for schizoaffective disorder specifies that mood symptoms meeting criteria for a major mood episode must be present for the majority of the total duration of the active and residual portion of the illness. Criterion C requires the assessment of mood symptoms for the entire course of a psychotic illness, which differs from the criterion in DSM-IV, which required only an assessment of the current period of illness. If the mood symptoms are present for only a relatively brief period, the diagnosis is schizophrenia, not schizoaffective disorder. When deciding whether an individual's presentation meets Criterion C, the clinician should review the total duration of psychotic illness (i.e., both active and residual symptoms) and determine when significant mood symptoms (untreated or in need of treatment with antidepressant and/or mood-stabilizing medication) accompanied the psychotic symptoms. This determination requires sufficient historical information and clinical judgment. For example, an individual with a 4-year history of active and residual symptoms of schizophrenia develops depressive and manic episodes that, taken together, do not occupy more than 1 year during the 4-year history of psychotic illness. This presentation would not meet Criterion C.

In addition to the five symptom domain areas identified in the diagnostic criteria, the assessment of cognition, depression, and mania symptom domains is vital for making critically important distinctions between the various schizophrenia spectrum and other psychotic disorders.

Associated Features Supporting Diagnosis

Occupational functioning is frequently impaired, but this is not a defining criterion (in contrast to schizophrenia). Restricted social contact and difficulties with self-care are associated with schizoaffective disorder, but negative symptoms may be less severe and less persistent than those seen in schizophrenia. Anosognosia (i.e., poor insight) is also common in schizoaffective disorder, but the deficits in insight may be less severe and pervasive than those in schizophrenia. Individuals with schizoaffective disorder may be at increased risk for later developing episodes of major depressive disorder or bipolar disorder if mood symptoms continue following the remission of symptoms meeting Criterion A for schizophrenia. There may be associated alcohol and other substance-related disorders.

There are no tests or biological measures that can assist in making the diagnosis of schizoaffective disorder. Whether schizoaffective disorder differs from schizophrenia with regard to associated features such as structural or functional brain abnormalities, cognitive deficits, or genetic risk factors is not clear.

Prevalence

Schizoaffective disorder appears to be about one-third as common as schizophrenia. Lifetime prevalence of schizoaffective disorder is estimated to be 0.3%. The incidence of

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schizoaffective disorder is higher in females than in males, mainly due to an increased incidence of the depressive type among females.

Development and Course

The typical age at onset of schizoaffective disorder is early adulthood, although onset can occur anywhere from adolescence to late in life. A significant number of individuals diagnosed with another psychotic illness initially will receive the diagnosis schizoaffective disorder later when the pattern of mood episodes has become more apparent. With the current diagnostic Criterion C, it is expected that the diagnosis for some individuals will convert from schizoaffective disorder to another disorder as mood symptoms become less prominent. The prognosis for schizoaffective disorder is somewhat better than the prognosis for schizophrenia but worse than the prognosis for mood disorders.

Schizoaffective disorder may occur in a variety of temporal patterns. The following is a typical pattern: An individual may have pronounced auditory hallucinations and persecutory delusions for 2 months before the onset of a prominent major depressive episode. The psychotic symptoms and the full major depressive episode are then present for 3 months. Then, the individual recovers completely from the major depressive episode, but the psychotic symptoms persist for another month before they too disappear. During this period of illness, the individual's symptoms concurrently met criteria for a major depressive episode and Criterion A for schizophrenia, and during this same period of illness, auditory hallucinations and delusions were present both before and after the depressive phase. The total period of illness lasted for about 6 months, with psychotic symptoms alone present during the initial 2 months, both depressive and psychotic symptoms present during the next 3 months, and psychotic symptoms alone present during the last month. In this instance, the duration of the depressive episode was not brief relative to the total duration of the psychotic disturbance, and thus the presentation qualifies for a diagnosis of schizoaffective disorder.

The expression of psychotic symptoms across the lifespan is variable. Depressive or manic symptoms can occur before the onset of psychosis, during acute psychotic episodes, during residual periods, and after cessation of psychosis. For example, an individual might present with prominent mood symptoms during the prodromal stage of schizophrenia. This pattern is not necessarily indicative of schizoaffective disorder, since it is the co-occurrence of psychotic and mood symptoms that is diagnostic. For an individual with symptoms that clearly meet the criteria for schizoaffective disorder but who on further follow-up only presents with residual psychotic symptoms (such as subthreshold psychosis and/or prominent negative symptoms), the diagnosis may be changed to schizophrenia, as the total proportion of psychotic illness compared with mood symptoms becomes more prominent. Schizoaffective disorder, bipolar type, may be more common in young adults, whereas schizoaffective disorder, depressive type, may be more common in older adults.

Risk and Prognostic Factors

Genetic and physiological. Among individuals with schizophrenia, there may be an increased risk for schizoaffective disorder in first-degree relatives. The risk for schizoaffective disorder may be increased among individuals who have a first-degree relative with schizophrenia, bipolar disorder, or schizoaffective disorder.

Culture-Related Diagnostic Issues

Cultural and socioeconomic factors must be considered, particularly when the individual and the clinician do not share the same cultural and economic background. Ideas that appear to be delusional in one culture (e.g., witchcraft) may be commonly held in another. There is also some evidence in the literature for the overdiagnosis of schizophrenia com-

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pared with schizoaffective disorder in African American and Hispanic populations, so care must be taken to ensure a culturally appropriate evaluation that includes both psychotic and affective symptoms.

Suicide Risk

The lifetime risk of suicide for schizophrenia and schizoaffective disorder is 5%, and the presence of depressive symptoms is correlated with a higher risk for suicide. There is evidence that suicide rates are higher in North American populations than in European, Eastern European, South American, and Indian populations of individuals with schizophrenia or schizoaffective disorder.

Functional Consequences of Schizoaffective Disorder

Schizoaffective disorder is associated with social and occupational dysfunction, but dysfunction is not a diagnostic criterion (as it is for schizophrenia), and there is substantial variability between individuals diagnosed with schizoaffective disorder.

Differential Diagnosis

Other mental disorders and medical conditions. A wide variety of psychiatric and medical conditions can manifest with psychotic and mood symptoms that must be considered in the differential diagnosis of schizoaffective disorder. These include psychotic disorder due to another medical condition; delirium; major neurocognitive disorder; substance/medication-induced psychotic disorder or neurocognitive disorder; bipolar disorders with psychotic features; major depressive disorder with psychotic features; depressive or bipolar disorders with catatonic features; schizotypal, schizoid, or paranoid personality disorder; brief psychotic disorder; schizophreniform disorder; schizophrenia; delusional disorder; and other specified and unspecified schizophrenia spectrum and other psychotic disorders. Medical conditions and substance use can present with a combination of psychotic and mood symptoms, and thus psychotic disorder due to another medical condition needs to be excluded. Distinguishing schizoaffective disorder from schizophrenia and from depressive and bipolar disorders with psychotic features is often difficult. Criterion C is designed to separate schizoaffective disorder from schizophrenia, and Criterion B is designed to distinguish schizoaffective disorder from a depressive or bipolar disorder with psychotic features. More specifically, schizoaffective disorder can be distinguished from a depressive or bipolar disorder with psychotic features due to the presence of prominent delusions and/or hallucinations for at least 2 weeks in the absence of a major mood episode. In contrast, in depressive or bipolar disorders with psychotic features, the psychotic features primarily occur during the mood episode(s). Because the relative proportion of mood to psychotic symptoms may change over time, the appropriate diagnosis may change from and to schizoaffective disorder (e.g., a diagnosis of schizoaffective disorder for a severe and prominent major depressive episode lasting 3 months during the first 6 months of a persistent psychotic illness would be changed to schizophrenia if active psychotic or prominent residual symptoms persist over several years without a recurrence of another mood episode).

Psychotic disorder due to another medical condition. Other medical conditions and substance use can manifest with a combination of psychotic and mood symptoms, and thus psychotic disorder due to another medical condition needs to be excluded.

Schizophrenia, bipolar, and depressive disorders. Distinguishing schizoaffective disorder from schizophrenia and from depressive and bipolar disorders with psychotic features is often difficult. Criterion C is designed to separate schizoaffective disorder from schizophrenia, and Criterion B is designed to distinguish schizoaffective disorder from a

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depressive or bipolar disorder with psychotic features. More specifically, schizoaffective disorder can be distinguished from a depressive or bipolar disorder with psychotic features based on the presence of prominent delusions and/or hallucinations for at least 2 weeks in the absence of a major mood episode. In contrast, in depressive or bipolar disorder with psychotic features, the psychotic features primarily occur during the mood episode(s). Because the relative proportion of mood to psychotic symptoms may change over time, the appropriate diagnosis may change from and to schizoaffective disorder. (For example, a diagnosis of schizoaffective disorder for a severe and prominent major depressive episode lasting 3 months during the first 6 months of a chronic psychotic illness would be changed to schizophrenia if active psychotic or prominent residual symptoms persist over several years without a recurrence of another mood episode.)

Comorbidity

Many individuals diagnosed with schizoaffective disorder are also diagnosed with other mental disorders, especially substance use disorders and anxiety disorders. Similarly, the incidence of medical conditions is increased above base rate for the general population and leads to decreased life expectancy.

Substance/Medication-Induced Psychotic Disorder

Diagnostic Criteria

A. Presence of one or both of the following symptoms:
   1. Delusions.
   2. Hallucinations.

B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
   1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
   2. The involved substance/medication is capable of producing the symptoms in Criterion A.

C. The disturbance is not better explained by a psychotic disorder that is not substance/medication-induced. Such evidence of an independent psychotic disorder could include the following:

   The symptoms preceded the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence of an independent non-substance/medication-induced psychotic disorder (e.g., a history of recurrent non-substance/medication-related episodes).

D. The disturbance does not occur exclusively during the course of a delirium.

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention.

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No. 125203

IN THE

SUPREME COURT OF ILLINOIS

PEOPLE OF THE STATE OF ILLINOIS, Plaintiff-Appellant, -vs- SHAWN MARLON BROWN Defendant-Appellee	))))))))))	Appeal from the Appellate Court of Illinois, No. 3-17-0119. There on appeal from the Circuit Court of the Tenth Judicial Circuit, Peoria County, Illinois, No. 16 CF 315. Honorable John P. Vespa, Judge Presiding.

NOTICE AND PROOF OF SERVICE

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Under penalties as provided by law pursuant to Section 1-109 of the Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct. On May 18, 2020, the Brief and Argument was filed with the Clerk of the Supreme Court of Illinois using the court's electronic filing system in the above-entitled cause. Upon acceptance of the filing from this Court, persons named above with identified email addresses will be served using the court's electronic filing system and one copy is being mailed to the defendant-appellee in an envelope deposited in a U.S. mail box in Ottawa, Illinois, with proper postage prepaid. Additionally, upon its acceptance by the court's electronic filing system, the undersigned will send 13 copies of the Brief and Argument to the Clerk of the above Court.

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