ILLINOIS STATE BAR ASSOCIATION

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Mental Health Matters

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

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From the chair and editor

BY SANDY BLAKE

For the first time in many years, the Mental Health Section Council held its monthly meeting outside the Chicago Regional Office. On April 15, the Section Council conducted its business in the Illinois Bar Center in Springfield.

Unfortunately, the actual meeting was somewhat sparsely attended, due in large part to the blizzard that hit the state on Sunday, April 14. For those who braved the hazardous weather, the meeting and its aftermath were well worth the trip.

In rapid order, we discussed our agenda items: appellate court updates, the May CLE program, *Mental Health Matters* newsletter, the online Central Community Mental Health Section discussion group and mental health legislation, including *Linda B.* implications (See separate article in this newsletter).

After we adjourned, we walked next door to the Illinois Supreme Court, where we enjoyed an event planned by Justice

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False imprisonment under the mental health code

BY ANDREAS LIEWALD

In a recent appellate opinion, the Fifth District Appellate Court held that a hospital may be held liable for false imprisonment if it does not comply with the requirements and procedures of the Mental Health and Developmental Disabilities Code (Mental Health Code), 405 ILCS 5/1-100 *et seq.*[1]

In this case, the plaintiff drove herself to an emergency room operated by the defendant, Southern Illinois Healthcare, and sought treatment for pain and swelling in her leg.[2] At some point, her primary care physician informed the attending emergency room physician that plaintiff recently "made suicide ideations."[3] After two to four hours there, plaintiff walked out of the hospital.[4] According to the defendant, the plaintiff was told that she was being detained for a mental health evaluation before she walked out of the hospital.[5] However, according to the plaintiff, she was never told why she was not allowed to leave.[6] She was approached in the parking lot by a nurse, who told her that she could not leave.[7] When the plaintiff refused to accompany the nurse back into the hospital, the nurse called security.[8] At some point, the police were also called.[9] The plaintiff was escorted back into the hospital with the two security guards and the nurse at about the same time the police arrived.

The plaintiff was then detained in an exam room by two security guards, a nurse, and three police officers.[10] While being detained there, she was required to get undressed, put on a paper hospital gown, provide blood and urine samples, and turn in her purse before emergency room personnel would request a mental

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From the chair and editor

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Anne M. Burke. Although the court was not in session, Justice Burke not only agreed to host our gathering, she made it a priceless event!

Justice Burke and Supreme Court Historic Preservation Commission Executive Director John A. Lupton greeted us as we passed through security. The two then personally guided us on a tour of the Supreme Court building—from the basement where Court records were originally archived to the Justices' living quarters when court is in session. We met with **Carolyn Taft Grosboll**, the Clerk of the Supreme Court, and Supreme Court Research Director John Robinson and part of his team.

During lunch in the appellate courtroom, we watched an edited version of the Insanity Retrial of Mary Todd Lincoln, focusing on the examination of expert witnesses Bennett L. Leventhal, MD and James L. Cavanaugh, MD. We then moved across the hall to the supreme court courtroom where Justice Burke and John Lupton concluded the tour in the court's deliberation chamber. They then led a discussion following the video in the courtroom.

Present day mental health issues became the next focus of our discussion, as Hon. Mary K. O'Brien, appellate justice in the third district and president of the Lawyer's Assistance Program Board of Directors; Hon. Lauren Ediden, associate judge in Cook County 2nd Municipal District Court, who oversees the Mental Health Court; and Cheryl Potts, director, The Kennedy Forum Illinois, each talked about the programs they work with and the mental health implications.

Justice Burke concluded the program with a call to action, challenging the members of the ISBA Mental Health Section to work to increase awareness of mental health issues and treatment. Recognizing the many resources of the ISBA—newsletters such as this one, CLE programs, "Ask a Lawyer" videos for the public and "Quicktakes" videos for lawyers—as well as the many practice sections in which lawyers are affected personally or professionally by mental illness, the challenge seems a little less daunting. Having been re-appointed chair of this Section Council for the 2019-20 bar year, I am looking at ways to meet the challenge and accomplish the goal of increased awareness and reduced stigma of mental health issues and treatment, and welcome any ideas. Active involvement of all members is crucial to our success! Please consider this your personal invitation.■

Mental Health Matters

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False imprisonment under the mental health code

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health counselor come to the room to evaluate her.[11] The plaintiff refused to do so and sat on her purse so it could not be taken from her.[12] A struggle ensued for possession of the purse involving the plaintiff, one of the police officers, and one of the security guards.[13] Although plaintiff denied biting the police officer during this struggle, she was subsequently convicted on one count of battery for doing so.[14] The plaintiff was then shackled to a bed until she was transported to a jail on the battery charge.[15] The appellate court noted that although plaintiff had to be medically cleared before she could be taken to jail, once she was shackled to the bed, no further medical or psychiatric evaluation took place.[16]

The plaintiff subsequently filed a lawsuit for false imprisonment.[17] The defendant filed a motion for summary judgment, arguing that the plaintiff could not prove that her detention was unlawful or unreasonable, one of the elements necessary to support a claim of false imprisonment.[18] The trial court granted summary judgment in favor of the defendant.[19]

Plaintiff appealed, arguing that summary judgment was inappropriate because there were genuine issues of material fact concerning the lawfulness of her detention.[20] The appellate court held that false imprisonment has two elements.[21] To prevail, a plaintiff must prove both that (1) her personal freedom was curtailed against her wishes and (2) her detention was unreasonable or unlawful.[22] The parties agreed that the plaintiff was detained against her wishes by the defendant.[23] As such, only the second element – the lawfulness of her detention was at issue.[24]

The appellate court found that there were genuine issues of fact on the questions of the lawfulness of plaintiff's detention.[25] First, the appellate court found that there were genuine questions of fact concerning whether the defendant's emergency room personnel made any efforts to persuade the plaintiff to submit to a mental health evaluation voluntarily before deciding to detain her.[26] This fact was material because before a patient may be detained for an evaluation, the detaining party must be able to attest that a diligent effort was made to convince the patient to submit to the evaluation willingly.[27] Second, the appellate court found that it was not clear from the record that the defendant complied with the requirement of presenting a petition to the director of a mental health facility to have the plaintiff detained for examination.[28] Thus, the record presented genuine questions of fact on the material issue of the defendant's compliance with the requirement of a petition.[29] Third, the appellate court found that there was some evidence in the record suggesting that the plaintiff may have reluctantly agreed to speak with a counselor as long as she could do so without additional delay.[30] The appellate court held that while the Mental Health Code authorizes the detention of a patient in a mental health facility, it does not authorize the detention of a patient in an emergency room to comply with the hospital's internal policy of imposing prerequisites on a patient's access to the mental health services.[31] If the plaintiff's presence in the emergency room became an unwilling detention only for the purpose of obtaining a urine sample and forcing her to change into a paper gown and surrender possession of her purse, it was not authorized by the Mental Health Code.[32] Fourth, the appellate court held that the detention of a patient for a mental health evaluation is only authorized if the petitioner believed that the patient is or may be subject to involuntary admission and that immediate hospitalization was necessary to prevent harm to the patient or others.[33] The appellate court found that it was not clear from the record what information plaintiff's primary physician gave to the emergency room physician who made the decision to detain the plaintiff.[34]

The appellate court held that in the face of these disputed questions of material fact, the defendant was not entitled to judgment as a matter of law.[35] As such the trial court erred in granting summary judgment.[36] The appellate court remanded for further proceedings consistent with its opinion.[37]

The opinion in *Irvin* underscores the importance for a hospital to properly instruct its personnel about the requirements and procedures of the Mental Health Code if it seeks to involuntarily confine a patient for mental health treatment. The Mental Health Code includes provisions that govern precisely the circumstances involved and procedures necessary to conduct an evaluation of an unwilling patient who may be subject to involuntary admission on an emergency basis.[38] If a hospital does not follow the Mental Health Code, it may readily be held liable for false imprisonment.■

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1. *Irvin v. Southern Illinois Healthcare, 2019 IL App (5th) 170446 (filed April 23, 2019).*
2. *Id. at* ¶¶ 1, 5.
3. *Id. at* ¶ 1.
4. *Id. at* ¶ 5.
5. *Id. at* ¶ 7.
6. *Id.*
7. *Id.*
8. *Id. at* ¶ 5.
9. *Id.*
10. *Id. at* ¶ 7.
11. *Id. at* ¶ 8.
12. *Id.*
13. *Id.*
14. *Id.*
15. *Id.*
16. *Id.*
17. *Id. at* ¶ 1.
18. *Id. at* ¶ 10.
19. *Id.* at ¶ 1.
20. *Id.*
21. *Id. at* ¶ 41.
22. *Id.*, citing *Doe v. Channon,* 335 Ill. App. 3d 709, 713 (2002).
23. *Id. at* ¶ 41.
24. *Id.*
25. *Id. at* ¶ 56.
26. *Id. at* ¶ 57.
27. *Id.*, citing 405 ILCS 5/3-603(b)(4)(West 2014).
28. *Id.*, citing sec. 3-601 and 3-603.
29. *Id. at* ¶ 58.
30. *Id. at* ¶ 59.
31. *Id.*
32. *Id.*
33. *Id.*, citing sec. 3-600, 3-601, 3-603.
34. *Id. at* ¶ 60.
35. *Id. at* ¶ 61.
36. *Id.*
37. *Id. at* ¶ 71.
38. *Id. at* ¶ 48.

In re Linda B.: Analysis and implications

BY REBECCA BOORSTEIN

Introduction and Summary

Many people with mental health conditions receive treatment in facilities that have not traditionally been considered "mental health facilities." These facilities include emergency departments, medical or surgical units of general hospitals, and nursing homes. More people are receiving inpatient psychiatric care in these types of facilities because: (1) the number of state-operated inpatient beds has declined by 95 percent during the past 60 years; (2) many general hospitals do not have inpatient psychiatric beds; and (3) persons requiring inpatient care for non-psychiatric conditions may also need psychiatric care.

Until recently, there was some uncertainty about whether the Mental Health and Developmental Disabilities Code (hereinafter "MHDD Code" or "Code") applied to patients receiving mental health treatment in non-traditional facilities.[1] This uncertainty has existed particularly with regard to voluntary admissions. However, a recent decision of the Illinois Supreme Court, when coupled with existing state law and legal precedents, has now removed that uncertainty. As will be discussed in detail below:

1. In *In re Linda B.*, 2017 IL 119392, 91 N.E.3d 813(Ill., 2017), the Illinois Supreme Court determined that all persons receiving inpatient mental health treatment are in a "mental health facility" under the definition provided by the Code.
2. The legislature only included one definition of a "mental health facility" in the Code, and it applies to the entire Code, including the provisions for informal and voluntary admission.
3. No one may be admitted to a "mental health facility" except under the provisions of the Code.
4. The United States Supreme Court has unanimously held that voluntary admission to a mental health facility implicates a liberty interest that is protected by the Due Process Clause of the 14th Amendment.The legislature's reasons for requiring specific procedures for informal and voluntary admission to mental health facilities apply to non-traditional settings, in addition to dedicated inpatient psychiatric facilities.
5. The Illinois Appellate Court has held that the Code applies to persons receiving mental health treatment in nursing homes.

Therefore, patients cannot be provided with mental health services in emergency departments, medical or surgical units of general hospitals, or nursing homes unless they have been admitted to such a facility pursuant to the provisions of the Code. While the scope of the law as clarified by *Linda B.* might seem overly broad to medical and legal practitioners, this problem can be addressed through specific amendments to the Code.

Analysis

1. In *Linda B.*, the Illinois Supreme Court determined that all persons receiving inpatient mental health treatment are in a "mental health facility" under the definition provided by the Code.

In *In re Linda B.*, the Illinois Supreme Court interpreted the definition of "mental health facility" in the Code to include persons receiving mental health treatment in all inpatient settings, including non-traditional ones, for the purpose of involuntary admission to those facilities. Specifically, the Court stated that "in those instances in which a facility ... provides psychiatric treatment to a person with mental illness ... it qualifies as a 'mental health facility' for the purpose of the Mental Health Code's application."[2]

Therefore, patients are in a "mental health facility" if they are receiving mental health services in those locations.

In reaching that decision, the court emphasized that the legislature's definition does not state that a facility must have a primary purpose of treating individuals with mental illness, so a non-specialized medical unit is not precluded from being a mental hospital merely because it primarily treats physical injuries. In fact, the court explicitly rejected this "primary purpose of care" test when it was proposed by the state.[3] Thus, a patient is still in a "mental health facility" regardless of any separate non-psychiatric medical treatments that the patient may have been receiving previous to or concurrently with mental health treatment in the same location.

However, the type of treatment provided to the patient is still relevant in determining how to label the facility. Specifically, the court decided that where a facility "provide[s] the [particular] individual [with] mental health services," it "is a mental health facility."[4] Therefore, the administration of psychiatric treatment to a particular patient creates a "mental health facility" for that patient.

The court considered the scope of the definition provided in the Code, which states that a "mental health facility" is:

[A]ny licensed private hospital, institution, or facility or section thereof, and any facility, or section thereof, operated by the State or a political subdivision thereof for the treatment of persons with mental illness and includes all hospitals, institutions, clinics, evaluation facilities, and mental health centers which provide treatment for such persons.[5]

Ultimately, the court emphasized the separate categories that the legislature intentionally included in the definition, as well as its purposeful use of the word "any" as evidence that the definition encompasses all such treatment settings. Application of the Code cannot be escaped by claiming a certain label or alternative primary purpose if mental health services are being administered in that treatment facility. Rather, the Court held that the Illinois legislature's definition of "mental health

facility" is broad in scope. This definition encompasses a much more diverse set of locations than traditional inpatient treatment facilities like state hospitals and specialized psychiatric wards. Thus, emergency departments, medical or surgical units of general hospitals, nursing homes, and other locations that provide inpatient mental health treatment fall under its umbrella.

2. The legislature only included one definition of a "mental health facility" in the Code, and it applies to the entire Code, including the provisions for informal and voluntary admission.

The Code only contains one definition of a "mental health facility."[6] The legislature intended for this definition to apply to the entire Code, and it additionally did not include separate definitions in distinct parts of the Code. The limitations of rights and concomitant protections listed in the Code are applicable to a broad range of patients, so the definition of "mental health facility" must be similarly inclusive for patients to meaningfully receive such protections.

The legislature's intent to protect all mental health patients, and not merely involuntarily admitted patients, is evident through the broad protections established for all patients in the Code. The rights listed in Chapter II, Article I apply to all "recipients of services." The phrase "recipient of services" itself is broadly defined in the Code to include all patients who are receiving mental health services, and the concepts of "mental health services" and "treatment" also are broadly defined.[7] If the legislature intended to define these concepts broadly, then the definition of "mental health facilities" must be similarly inclusive.

Moreover, *Linda B.* clarifies how the Code's broad definition applies in existing settings for inpatient mental health treatment, rather than creating a new definition of "mental health facilities." Consistent with *Linda B.,* the Illinois appellate court has invalidated emergency room admission practices that ignore the Code's provisions, and it has reinforced that this policy comes from the legislature rather than as a new invention of the court.[8] In *In re Wilma T.*, the court invalidated the involuntary commitment of a patient in an emergency room setting when medical professionals disregarded the procedures for admission to a "mental health facility" specified in the Code.[9] Furthermore, the dissent highlighted that the definition of "mental health facility" is mandated by well-established definitions and procedures contained within Illinois statutes when it remarked that the majority's analysis "constitutes [nothing] other than a recitation of existing law."[10] Likewise, *Linda B.* merely recounts the existing law in the Code, clarifying its application to types of treatment facilities as their use becomes more prevalent.

3. No one may be admitted to a mental health facility except under the provisions of the Code.

In *In re Gardner*, the Illinois appellate Ccourt held that the Code provided the only legal authorization for admission to a mental health facility.[11] The Code states: "A person may be admitted as an inpatient to a mental health facility for treatment of mental illness only as provided in this Chapter "[12] In *Gardner*, the court held that, "[b]y enacting Section 3-200 [of the MHDD Code] the legislature has clearly provided that the MHDDC is to be the exclusive means by which a mentally ill person is admitted to a mental health facility."[13]

The court explained that alternative admission procedures would frustrate the legislature's intent "to prevent the warehousing of disabled adults in substandard conditions when they do not qualify for entry into a mental health facility under the direct control of the State."[14] Most importantly, the court reasoned that, "the Code contains an elaborate and complex system of procedures designed to protect the rights of the mentally ill. In bypassing the procedures for involuntary commitment set forth in the Code, the trial court has denied respondent the rights guaranteed under the provisions."[15] Thus, admissions procedures other than the ones provided by the Code are not only unlawful and void, but they can also result in serious rights deprivations where patients are denied the protections that the legislature intended to provide.

4. The United States Supreme Court has unanimously held that voluntary admission to a mental health facility implicates a liberty interest that is protected by the Due Process Clause of the 14th Amendment.

Voluntary patients, in addition to involuntary patients, can experience rights deprivations while they receive mental health treatment. As acknowledged in the Code itself, patients may experience deprivations related to restrictions on their communication with others by mail, telephone, or in-person visitation, their ability to refuse medication, restrictions on property ownership and control, and deprivations of their physical liberty, including forcible seclusion and restraint.[17] Admission to an emergency room for maladies outside of the field of mental health treatment does not carry the same risks.

In *Zinermon v. Burch*, the United States Supreme Court unanimously held that voluntary admission to a mental health facility implicates a liberty interest protected by the Due Process Clause of the 14th Amendment.[18] The majority held that Burch, a voluntarily admitted patient, was "deprived of a substantial liberty interest," that the agents responsible for his commitment incorrectly exercised the "power to deprive mental patients of their liberty," and that his claim demonstrated a "violation of his procedural due process rights."[19]

Although the dissent did not believe that a due process violation occurred in the particular facts of the case, it upheld that voluntary admission does in fact implicate a liberty interest protected by the Due Process Clause. This agreement is evident from the dissent's opening words: "Without doubt, respondent Burch alleges a serious deprivation of liberty"[20] Hence, voluntary patients must be admitted according to the Code to protect the liberty interest identified by the Supreme Court in *Zinermon*.

5. The legislature's reasons for requiring specific procedures for voluntary admission to mental health facilities apply to non-traditional settings, as well as dedicated inpatient psychiatric facilities.

The legislative history of the Code

demonstrates that the reasons for requiring specific procedures for voluntary admission to mental health facilities also apply to non-traditional settings. The legislature explained that the Code includes procedures that help the patient to "understand his rights, particularly in a situation where a long-term period of inpatient treatment may be required"[20] Voluntarily admitted patients also need to receive accurate information regarding their rights and treatment options.

Specifically, the Code provides for periodic review of voluntary patients' records to reassess the need for continued hospitalization, as well as a procedure for securing reaffirmation from patients of continued desire for voluntary inpatient care.[21] The legislature intended for this provision to create better monitoring of "the treatment relationship" and to "assure that treatment continues on a consensual basis."[22] Non-traditional facilities must also monitor treatment relationships and obtain valid consent.

In fact, the legislature's concern is perhaps even more pressing in non-traditional settings. Patients may be even less aware of the extent of their rights and liberty limitations in an environment that does not as blatantly signal that it is a site for administering mental health treatment as a dedicated inpatient psychiatric facility. Ultimately, the Code's history demonstrates that the legislature intended for these admission procedures to apply to non-traditional facilities if they provide inpatient mental health treatment.

6. The Illinois appellate court has held that the Code applies to persons receiving mental health care in nursing homes.

The Illinois appellate court previously ruled that the Code applied to persons who receive mental health care in nursing homes in *In the Matter of Guardianship of Muellner v. Blessing Hospital*.[23] In this case, the court found that a trial court may not grant a guardian the power to admit a nonconsenting ward to a mental health facility for treatment as a voluntary patient. To reach this holding, the *Muellner* court interpreted the same statutory definition at issue in *Linda B*.[24] The court found that the nursing home's behavioral unit "qualifies as a 'mental health facility' under the Mental Health Code," and that admission must therefore "proceed under the Mental Health Code."[25] While *Muellner* specifically finds that a nursing home's behavioral unit is a mental health facility, *Linda B.* clarifies that this holding extends to all patients receiving inpatient mental health treatment in nursing homes.

Conclusion

Ultimately, *Linda B.* determines that all persons receiving inpatient mental health treatment are in a "mental health facility." The Code contains only one definition of a "mental health facility," and that definition applies to the admission procedures contained in the Code. No other definition may be applied to admit patients to a mental health facility. Voluntary patients, in addition to involuntary patients, have a constitutionally-protected liberty interest at stake in being admitted to a mental health facility. As such, voluntary patients must also be admitted according to the provisions in the Code, as the Code was expressly formulated to protect such liberty interests.

Linda B. clarifies that the scope of the legislature's definition is broad, and the legislature itself provides justifications for this breadth. These justifications are not only relevant to protecting patients in traditional settings, but they are also relevant to protecting patients in the types of non-traditional settings that are becoming more heavily utilized by providers of inpatient mental health care. In addition, nursing homes are specifically included in this mandate as a result of existing case law. Therefore, patients cannot be provided with mental health services in emergency departments, medical or surgical units of general hospitals, or nursing homes unless they have been admitted to such a facility pursuant to the provisions of the Code.

The scope of the law as clarified by *Linda B*. might be overly broad, but it is possible to narrow it through legislative amendment. Without narrowing the scope of the law, the burdens upon healthcare providers and some types of patients could be substantial. One course of action to pursue would be to entirely prohibit the admission of any patients to non-specialized facilities for inpatient psychiatric care. The State of Washington adopted such a law to avoid "psychiatric boarding" in locations like emergency rooms and acute care centers.[26]

However, this course of action is not likely a viable solution for the State of Illinois, as the number of psychiatric beds available in inpatient facilities is severely deficient to provide for the number of patients who require treatment. Furthermore, Illinois is not likely to have the requisite funding available in its budget to provide for vast expansion of state mental health treatment facilities. Thus, if this course of action is pursued, many patients with mental health conditions will be unable to receive mental health treatment.

Instead, healthcare providers and legal practitioners should consider amending the Code to specifically exclude some patients to make the law more practical in its application to non-specialized facilities. While many reasons might bring patients to these locations for treatment, most cases can be placed into one of three distinct categories. First, a person might be admitted to a non-psychiatric unit for the sole purpose of non-psychiatric medical care, and during that admission, mental health treatment might also become necessary or appropriate, as was the case for Linda in *Linda B*. cond, a person might be admitted to a non-psychiatric unit specifically for the purpose of receiving mental health treatment. This practice can occur because the patient was transported to a facility that did not have a psychiatric unit or had already filled all of the beds in its psychiatric unit, and it also had no option to transfer this patient. Patients in these two categories receive mental health treatments that they have not previously consented to receive, and thus, for the reasons articulated in the Code and repeated in the case law presented above, the Code should continue to apply to them.

However, the burden upon non-specialized providers of mental health treatment can be substantially lessened by carving out a third category of patients

from the Code. A vast majority of patients are admitted to non-specialized facilities solely for the purpose of receiving non-psychiatric medical care. Many patients received mental health treatment prior to their admission to a non-psychiatric unit and that mental health treatment must be continued during their hospitalization.

Assuming that they received the requisite protections when these treatments were previously initiated, these patients have already provided valid consent and have been afforded adequate protection. Nonetheless, non-psychiatric facilities would still be required to comply with the Code before providing them with their ongoing mental health treatments under existing law. This requirement hinders non-traditional facilities in their primary function of providing non-psychiatric treatment. Carving out these patients not only helps facilities provide better care, but it also relieves burdens upon patients by obviating the need to readmit them before they can receive treatments to which they have already consented and might require immediately. As the potential benefits to both healthcare providers and patients outweigh the cost of removing the protections provided by the Code to this category of patients, and because this category is substantial, it would be valuable carve them out of the Code through a specific legislative amendment.■

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1. 405 ILCS 5/1-100 *et seq.* (West 2016).
2. *In re Linda B.*, 91 N.E.3d 813, 823 (Ill. 2017).
3. *Id.* at 822.
4. *Id.* at 823.
5. *Id.* at 823, citing 405 ILCS 5/1-114.
6. 405 ILCS 5/1-114.
7. *Id.* at 5/2-100, 1-123, 1-115, and 1-128.
8. *In re Wilma T.*, 2018 IL App (3d) 170155, ¶¶ 15-20.
9. See *Id.* at ¶ 19.
10. *Id.* at ¶ 31.
11. 121 Ill.App.3d 7, 459 N.E.2d 17, 20, 76 Ill.Dec. 608 (4th Dist. 1984).
12. 405 ILCS 5/3-200.
13. *In re Gardner*, 459 N.E.2d at 20.
14. *Id.*
15. *Id.* at 20.
16. 405 ILCS 5/2-100 *et seq.*
17. 494 U.S. 113, 118-20 (1990).
18. *Id.* at 138, 139.
19. *Id.*
20. *Governor's Commission for Revision of the Mental Health Code of Illinois*, 39 (1976).
21. 405 ILCS 5/3-404.
22. *Gov. Comm'n.* at 42.
23. 335 Ill. App.3d 1079, 782 N.E.2d 799, 270 Ill.Dec. 240 (4th Dist. 2002).
24. *Id.* at 802.
25. *Id.* at 802-03.
26. *In re the Detention of D.W., et. al.* No. 90110-4.

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