The Baker Act

Chapter 394, Florida Statutes

What is the "Baker Act"? The term is used to denote two legally distinct processes:

- Involuntary Examination (§ 394.463, F.S.) – 72-hour limit*
- Involuntary Treatment (§ 394.467, F.S.) – requires petition and hearing

BRIEF HISTORY: Passed in 1971 and championed by then-Representative Maxine Waters, the revamped commitment laws were passed as a means to respect the constitutional rights of the mentally ill. Prior to the Baker Act, it was exceedingly easy to have someone committed based on little to no evidence, and there was also no codified process to ensure that a person could be released or to ensure that treatment was provided while in the facility.

It has remained largely unchanged (except, for example, the provisions on commitment for self-neglect) since its inception, with only minor changes around the margins.

DEFINITIONS (see primarily § 394.455, F.S.):

- **Mental Illness****: "[A]n impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse. [§ 394.455(28), F.S.]

- **Developmental Disability**: "[A] disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely." [§ 393.063(12), F.S.]

- **Baker Act Receiving Facility*****: "[A] facility approved by the department which may be a public or private hospital, crisis stabilization unit, or addictions receiving facility; which provides, at a minimum, emergency screening, evaluation, and short-term stabilization for mental health or substance abuse disorders; and which may have an agreement with a corresponding facility for transportation and services." [§ 394.455(12), F.S.]

- **Express and informed consent**: "[C]onsent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion." [§ 394.455(15), F.S.]

****Rule 65E-5.160(3)(b), F.A.C.** (Right to Treatment) also states that anyone held more than 12 hours must be given a physical exam that includes "[a] determination that abnormalities of thought, mood, or behavior due to non-psychiatric causes have been ruled out."

*****Baker Act Receiving Facility (BARF)**: One of the most important questions you will need to ask is whether the facility where the client is being held is a designated BARF. This has substantial impacts on the amount of time the facility may hold the patient involuntarily (12 versus 72 hours). The link to the list of designated BARFs is provided in the Resources section at the end of this presentation.

INITIATION OF AN INVOLUNTARY EXAMINATION

An involuntary examination under § 394.463, F.S., may be initiated in one of three ways: by a law enforcement officer; by certain health providers (see the list below); or by the court via an *ex parte* order. Note the differences between the standard for an LEO versus a health provider. An LEO **must** initiate the Baker Act if the person "appears to meet the criteria," while a health care provider **isn't mandated** to do so:

- *Law Enforcement Initiation* – § 394.463(2)(a)2., F.S.: "A law enforcement officer **shall** take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for examination. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, which must be made a part of the patient's clinical record.

- *Health Provider Initiation* – § 394.463(2)(a)3., F.S.: "A **physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker** may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means, such as voluntary appearance for outpatient evaluation, are not available, a law enforcement officer shall take into custody the person named in the certificate and deliver him or her to the appropriate, or nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination.

- *Ex Parte Initiation* – § 394.463(2)(a)1., F.S.: "A circuit or county court may enter an *ex parte* order stating that a person appears to meet the criteria for involuntary examination and specifying the findings on which that conclusion is based. The *ex parte* order for involuntary examination must be based on written or oral sworn testimony that includes specific facts that support the findings. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462... If no time limit is specified in the order, the order shall be valid for 7 days after the date that the order was signed.

Baker Acts from schools: Schools per se do not have the authority to initiate but are able to call local law enforcement to do so. Whether or not the officers exercise discretion is a matter of internal training and policies (e.g., refusing to Baker Act autistic children). See the definition of mental illness above, which explicitly excludes "antisocial behavior," which is in fact the basis for many schools' calls to law enforcement.

Transportation to a Designated BARF (§ 394.462, F.S.): Each county is required to come up with a "transportation plan" that law enforcement officers must use when determining where to take an individual. It usually requires that the person be taken to the closest BARF. However, police may take someone to a hospital if that person is experiencing an "emergency medical condition" requiring immediate treatment, regardless of whether it is a designated BARF. *See* § 394.462(1)(i), F.S.

Searches and Home Entry Incidental to a Baker Act: Law enforcement may enter a home to effect a Baker Act if it 1.) reasonably appears necessary to prevent an emergency or medical crisis and 2.) the initial purpose for entry was not to search or seize any property. *See Estes v. State*, 960 So. 2d 873 (Fla. 5th DCA 2007).

Police In-House Report: Law enforcement will usually create a separate report for themselves about the Baker Act (each agency does this differently). This "in-house" report is NOT part of the clinical record and therefore is not confidential. It may be requested pursuant to public records laws. *See* AGO 93-51.

EMERGENCY MEDICAL CONDITIONS [§ 395.002(8), F.S.]

When a person is Baker Acted and either taken directly to a hospital for emergency treatment OR transferred from a BARF to a hospital for emergency treatment, the 72-hour examination window is *tolled* while the emergency is ongoing. The clock stops when the treating physician documents that an "emergency medical condition" exists (defined in § 395.002(8), F.S.), and it starts back up when the physician documents that the emergency medical condition is no longer present (IOW, that the person is "medically cleared").

Some hospitals are designated BARFs, which means they can keep the patient for the full 72 hours. However, many are not BARFs. If the facility is not a BARF, then once the patient is medically cleared, the facility has **12 hours** to either transfer the patient or have one of its own physicians conduct the exam. If they fail to comply yet hold the patient involuntarily beyond 12 hours, the stay converts into a **false imprisonment**.

***I had a case in which the patient was taken to a non-BARF hospital, and doctor (who was a psychiatrist) was totally unaware that he could conduct the psych exam himself and discharge the patient. The patient was clearly not a threat, but the doctor simply refused to do the exam himself because he didn't know if he was "allowed" to do so. You can refer to these statutes if such a situation arises.*

In its guidance paper on Emergency Medical Conditions, DCF has noted, "The only purpose of stopping the Baker Act involuntary examination clock is the presumption that a psychiatric examination cannot be performed while a patient is in the middle of a medical emergency. ***It isn't intended to be used to hold a person against their will for an extended period of time without due process***." Emergency Medical Conditions, EMTALA, and Hospital Transfers, p. 3. (Emphasis supplied.)

§ 395.002(8)(a), F.S. ("Emergency Medical Condition"): A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to patient health, including a pregnant woman or fetus.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

§ 394.463(2), F.S.:
(h) A person… who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a facility within the examination period specified in paragraph (g). The examination period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient services pursuant to s. 394.4655(2) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary services or placement, if appropriate, **or released directly from the hospital providing emergency medical services**…

(i) One of the following must occur **within 12 hours** after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a facility and released; or
2. The patient must be transferred to a designated facility in which appropriate medical treatment is available. However, the facility must be notified of the transfer within **2 hours** after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

INVOLUNTARY EXAMINATION

394.463 Involuntary examination.—

(1) CRITERIA.—A person may be taken to a receiving facility for involuntary examination if there is reason to believe that the person **has a mental illness and because of his or her mental illness**:

> **(a)1.** The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **or**
>
> **2.** The person is unable to determine for himself or herself whether examination is necessary; **and**
>
> **(b)1.** Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **or**
>
> **2.** There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

- Overwhelming majority of calls are based on self-harm or suicidal ideation/behavior rather than danger to others.
- Quite a few are Baker Acts of children who do not actually have a mental illness as defined in the statutes but instead are autistic, have some other developmental disability, or were simply engaged in antisocial behavior.
- 72 hours is an **upper limit**. Once an examination is conducted, the person must be released if he or she fails to meet the enhanced criteria in § 394.467 (e.g., least restrictive environment). The law cannot be used for "observation" if the person doesn't meet the criteria.
- No case law or definition specifically on what is "recent" behavior.
- Criteria **(1)(b)1.** (Self-neglect) is, technically, the only criterion that may not be invoked if there are willing and responsible family members and friends. This is based on ***In re Beverly***, 342 So. 2d 481 (Fla. 1977): "[A] state cannot constitutionally confine without more a non-dangerous individual who is capable of surviving… with the help of willing and responsible family members and friends."
    - Technically, you cannot invoke "willing and responsible family members and friends" if the person is being detained based on suicidal behavior or danger to others. However, there is some case law implying that petitions based on a patient's suicidal behavior required an analysis of whether the person could survive on the outside with family or friends, so it's a fuzzy question. If you're dealing informally with the facility pre-hearing, this argument might work.
- The patient must be examined by a physician or clinical psychologist without unnecessary delay to determine if the criteria for involuntary services are met. *See* § 394.463(2)(f), F.S.
- The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist or a clinical psychologist. *Id*. *But see* § 394.463(2)(h), F.S. (non-BARF hospitals).

WHAT MUST HAPPEN WITHIN 72 HOURS

Pursuant to § 394.463(2)(g), F.S., the facility must do one of four things within the 72-hour time period ("**VOIR"**):

1. Request that the person admit himself or herself **V**oluntarily:
    - The facility will almost always ask the person to admit voluntarily if he or she is competent. It is usually not advisable to have client do this (or you may need to have the client rescind the voluntary paperwork if s/he already signed, and s/he didn't know what s/he was signing, as this is a violation of express and informed consent).
    - Sometimes the facility will falsely tell the patient that signing the voluntary paperwork is the only way to be released. This is legally false and clinically unnecessary; it is a way for the facility to compel payment and reduce paperwork (by avoiding filing a petition).
    - Once a patient has signed the voluntary admission paperwork, s/he may then request a release. A person must be released within 24 hours of signing the request for release form. HOWEVER, the facility may also convert the individual back onto involuntary status, at which point it has two business days to file a petition with the circuit court for involuntary treatment. *See* § 394.4625, F.S. (see below section on Voluntary Admissions).
2. File a petition for involuntary **O**utpatient treatment (Kendra's Law – *almost never used*);
3. File a petition for involuntary **I**npatient treatment;
4. **R**elease the person with no strings attached. (Note: The law states that the facility may release the person for voluntary outpatient treatment. This isn't really a legal status, and this paragraph is meaningless. Either the person is released or s/he isn't, but the facility has no legal way to compel "voluntary outpatient" if the person is being released.)

CAVEATS: There are some caveats to the 72-hour rule. Discharges do not have to be done on weekends and holidays. *See* § 394.463(2)(g), F.S. Thus a person who is Baker Acted on a Wednesday risks spending the weekend (5 days) in the facility. However, weekends and holidays are *counted* toward the 72 hours (I have had some patients tell me that they were informed that the weekends weren't part of the 72 hours. This is not accurate!).

VOLUNTARY ADMISSIONS (§ 394.4625, F.S.)

Should Client Sign the Voluntary Form? As noted above, most facilities will try to goad the patient into signing a voluntary admission form. It is usually not a good strategic idea to do so, because although the patient has the immediate right to request his or her own release once on voluntary status, the facility can convert the patient back to involuntary status and then file a petition with the court within 2 business days (!). *See* § 394.4625(2)(a)2., F.S. This may effectively extend the amount of time the person is in the facility beyond what it otherwise would have been. Additionally, the 24-hour time period can be extended to **3 days**, exclusive of holidays and weekends, if the facility claims it's necessary for "adequate discharge planning." *Id*.

Minors & Voluntary Admission: "A person age 17 or under may be admitted only after a hearing to verify the voluntariness of the consent." § 394.4625(1)(a), F.S. (These hearing are often not conducted.)

A person who is incompetent may not voluntarily admit herself to a facility.

NOTICE (§ 394.4599, F.S.)

One of the biggest problems I see at facilities is the lack of notice provided to patients, their guardians and proxies (including parents), and attorneys. Section 394.4599(2)(a), F.S., states:

> "Whenever notice is required to be given under this part, such notice shall be given to the individual and the individual's guardian, guardian advocate, health care surrogate or proxy, attorney, and representative.
>
> 1. When notice is required to be given to an individual, it shall be given both orally and in writing, in the language and terminology that the individual can understand, and, if needed, the facility shall provide an interpreter for the individual."

The problem is that notice to everyone other than the patient must only be given by **mail**. *See* § 394.4599(2)(a)2., F.S. Obviously, in a proceeding that is as time-sensitive as the Baker Act, notice by mail is woefully deficient. However, the facilities *don't even provide mail notice*. In two years, I have never – not once – received notice of any of the items listed below that require notice pursuant to § 394.4599, F.S.

Technically, notice must be given to the patient and the individuals listed above of:

- The filing of a petition for involuntary treatment [§ 394.467(2), F.S.];
- A transfer or request for transfer to a different facility [§ 394.4685(1)(b), F.S.];
- Any restrictions on the patient's rights to communicate with the outside world [§ 394.459(5)(c), F.S.];
- That a person or minor has been admitted for involuntary examination [§ 394.4599(2)(b) and (c), F.S.] (*this one must be given by phone where possible*);
- Any restrictions on the patient's rights to access his clinical record [§ 394.4615(10), F.S.];
- Transfer from involuntary to voluntary status [§ 394.4625(4), F.S.];
- Release from involuntary examination [§ 394.463(3), F.S.]; and
- Discharge of an involuntary patient [§ 394.469(3), F.S.].

PROXIES AND GUARDIAN ADVOCATES (§ 394.4598)

During the examination period, if a person is deemed by the psychiatrist to be incompetent to consent to his or her own treatment, s/he must be appointed a *proxy* to make medical decisions (including medication decisions). Proxies have all of the powers of any other proxy under part IV of Chapter 765, F.S. *See* § 394.4498(7), F.S

(Note: I have had one facility argue that Chapter 765, F.S., does not give the proxy authority to have the individual's medical records. The authority isn't specifically listed within the statute but can be inferred, as it would be absurd for the proxy to be forced to make medical decisions without the benefit of this information.)

The person who is designated to make medical decisions *after* a hearing is called a "**guardian advocate**," but their role is essentially the same. The appointment of a guardian advocate requires notice and a hearing just the same as a petition for involuntary treatment, because removing a person's ability to make his own medical decisions amounts to a partial loss of liberty requiring due process. *See In re Pickles Petition*, 170 So. 2d 603 (Fla. 4th DCA 1965). If the facility has filed a petition for involuntary treatment and seeks to have a guardian advocate appointed at the same hearing, this must be in the petition.

Section 394.4598, F.S., sets forth an order of appointment of proxies and guardian advocates. Many facilities will disregard this order of appointment and have someone in-house or court-appointed act as the proxy, which is improper not only as a matter of statutory law but also as a matter of constitutional law.

Article I, sec. 23 of the Florida Constitution enshrines a right of privacy that includes a right to make one's own medical decisions – even when you are incompetent or unable to make those decisions for yourself. As such, Florida has adopted a "substituted judgment" standard for proxy medical decision-makers, rather than a "best interests" standard. In other words, the proxy is required to make the decisions that s/he feels the incompetent person would make were the person not incompetent; the proxy is NOT supposed to make decisions in "the best interests" of the patient unless the proxy simply does not know what the person's wishes would be. *See, e.g., John F. Kennedy Hosp*. v. *Bludworth*, 452 So. 2d 921 (1984).

For these reasons, the proxy is most appropriately a person who knows the incompetent person. A stranger is totally unable to effect the "substituted judgment" standard recognized under Florida law. Accordingly, § 394.4598(6), F.S., sets forth the following order of appointment:

(a) The patient's spouse.
(b) An adult child of the patient.
(c) A parent of the patient.
(d) The adult next of kin of the patient.
(e) An adult friend of the patient.
(f) An adult trained and willing to serve as guardian advocate for the patient.

If a facility attempts to appoint a stranger or someone else outside of the order of appointment, it is imperative that you raise the constitutional issues mentioned above. Additionally, if the facility attempts to remove a parent, spouse, etc. as proxy because that person is refusing medication decisions of the psychiatrists, raise the constitutional issue. It is legally improper for the facility to remove a proxy simply because that person is making medical decisions that the psychiatrist does not like or does not agree with.

Finally, and despite the above, parents should be aware that if they refuse the psychiatrist's medication decisions, they may be subject to a DCF complaint. It is highly unlikely that such a complaint would result in any actions, but clients should be aware of this possibility.

PETITIONS AND INVOLUNTARY TREATMENT – § 394.467, F.S.

The criteria for involuntary treatment are almost identical to those for involuntary examination, with one notable exception: in order to obtain an order for involuntary treatment, the state must prove that inpatient is the **least restrictive environment** in which the patient can see improvement.

394.467(1) CRITERIA.—A person may be ordered for involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:

(a) He or she has a mental illness and because of his or her mental illness:

1.a. He or she has refused voluntary inpatient placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of inpatient placement for treatment; **or**

b. He or she is unable to determine for himself or herself whether inpatient placement is necessary; **and**

2.a. He or she is incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; **or**

b. There is substantial likelihood that in the near future he or she will inflict serious bodily harm on self or others, as evidenced by recent behavior causing, attempting, or threatening such harm; **and**

(b) All available less restrictive treatment alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.**

**Note the weasel language in this section. It is written in the passive tense, so that it's not really clear what the court is deciding. Does the state have to prove by clear and convincing evidence that the facility has "judged" less restrictive alternatives to be inappropriate? Is it the judge who is deciding that less restrictive alternatives are not appropriate? You will eventually encounter a case in which the court tries to twist these words to its advantage in granting the petition, especially if your defense rests on the availability of less restrictive alternatives.

Timing: If the facility decides to file a petition for involuntary treatment, it then it has 5 business days (excluding holidays) within which to hold the hearing. Hearings are held at the facility. There is almost always a magistrate rather than a judge. Although the facility files the petition, the state of Florida is the real party in interest. There will be a state attorney prosecuting the action.

Gaming the System: Many facilities will file the petition just to get more time, and then they just discharge the patient before the hearing is set to happen. I believe that this is highly unethical and a way of gaming the system, but there's virtually nothing that can be done about it.

Preemptive Petitions: Some facilities will have a petition drafted the same day the person arrives, but they'll hold onto it and only file it if they "need" to. The problem with this is that the factual findings on the petition might be very different from the patient's actual behavior and mental state just a couple of days later, such that the petition is no longer accurate. This is also a way that some facilities will try to "remedy" failing to get the petition filed on time – a form of backdating.

Overview of Baker Act Hearings

Baker Act hearings are, if we're being honest, often sham proceedings. The court is going to automatically swing toward the state and be partial to the psychiatrist. What is even more frustrating is that the psychiatrist is a black box – none of his testimony is based on objective factors (e.g., blood tests, brain scans), and it is very difficult to cross-examine a person who is conjuring all of his testimony from thin air (ahem, "observation"). However, the Rules of Evidence DO apply, including rules barring hearsay. You can ask for a waiver from subpoena requirements for last-minute witnesses, considering the tight time frames of hearings.

HEARING STRATEGIES & TIPS:

1.) "Least restrictive environment"

   a. Gather as much evidence as possible, including the names of doctors, therapists, and collateral care providers.

   b. Subpoena individuals to appear (by telephone if necessary) at the hearing to explain other alternatives. Subpoenas will typically need to be served by email due to the tight time frame (or provide a witness list to the state to meet notice requirements).

2.) Does this person actually have a "mental illness" as defined in the statutes?

3.) Flaws in the petition – filed outside of the time frames? (Court loses jurisdiction)

4.) Contrary evidence within the clinical record.

5.) Should I ask for a continuance?

   a. Only the respondent/patient may request a continuance for "up to four weeks."

   b. This might be a good strategy if you cannot gather evidence or witnesses.

   c. You can try to get an independent evaluation, but keep in mind that this will de facto extend the amount of time the person is in the facility.

6.) Evidence, evidence, evidence. Much of your strategy is just going to be making sure that there are gaps in their evidence and using the Rules of Evidence to your advantage.

7.) Cite past cases (almost all from the 1st DCA):

   a. Unwillingness to take medications is not enough;

   b. Deterioration of condition, standing alone, is not enough;

   c. Agitation, bad attitude, etc. are not enough.

8.) Willing and responsible family members and friends – if the petition is truly based on self-neglect allegations (rather than pretextual claims of self-harm), emphasize the availability of family and friends to care for the person.

9.) Why this person?

If the Petition is Granted: You have a couple of options if the petition is granted. (Don't feel bad about this. As noted above, these are often sham hearings, but all hope is not lost!)

1. **Exceptions** – File exceptions to the magistrate's report under Fla. R. Civ. P. 1.530 within 10 days. *See Crum v. State*, 507 So. 2d 759, 760 (Fla. 1st DCA 1986).

2. **Habeas to the DCA** – File a habeas immediately to the appellate court. The DCAs have original jurisdiction over habeas proceedings pursuant to Fla. R. App. P. 9.100.

RIGHTS OF PATIENTS (§ 394.459, F.S.)

Section 394.459, F.S., sets forth the rights of patients within a mental health facility. If a patient is transferred to a hospital for emergency treatment, these rights still apply just as if the person were still at the BARF.

1. Right to Dignity (**§ 394.459(1)**), incl. the right "not [to] be deprived of any constitutional rights"

2. Right to Appropriate Treatment (**§ 394.459(2)**). Within this section are the rights to:
    a. Not be denied or delayed treatment;
    b. Be given the least restrictive appropriate and available treatment;
    c. Be given a physical exam (if held more than 12 hours) within 24 hours;
    d. Participate in activities "designed to enhance self-image and the beneficial effects of other treatments;"
    e. Have an individualized treatment plan within 5 days of admission, which the patient was able to have input in creating and implementing.

3. Right to Express and Informed Consent (**§ 394.459(3)**). If the patient is appointed a guardian, is a minor, or is deemed incompetent, then the proxy, guardian (parent), or guardian advocate has the right to express and informed consent on behalf of the patient. This includes the right to be informed of:
    a. the reason for admission or treatment;
    b. the proposed treatment and purpose of that treatment;
    c. the common risks, benefits, and side effects thereof;
    d. the specific dosage range for the medication, when applicable;
    e. alternative treatment modalities;
    f. the approximate length of care and how treatment will be monitored;
    g. the potential effects of stopping treatment; and
    h. that consent for treatment may be revoked orally or in writing at any time.

4. Right to Quality of Treatment (**§ 394.459(4)**) (including a complaint system for patients or proxies)

5. Right to Communicate and Receive Visitors (**§ 394.459(5)**). This includes the right to:
    a. Communicate "freely and privately" with outside persons unless it is "likely to be harmful to the person or others." Including having free local calls and "access to" long distance;
    b. Correspond via mail and not have it opened and read by staff unless there's a security risk;
    c. Be accessed by "family members, guardian, guardian advocate, representative, Florida statewide or local advocacy council, or **attorney**, unless such access would be detrimental to the patient." If there is a restriction on visitation, it must be documented in the clinical record and reviewed every 7 days.
    d. "Least restrictive" visiting hours and telephone usage policy possible.
    e. Access to a telephone to report abuse at all times.

6. Right to Care and Custody of Personal Items (**§ 394.459(6)**). A person's clothing and items may only be taken away for "medical and safety reasons."

7. Right to Vote in Public Elections (**§ 394.459(7)**).

8. Right to Petition for Writ of Habeas Corpus and for Redress of Violations (**§ 394.459(8)**).

9. Right to Participate in Discharge and Treatment Planning (**§ 394.459(11)**).

HABEAS AND OTHER RELIEF

Section 394.459(8), F.S., expressly codifies the right to habeas corpus as a mental patient:

(8) HABEAS CORPUS.—

(a) At any time, and without notice, a person held in a receiving or treatment facility, or a relative, friend, guardian, guardian advocate, representative, or attorney, or the department, on behalf of such person, may petition for a writ of habeas corpus to question the cause and legality of such detention and request that the court order a return to the writ in accordance with chapter 79. Each patient held in a facility shall receive a written notice of the right to petition for a writ of habeas corpus.**

(b) At any time, and without notice, a person who is a patient in a receiving or treatment facility, or a relative, friend, guardian, guardian advocate, representative, or attorney, or the department, on behalf of such person, may file a petition in the circuit court in the county where the patient is being held alleging that the patient is being unjustly denied a right or privilege granted herein or that a procedure authorized herein is being abused. Upon the filing of such a petition, the court shall have the authority to conduct a **judicial inquiry** and to issue any order needed to correct an abuse of the provisions of this part.***

**If the patient files a habeas and it is denied on the merits, this technically *precludes the filing of another petition by you*. See § 79.10, F.S.:

79.10 Effect of judgment.—The judgment is conclusive until reversed and no person remanded by the judgment while it continues in force shall be at liberty to obtain another habeas corpus for the same cause or by any other proceeding bring the same matter again in question except by an appeal or by action of false imprisonment…

***A request to correct rights violations must be filed while the person is in the facility. *See Administrator, Retreat Hosp. v. Johnson In and For Broward County*, 660 So. 2d 333 (Fla. 4th DCA 1995).

Practical Considerations:

1. Try to find out if the patient has already tried to file a petition. If they have, you may be out of luck (see above).
2. A habeas petition must be accompanied by evidence. See § 79.01, F.S. ("When any person detained in custody, whether charged with a criminal offense or not, applies… for a writ of habeas corpus and shows *by affidavit or evidence* probable cause to believe that he or she is detained without lawful authority…")
    a. This means, in most circumstances**, affidavits of the patient** and any other person have knowledge of the circumstances, but it might also include other medical records or anything else tending to prove that the commitment is illegal.
    b. The patient's affidavit may be self-verified pursuant to § 92.525(2), F.S. (because how the heck are you going to get a notary in there?).
3. It is often pointless to invoke the circuit court's jurisdiction over habeas proceedings. The DCAs have original jurisdiction pursuant to the Florida Constitution and Fla. R. App. P. 9.100. There has been a spate of favorable rulings out of the 5th DCA in the past year or so (although, admittedly, without much in the way of written opinion). The DCAs will typically take the complaint more seriously than the circuit court – which will often summarily deny without a hearing.
4. Moreover, as a matter of timing it often makes no sense to invoke the circuit court's jurisdiction, depending on whether a hearing has already happened.
5. **Read Chapter 79, F.S**. (and associated jurisprudence).

WHAT TO DO ABOUT RECALCITRANT FACILITIES

AHCA Complaint: AHCA licenses facilities and has an online complaint form. If you file a complaint, they will do an unannounced inspection. However, keep in mind that AHCA's ability to regulate these facilities derives from Chapter 395, F.S., so it is handy to familiarize yourself with the hospital licensing requirements of Chapter 395 and include those in your complaint. Regardless, § 395.1055(5), F.S., requires that AHCA "shall enforce the provisions of part I of chapter 394, and rules adopted thereunder, with respect to the rights, standards of care, and examination and placement procedures applicable to patients voluntarily or involuntarily admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment."

Joint Commission Complaint: The Joint Commission is a private accrediting entity. It takes patients' rights pretty seriously but is looking for patterns and practices rather than one-off violations.

Department of Financial Services: If the facility appears to be engaged in insurance fraud, contact DFS.

Civil Suit: Sometimes the best way to deal with a facility that is violating the patient's rights is to just file a civil lawsuit. Justin will be discussing some of the ways to improve our ability to pursue offending facilities, which will require changes to the laws themselves. Section **394.459(10), F.S**., makes violations of statutory rights under the Baker Act explicitly actionable.

RISK PROTECTION ORDERS (§ 790.401, F.S.)

In March of 2018, less than a month after Parkland, the legislature passed the Marjory Stoneman Douglas Act. Within it was a provision called the Risk Protection Order Act. This is Florida's "red flag law." The law allows law enforcement to petition the courts for an *ex parte* order permitting the immediate seizure of a person's firearms as well as a final order restricting the person from purchasing or possessing firearms for up to 12 additional months. Like the Baker Act, there is no minimum age for an RPO (which doesn't make much sense considering that Florida law already prohibits minors from purchasing or possessing guns and ammo).

There is a bizarre provision within the RPO Act that allows the court to order a mental health examination at the final hearing, but it does not say what the court can do with the examination or who is to pay for it.

I raise the topic here because RPOs are often filed in conjunction with or shortly after a Baker Act. This is VERY jurisdiction-dependent. Some counties are filing them like crazy and some haven't filed any at all. For example, Lee County and Polk County are similarly-sized. Lee has filed 6 petitions since the law was passed while Polk has filed nearly 250.

Also note that the MSD Act included modifications to the Baker Act that allow for broader confiscation of firearms at the time a Baker Act is effected if the person has made a credible threat toward others. The process for confiscating and returning firearms can be found at § 394.463(2)(d), F.S.

Additionally, § 790.065(2), F.S., contains a relatively new provision whereby a voluntary patient for whom the facility documents (and warns in advance) that it *would have* filed a petition for involuntary placement had the individual not agreed to voluntary placement can be denied firearms rights, just the same as if s/he had been subject to a petition and adjudicatory hearing. (This section may very well be unconstitutional, but it hasn't been challenged yet, and very few facilities are actually complying with it because it's a PITA.)

Keep an eye out for the RPO issue to come up. I cannot get into the specifics of the law here – it is quite complicated – but feel free to refer to my office. Parris Law, P.A.; info@parrislaw.org; https://parrislaw.org.

RESOURCES

DCF Guidance Papers:

- Clinical Records and Confidentiality
- Emergency Medical Conditions, EMTALA, and Hospital Transfers
- Emergency Treatment Orders
- Express and Informed Consent
- Involuntary Examination
- Law Enforcement
- Rights of Patients
- Receiving Facilities
- Transportation Under the Baker Act
- Voluntary Admissions - Adults
- Weapons and Contraband
- DCF Baker Act Manual (2014)

Florida Administrative Code:

- 65E-5 (MENTAL HEALTH ACT REGULATION)
- 59A-3 (HOSPITAL LICENSURE)

Statutes:

- Chapter 394 (MENTAL HEALTH ACT)
- Chapter 395 (HOSPITAL LICENSING AND REGULATION)
- Chapter 79 (HABEAS CORPUS)

Miscellaneous:

- Baker Act Benchguide (2016)
- Baker Act Enforcement Regulations (AHCA)
- DCF - Designated Baker Act Receiving Facilities (BARFs)

CASES

PATIENTS' RIGHTS IN BAKER ACT HEARINGS

O'Connor v. Donaldson, 422 U.S. 563 (1975): The state cannot hold a non-dangerous individual who is capable of safely surviving outside of confinement with the help of willing family and friends. Additionally, facilities are obligated to provide treatment while an individual is committed. (This case became the basis for the Florida Supreme Court's seminal case on the same issue, *In re Beverly*, in 1977).

Humphrey v. Cady, 405 U.S. 504 (1972): Involuntary commitment amounts to a "massive curtailment of liberty" requiring due process, including effective assistance of counsel. (Note: right to counsel for civil commitments derives from the 14th rather than 6th Amendment.)

In re Beverly, 342 So. 2d 481 (Fla. 1977): "[A] state cannot constitutionally confine without more a non-dangerous individual who is capable of surviving… with the help of willing and responsible family members and friends."

JUDICIAL INQUIRY UNDER § 394.459(8)(b), F.S.

Administrator, Retreat Hosp. v. Johnson In and For Broward County, 660 So. 2d 333 (Fla. 4th DCA 1995): Parameters of a judicial inquiry conducted pursuant to § 394.459(8)(b), F.S.

BAKER ACT REQUIRES POTENTIAL BODILY INJURY

Craig v. State, 804 So. 2d 532 (Fla. 3d DCA 2002): Baker Act requires that the respondent be likely to commit serious bodily injury. Emotional injury does not suffice, and it was improper to commit respondent for stalking a reporter and causing her emotional distress.

EXPUNGEMENT OF MENTAL HEALTH RECORDS

Johnston v. State, 466 So. 2d 413 (Fla. 1st DCA 1985): Implying that involuntary examination records that are the result of fraud or dishonesty may be expunged in a manner similar to § 943.058, F.S., so that a person can deny that the examination or commitment ever happened: "We accept the rule adopted by the Pennsylvania courts insofar as it states that expungement of all hospital and court records is a proper remedy in those situations where the records are the result of an illegal commitment or an illegal involuntary examination proceeding."

FALSE IMPRISONMENT & OTHER TORTS

Everett v. Florida Institute of Technology, 503 So. 2d 1382 (Fla. 5th DCA 1987): Individuals who are wrongly Baker Acted may pursue a cause of action for false imprisonment.

Foshee v. Health Management Associates, 675 So. 2d 957 (Fla. 5th DCA 1996): Wrongful Baker Act gave rise to cause of action for false imprisonment, which did not require presuit notice, but could not permit intentional infliction of emotional distress because the latter tort is defined as outrageous behavior "which conduct is not violative of any other recognized tort."

National Deaf Academy, LLC v. Townes, SC16-1587 (2018): Exploring when conduct arises out of medical decision-making and therefore requires presuit notice.

STRICT CRITERIA

Jones v. State, 611 So. 2d 577 (Fla. 1st DCA 1992): Due process violation for court to admonish respondent to "keep it short" when addressing the court and for facility to neglect to give notice to state attorney. Additionally, the state failed to meet the strict criteria for commitment based on psychiatrist's testimony that respondent "was throwing items,

hollering and threatening that he will get him," and that he acted "aggressively on a few occasions, and threatened harm to his son-in-law." This does not rise to the level of alleged harm required to curtail respondent's liberty.

Braden v. State, 575 So. 2d 756 (Fla. 1st DCA 1991): State must prove by clear and convincing evidence that the respondent poses a "real and present threat of substantial harm to himself or others." Testimony that the patient was "at times verbally and physically aggressive towards others, unpredictable, and in need of a structured environment with supervision" was not enough to order commitment.

In re Lehrke, 12 So. 3d 307 (Fla. 2d DCA 2009): Conclusory testimony that admittedly psychotic patient was "threatening," without specific examples, did not suffice to order commitment, because there was no evidence that he was in fact a danger to himself or others. Additionally, the case was not moot because of the potential collateral legal consequences of a Medicaid lien for the costs of treatment pursuant to § 402.33(8)(a), F.S.

In re Glant, 634 So. 2d 318 (Fla. 1st DCA 1994): Commitment was improper because court failed to make a specific finding that patient had refused voluntary treatment or was unable to determine for herself whether voluntary treatment was proper as required by § 394.463(2)(a)(1), F.S.

Olive v. State, 509 So. 2d 1375 (Fla. 1st DCA 1987): State alleged that the patient had to be committed because her behavior might make other people harm her. This required specific factual findings showing that such harm was likely, which was missing in the record.

Blue v. State, 764 So. 2d 697 (Fla. 1st DCA 2000): Refusal to take medications and general deterioration of psychiatric condition does not suffice to order commitment. The court stated: "Appellant is unstable and threatening to others at times. Her emotional outbursts scare her family. Her examining psychiatrist testified Appellant can be pleasant sometimes, but is generally very argumentative and hostile. Her interaction with other patients can escalate into conflicts and problems. Without specificity, the evidence is not clear and convincing that there is a substantial likelihood that in the near future Appellant will inflict serious bodily harm on herself or another person."

Boller v. State, 775 So. 2d 408 (Fla. 1st DCA 2000): The evidence presented of potential harm was that the patient refused to take her psychotropic medications. This is not enough to order commitment. Moreover, there was evidence that the patient slapped a nurse one time while being taken into a room, but the court noted that "there is no evidence that the slap caused serious bodily harm."

Schexnayder v. State, 495 So. 2d 850 (Fla. 1st DCA 1986): The court was obligated to act on the record before it, which did not contain clear and convincing evidence that the patient was likely to harm herself or others or was incapable of living with the help of family and friends. The court recognized that the problem was an "ongoing one, that conditions change, and indeed, that the state may be obliged to institute further proceedings for the protection of the appellant. However, this knowledge cannot justify our failure to act on the basis of the record as we find it today."

Smith v. State, 508 So. 2d 1292 (Fla. 1st DCA 1987): Patient admitted after fight with police for being nekkid in public. Court held that despite this, and despite that the psychiatrist testified that the patient's "beliefs made him dangerous in the sense that he becomes very aggressive and elicits aggression from others based on his aggressiveness, so that his aggressiveness endangers him," the state had not proved that he was likely to cause injury to himself or others.

MOOTNESS & COLLATERAL CONSEQUENCES

Godwin v. State, 593 So.2d 211 (Fla. 1992): "The imposition of a lien under section 402.33(8) on the property of an involuntarily committed person is a collateral legal consequence," so that the case was not moot. Additionally, it didn't matter whether a lien was in fact imposed; all that mattered was that a lien could potentially or possibly be imposed.

CONFIDENTIALITY OF PATIENT RECORDS

C.L. v. Judd, 993 So. 2d 991 (Fla. 2d DCA 2007): Quashing an order requiring the Appellant to reveal her confidential mental health records in the context of a separate criminal proceeding.