Involuntary Inpatient Placement

Criteria & Eligibility

Q. What is the difference between the criteria for involuntary examination and involuntary placement?

The Baker Act requires that there be "clear and convincing evidence" that the criteria is met for placement, rather than "reason to believe" by one of the specified persons authorized to initiate the examination. Further, the criteria for placement requires that all less restrictive treatment alternatives which would offer an opportunity for improvement of the person's condition have been judged to be inappropriate.

The burden of proof is by "Clear and Convincing Evidence", defined in standard jury instructions for criminal cases, and published by the Supreme Court of Florida, No. SC95832, June 15, 2000).as "evidence that is precise, explicit, lacking in confusion, and of such weight that it produces a firm belief or conviction, without hesitation, about the matter at issue".

Q. We received an involuntary client from jail on a Baker Act from our jail with an order for ROR and Direct Transport to Baker Act Facility from the MH Court Judge. We did a 1st and a 2nd opinion and filed with the court for a hearing to obtain a court order for 90 days SRT and to appoint her mother who is a Plenary Guardian as a Guardian Advocate. When we arrived in court, the State's Attorney told the Magistrate we did not need an order from him to place the client on SRT. He stated that the existing court order was all that was needed. At that point the Magistrate and State Attorney decided we were in error and that a judge's order was good enough to hold someone. No time frame, no GA. They have now postponed the court hearing until next week to make a determination. I feel they are violating patient right to a hearing. It is my understanding that the Baker Act takes precedence in order to protect patients from being "dumped" in a psych unit. Please advise.

This is indeed a very confusing situation, needing a little more information:

1. Was the involuntary examination initiated by through the ex parte process?
2. If so, was it based on documented sworn written or oral testimony as required by law?
3. Was the Mental Health Court Judge a Circuit Judge or a County Judge? If County, the Baker Act provides no jurisdiction to order an involuntary examination under the Baker Act.

Once released from the criminal justice system into the civil system for the involuntary examination or placement, the Baker Act prevails. A criminal court order to a civil facility for examination and placement wouldn't be sufficient on its own – the provisions of 394.467, FS would apply. There have been two new appellate decisions issued by the 2nd DCA that criminal court orders are insufficient to justify civil placement under the Baker Act.

What is the position of the Assistant Public Defender? Surely the PD was present and arguing for the due process rights of the individual. I've attached a 1st DCA case that identifies the role of a public defender in a Baker Act case as well as clearly stating that the rights of the patient under the Baker Act outweigh any rights of a guardian under the guardianship statute.

There probably was no need to seek appointment of a guardian advocate to provide consent for treatment of an adult with a plenary guardian appointed by the court.

> **394.459(3), FS RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT.—**
> (a)1.Each patient entering treatment shall be asked to give express and informed consent for admission or treatment. If the patient has been adjudicated incapacitated or found to be incompetent to consent to treatment, express and informed consent to treatment shall be sought instead from the patient's guardian or guardian advocate.

Q. I have a question about a jail inmate that we have been unable to get post-release disposition for. He has a history of violent physical assault, verbal aggression, Dementia, borderline Intellectual functioning, numerous medical issues including uncontrolled hypertension & coronary artery disease, and he refuses medication. He had 5 plus years in State Hospital with no Axis I diagnosis. He was found to be incompetent and non-restorable with recommendations for civil ALF placement. Inmate has no family and no appointed guardian. No facility will accept this man. A Court is scheduled soon with planned release to community unless Baker Act is instituted or Court ex parte order.

There are a couple of issues here – one is the diagnosis and the other is the remaining criteria for involuntary examination / placement. The legal definition for "mental illness" is as follows:

> **394.455(18)"Mental illness"** means an 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 a person's ability to meet the ordinary demands of living, regardless of etiology. For the purposes of this part, the term does not include retardation or developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

Therefore, a singular diagnosis of dementia wouldn't disqualify him from admission under the Baker Act because dementia isn't one of the exclusions listed in the law. You mentioned by phone that this man has a history of sexual assaults on children. However, you said he hasn't had any violence in the last five years. Therefore, the "danger to self or others" criteria wouldn't be met because that requires that there be 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.** However, you also indicated that the man has been refusing his medication for high blood pressure due to his mental illness. This could constitute **real, present, and substantial self-neglect** if necessary to maintain his life/health and the refusal is due his mental illness rather than a cogent refusal.

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.

If admitted to a receiving facility for involuntary placement and the above criteria are documented by the two required psychiatrists, one more criteria must be met – that all available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate. You indicated that all nursing homes and ALF's in your area of the state have refused to admit this man due to his sex offender status.

394.467 Involuntary inpatient placement.
(1)CRITERIA.—A person may be placed in involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:
(a)He or she is mentally ill and because of his or her mental illness:
1.a.He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or
b.He or she is unable to determine for himself or herself whether placement is necessary; and
2.a.He or she is manifestly 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 himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and
(b)All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

For the reasons indicated above, there may be a basis for the involuntary examination and involuntary placement of this man if clinically documented and testimony at the hearing reaches the clear and convincing level required by law.

Q. It is my understanding that on a psychiatric unit within a Baker Act receiving facility, once a patient no longer meets Baker Act criteria they must either sign voluntary or be discharged. Can you please elaborate on what our responsibility is if there is no safe place to send the patient? For example, dementia patients that have been medicated to reduce the likelihood of behavioral outbursts - if the family states they cannot handle them at home, but there is no ALF or NH that has accepted the patient yet, what do we do? If they do not really meet Baker Act criteria, but they cannot sign voluntary because of their dementia, are we infringing on their rights by keeping them on a locked unit? Most of the time we cannot transfer them to a medical floor because they don't really have a medical diagnosis either.

You are correct that if a person no longer meets the criteria for involuntary status and is unable or unwilling to transfer to voluntary status, he/she must be released. However, in the situation you describe, the individual with dementia may not be actively dangerous, but may be subject to substantial self-neglect if unable to care for his/her own needs and no caregiver is available. It is unlikely that such a person could be on voluntary status anyway because of incapacity – unable to make well-reasoned, willful, and knowing decisions about mental health and medical issues.

Your best alternative is to file a petition for involuntary placement within the 72-hour examination period based on the individual's serious impairment resulting in substantial self-neglect. That will allow you to keep the person until the hearing takes place, continuing to see a less restrictive available and appropriate alternative.

Q. Regarding completion of the evaluation and next steps: #1 A facility completes the evaluation in 72 hours, but is not clear if the member should get released or extend to a BA 32. Are they still legally covered under the original BA 52? #2. When a court orders two weeks for treatment under a BA 32 extension, but during the two week stay the member symptoms improve back to baseline, and medication levels are therapeutic. The hospital/facility does not transition the member to the next level of care because they are still within the two week period. I believe the member is still legally covered under the court order. Is that right?

A receiving facility must decide within the legally permitted 72 hours whether or not the individual meets the involuntary placement criteria or must release the individual from the facility. A receiving facility's only other options are to transfer a person who is both able and willing to voluntary status or to file a petition (BA-32) with the clerk of court. Timely filing of the petition authorizes retaining the individual until the court hearing. If the individual begins to stabilize prior to the court hearing and no longer meets the involuntary placement criteria, the facility can request to withdraw the petition and the person can be released or transferred to voluntary status.

If a person is ordered to involuntary placement and is found not to meet the criteria before the end of the period authorized by the order, the receiving facility administrator is required to discharge the person or convert to voluntary status, as follows:

> **394.469 Discharge of involuntary patients.**
> (1)POWER TO DISCHARGE.—**At any time a patient is found to no longer meet the criteria for involuntary placement, the administrator shall:**

(a)Discharge the patient, unless the patient is under a criminal charge, in which case the patient shall be transferred to the custody of the appropriate law enforcement officer;
(b)Transfer the patient to voluntary status on his or her own authority or at the patient's request, unless the patient is under criminal charge or adjudicated incapacitated; or
(c)Place an improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.

Q. A man whose primary diagnosis is dementia was admitted to our unit on a Baker Act due to violence against his grandchildren in his daughter's home where he was living. A DCF investigation is in process and the daughter states he can't come back to her home. We've made a referral to a nursing home, but his BA-52 expires today and the psychiatrist states he must be discharged because he is not competent to sign voluntarily. Because of the diagnosis of dementia she does not feel she should do a 32 to hold him. She has requested that I give an administrative order to hold him. It is my understanding I cannot do that and the only way we can legally hold him is if she initiates a 32. What are our alternatives?

You are correct. The definition of mental illness requires a severe thought or mood disorder that interferes with a person's ability to meet the ordinary demands of living, regardless of etiology -- the only exceptions are substance abuse, developmental disabilities and antisocial behavior. Therefore, dementia would not necessarily be an exception. If, because of this thought disorder, he is unable to determine that treatment is needed and is either self-neglectful or dangerous to self or others, he would meet the criteria for involuntary placement, assuming there was not currently a less restrictive alternative appropriate/available to him. A petition for involuntary inpatient placement would be entirely appropriate. There is no such thing as an "administrative hold". Since the 72-hour exam period is expiring and he is incompetent to be voluntary, you have no other choice but to file the petition.

Q. I have a question about the Baker Act Process with a patient that is not a citizen of the U.S and in our care. The patient is psychotic and in need of medications for stabilization. He is refusing medications. Do we follow the same process of 1st and 2nd Opinion, obtain a Proxy and Court or does INS act as the decision maker / Court?

Any person who is present in the state of Florida is subject to the Baker Act. Such persons, if they meet the criteria for involuntary examination, can be taken into custody and legally examined under the law. If they are found to meet the criteria for involuntary placement, a petition can be filed to further detain the person for treatment. This isn't unusual in that Florida has many people visiting from other countries, both legally and illegally. If the person is a foreign national with citizenship in another country (even if with dual citizenship in the US), you need to remember your obligations for Consular Notification and Access.

Regarding medications, if the person has been certified by a physician as able to make well-reasoned, willful and knowing decisions about his/her treatment, the patient can

consent or refuse consent to treatment. If not competent and without a duly executed advance directive, a relative or close personal friend can be designated as a health care proxy until a guardian advocate is appointed by the court. Otherwise, an emergency treatment order can be used in cases where the physician has documented imminent danger.

Initiation & Filing of Involuntary Inpatient Placement

Q. We have a patient who was admitted on a voluntary basis and her MD changed her status to involuntary. We filed the petition within the 2 working day guideline. The question that came up was whether we also have to complete a Professional Certificate in addition to the petition?

No Professional Certificate is necessary in the circumstance you describe. The statute only refers to the Certificate, a law enforcement officer's report, or a Court's ex parte order as the methods to have a person taken into custody and delivered to a receiving facility. Once in a receiving facility, none of these documents are needed. You would just file the petition within the two working days as you described.

Q. Should the hospital should be starting the BA-32 petition for involuntary placement if the patient still meets involuntary criteria for BA52 but exceeds 72 hours of medical clearance and no placement available? If so, is it okay just to have the 1st opinion completed and continue to keep the patient and pursue psych placement for 2nd opinion? If not, what would be the appropriate action by the hospital in this situation?

A BA-32 is the petition for Involuntary Placement that can only be signed by a receiving facility administrator based upon the expert opinion of two psychiatrists (2nd opinion can be by a clinical psychologist). The only time it would be considered for use in your hospital is if a patient's non-emergency medical condition prevented transfer and a designated Baker Act receiving facility worked with you to perform the required examinations and filed the petition – a change of venue for the court hearing could be requested to conduct the hearing at your hospital instead of the courthouse or a receiving facility.

A hospital's consulting psychiatrist can complete the 1st opinion, leaving the 2nd opinion to the psychiatrist at the receiving facility to complete – this can expedite the filing of the petition with the court once the transfer is complete and permit the 2nd psychiatrist to actually provide the testimony at the court hearing. However, this process still doesn't address the statutory requirement that the person be released or transferred within 12 hours following medical stabilization and many receiving facilities might not accept a psychiatrist's opinion unless he/she also has privileges at the receiving facility.

There is no legal way to remedy holding a patient past 12 hours after determined by a physician to be medically stable. It is best that your ED physician release people no longer meeting criteria for involuntary placement rather than putting them on a list for transfer. An emergency physician is qualified under the law to perform this examination and one of the two attached forms could be used for documentation. An alternative if your ED physicians are unwilling to release people directly is to contract with a clinical

psychologist to perform the examination and authorize the person's release. Either of these methods would reduce the number of persons waiting for transfer and reduce the length of time waiting in your ED's, thereby reducing your hospital's liability should an adverse event occur while in your care.

Q. A local hospital wanted to send us a client on a B32 1st opinion. In the past, this was acceptable. Our new psychologist advised me to say no -- the 1st opinion is not a stand alone document. What if the person was admitted and we disagreed with the 1st opinion? I told them to either BA the person or have them sign voluntary. My boss told me we used to have them do both opinions and then we did a 3rd opinion but our local magistrate and Public Defender wouldn't go for that. That's when we started taking folks on the 1st opinion. Do you know the answer?

If a person can't be transferred in time for both opinions to be done by the filing facility, it is best to send on a first opinion only. This allows the facility that will actually file the petition to provide the 2nd opinion and that second expert will actually provide the testimony at the court hearing. A 3rd opinion would not be eligible for providing the statutorily required testimony at the hearing. The law provides that:

> **394.467 (2) ADMISSION TO A TREATMENT FACILITY.--**A patient may be retained by a receiving facility or involuntarily placed in a treatment facility upon the recommendation of the administrator of the receiving facility where the patient has been examined and after adherence to the notice and hearing procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary inpatient placement are met.
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> **394.467(6) HEARING ON INVOLUNTARY INPATIENT PLACEMENT.--**
> (a)2. The court may appoint a general or special magistrate to preside at the hearing. One of the professionals who executed the involuntary inpatient placement certificate shall be a witness.

You're correct -- if your physician disagrees with the first opinion, that would be documented in the chart and the petition would never be filed with the court. The person would either be released or transferred to voluntary status.

Q. A BA-32 has been filed on a Veteran for private placement. Mental health providers are now seeking state placement. A court date has been established; what is the process required to amend BA-32 petition for state placement in lieu of private placement?

This is something you need to ask of the Clerk of Court to be sure you follow the court's procedures. There isn't any restriction in the rule about filing an amended petition, however, prior to the hearing there must be a Transfer Evaluation completed by the community mental health center.

One of the criteria for involuntary inpatient placement is that “all available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.” (394.467(b), FS)

The Florida Legislature enacted provisions in the Baker Act requiring that a community mental health center or clinic confirm the sworn statements of experts testifying in involuntary inpatient placement hearings as to the availability and appropriateness of less restrictive community alternatives.

394.455 FS provides related definitions related, as follows:

> (29) "Transfer evaluation" means the process, as approved by the appropriate district office of the department, whereby a person who is being considered for placement in a state treatment facility is first evaluated for appropriateness of admission to the facility by a community-based public receiving facility or by a community mental health center or clinic if the public receiving facility is not a community mental health center or clinic.
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> (6) "Community mental health center or clinic" means a publicly funded, not-for-profit center which contracts with the department for the provision of inpatient, outpatient, day treatment, or emergency services.

The Baker Act also specifies in s.394.461(2),FS that governs the designation of receiving and treatment facilities that a civil patient shall not be admitted to a state treatment facility without previously undergoing a transfer evaluation. Before a court hearing for involuntary placement in a state treatment facility, the court shall receive and consider the information documented in the transfer evaluation…

Florida Administrative Code has been promulgated to implement these provisions of statute. These are as follows:

> **65E-5.1301 Transfer Evaluations for Admission to State Mental Health Treatment Facilities from Receiving Facilities.**
> (1) A person in a receiving facility shall not be transferred to a state treatment facility without the completion of a transfer evaluation, in accordance with Section 394.461(2), F.S., using mandatory form CF-MH 3089, Feb. 05, “Transfer Evaluation,” which is hereby incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter. **The process for conducting such transfer evaluations shall be developed by the community mental health center or clinic and be approved by the district or regional office of the department where the center or clinic is located and shall include:**
> **(a) Designation of the contracted mental health centers or clinics that are responsible for conducting the transfer evaluations, including the receiving facilities or persons for which each center or clinic is responsible;**
> (b) Establishment of the time within which a mandatory form CF-MH 3089, “Transfer Evaluation,” as referenced in subsection 65E-5.1301(1), F.A.C., shall be completed. This form shall be completed by the designated community mental health center and submitted to the court for all persons for whom involuntary placement in a state treatment facility is sought, and directly to the state treatment facility for all persons for whom voluntary admission is sought; and

(c) Specification of the minimum training and education of the persons qualified to conduct the transfer evaluations and the training and educational qualifications of the evaluators' immediate supervisor. Unless otherwise established in writing by the district or region, the evaluator shall have at least a bachelor's degree and the immediate supervisor a master's degree in a clinical or human services area of study.

(2) A community mental health center or clinic shall evaluate each person seeking voluntary admission to a state treatment facility and each person for whom involuntary placement in a state treatment facility is sought, to determine and document:

(a) Whether the person meets the statutory criteria for admission to a state treatment facility; and

(b) Whether there are appropriate more integrated and less restrictive mental health treatment resources available to meet the person's needs.

(3) Following an evaluation of the person, the executive director of the community mental health center or clinic shall recommend the admission to a state treatment facility or, if criteria for involuntary placement are not met, to alternative treatment programs and shall document that recommendation by completing and signing the form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E-5.1301(1), F.A.C.

(a) The executive director's responsibility for completing and signing mandatory form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E-5.1301(1), F.A.C., may be delegated in writing to the chief clinical officer of the center or clinic.

(b) An original signature on the mandatory form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E- 5.1301(1), F.A.C., is required.

(c) A copy of the mandatory form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E-5.1301(1), F.A.C., shall be retained in the files of the community mental health center or clinic.

(d) The completed and signed mandatory form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E- 5.1301(1), F.A.C., shall be forwarded to the court before the hearing at which a person's involuntary placement in a state treatment facility will be considered. The evaluator, or in the absence of the evaluator, another knowledgeable staff person employed by the community mental health center or clinic, shall be present at any hearing on involuntary placement in a state treatment facility to provide testimony as desired by the court.

Q. I'm an assistant Public Defender. We have filed Motions to Dismiss Baker Act Petitions due to our belief that they are legally insufficient because the 1st and/or 2nd Opinions don't contain sufficient facts/observation to support the conclusion that a patient meets Baker Act criteria. While observations may support the conclusion that the patient has a mental illness, they don't support the conclusion that the patient meets the Baker Act criteria. While we have no case law on this issue, we are citing 65E-5.290(2), FAC which states that "Each criterion alleged must be supported by evidence." We believe this refers to the Petition. Since Florida Courts have consistently held that a Baker Act is a massive curtailment of a person's liberty interest, it is incumbent on the psychiatrists to sufficiently support their conclusion with facts/observations that a patient meets Baker Act criteria and that failure to do so warrants a dismissal of the Baker Act Petition and

release of the patient. Some of the facilities have tried to remedy this situation by filing Addendums to the Baker Act Petitions. We believe that there is no legal authority for same. Any other thoughts or recommendations?

Unless the evidence elicited at the hearing reaches a "clear and convincing" level on each of the involuntary placement criteria, the court has no choice except to dismiss the petition. A public defender provided me with a definition of Clear and Convincing Evidence provided by the Florida Supreme Court as "evidence that is precise, explicit, lacking in confusion, and of such weight that it produces in your mind a firm belief or conviction, without hesitation, about the matter in issue"

While its up to the court to make a determination as to what is sufficient, the appellate courts of Florida have done this many times where various DCA's have reversed court order for placement on sufficiency of evidence. These are excellent examples for clinical witnesses in placement hearings so they will better know what to include in their testimony supporting the petition. The Assistant State Attorney may want to specifically ask such questions to elicit the testimony to support clear and convincing evidence.

Appellate cases have found that expert opinions and conclusions of physicians testifying at hearings aren't sufficient without testimony of witnesses to facts. This is why inclusion of a list of witnesses who will testify to facts supporting the petition for involuntary placement is essential (see question #7 on the BA-32). Often staff fails to include these witnesses of fact in this section of the petition and insufficient testimony can be elicited by the state attorney at the hearing. While the psychiatrist as an expert witness will render opinions and conclusions, the facilities should also identify these fact witnesses so support the opinions of the psychiatrist.

The opinions on the BA-32 should address the issues included in the appellate decisions, as should their testimony at hearing. There is intentionally very little space left on the BA-32 petition form for the second opinion. If you have two separate opinions, the public defender may want to cross examine both witnesses, even though the law only requires the testimony of one. The "second opinion" simply concurs with the first opinion, avoiding this problem. If the court wishes to amend the petition form, it can certainly do so as it is only a "model" provided by DCF.

Q. We are arguing that the Baker Act petition be dismissed before any hearing on the merits of the case. We are arguing that the Baker Act Petition be dismissed and the patient discharged because the Baker Act Petition is legally insufficient due to the legal insufficiency of the 1st/2nd Opinions. It is our position that a legally insufficient 1st/2nd is tantamount to no Opinion at all. If a Baker Act petition lacks the proper Opinion(s), it should be dismissed. An analogy would be the dismissal of a Baker Act Petition if there was not a First and/or Second Opinion altogether. What do you think?

This sounds like the equivalent of a "summary judgment" in a civil case. As you know, courts are loath to grant these if there could be any legitimate issue to be litigated, despite inadequacies in the filings. It certainly would be a novel legal approach.

The Supreme Court Commission on Fairness did look at this issue. It recommended that the Assistant State Attorney review any such petition for sufficiency. Pages 70-71 of that report has the following content:

> **What is the appropriate role of the state attorney's office in involuntary placement proceedings?**
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> **Discussion:**
> According to section 394.467, Florida Statutes, "the state attorney for the circuit in which the patient is located shall represent the state, rather than the petitioning facility administrator, as the real party in interest in the proceeding." It is important to remember that while the facility is the petitioner, the state is the real party of interest and must prosecute the petition.
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> The state is the only entity with the authority to restrict a person's liberty. In an adversarial proceeding, the state attorney is required to meet a burden of proof for involuntary placement. The state attorney should gather information independently, and evaluate and confirm the information contained in the petitions. In involuntary placement proceedings, the state has the responsibility to present evidence and testimony as to the elements and requirements of the applicable statutes. As discussed previously in this report, participation by the state attorney's office is an integral part of the proceeding. In Jones v. State, 611 So. 2d 577 (Fla. 1st DCA 1992), the court found that "in the instant case, it appears the absence of the state was a contributing factor in the due process deficiencies attendant upon the proceeding." Thus, the role of the state attorney is critical to the process. It is incumbent upon the state attorney to vigorously investigate and prosecute the petition, just as the public defender must protect the patient's rights and represent the patient's expressed desires. Further, if the state attorney's independent review does not show the statutory criteria are provable, then the state attorney should withdraw the petition.
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> **The Subcommittee recommends that:**
> a. Each state attorney's office should independently evaluate and confirm the allegations set forth in the petition for involuntary placement. If the information is found to be correct, the state attorney should vigorously prosecute the petition. If the allegations are not substantiated, the state attorney should withdraw the petition.
> b. Assistant state attorneys representing the state in involuntary placement proceedings must be bound to the same legal and ethical obligations of assistant state attorneys prosecuting other cases.
> c. The bar should be educated as to attorneys' roles and responsibilities in handling involuntary placement proceedings.

If the Assistant State Attorney believes the petition is sufficient, the court should hear the petition and either dismiss it if found to be insufficient or grant the petition if evidence raised at the time of the hearing clearly met the clear and convincing standard. It's clear that the ASA has this authority; however, it isn't as clear that the defense attorney has the same authority. If the petition is patently insufficient, the patient or his/her attorney could file a Habeas petition for release from the facility.

Q. We have a client that the court granted 7 days on our BA-32 petition which ran out yesterday. We were in the process of ALF placement but this is not available until Monday. The client agreed to stay voluntarily yesterday and was allowed as a competent adult to sign. Today he wishes to be discharged and has made a verbal request. My question is our physician wants to file another BA-32 because of his refusal to stay and be placed in an ALF and client states he would rather be homeless, are we as a receiving facility violating the law if we enact another BA-32?

You would be violating the law if you filed another BA-32 without evidence that the patient meets each of the statutory criteria for involuntary inpatient placement. Your facility should have filed for a continuation of the order if the individual continued to meet involuntary placement criteria. If he doesn't meet all of the criteria, he should be released. If the only criteria in question is the availability of a less restrictive alternative to inpatient placement and he was agreeable to an ALF, it is clear why you didn't file for continued placement. Now that he is refusing such ALF and otherwise meets each of the other criteria, it would be entirely appropriate to file a new BA-32.

It isn't an uncommon practice in extraordinary circumstances for a facility to file a new petition when an individual's clinical picture changes and there isn't time to file for reconsideration of an existing petition or to petition for continued involuntary inpatient placement. You may face the wrath of the public defender, but this may be the only way to ensure the court is aware of the continued detention beyond the period authorized in the order.

Since the patient is now on voluntary status and has requested discharge, the following applies:

> **394.4625, FS Voluntary admissions.--**
> (5) TRANSFER TO INVOLUNTARY STATUS.--When a voluntary patient, or an authorized person on the patient's behalf, makes a request for discharge, the request for discharge, unless freely and voluntarily rescinded, must be communicated to a physician, clinical psychologist, or psychiatrist as quickly as possible, but not later than 12 hours after the request is made. If the patient meets the criteria for involuntary placement, the administrator of the facility must file with the court a petition for involuntary placement, **within 2 court working days after the request for discharge is made. If the petition is not filed within 2 court working days, the patient shall be discharged**. Pending the filing of the petition, the patient may be held and emergency treatment rendered in the least restrictive manner, upon the written order of a physician, if it is determined that such treatment is necessary for the safety of the patient or others.

If the PD strongly objects to the individual's continued stay in your facility, he/she can file a petition for a writ of habeas corpus on behalf of the client – in fact you may need to offer a copy of the petition form to the patient and offer assistance in completing it. The petition must be filed with the court no later than the next court working day after receiving the petition from the patient.

Q. Is it legal for the second opinion on a BA-32 to be dated and timed prior to the first opinion or must the first opinion be documented on the 32 form itself to properly trigger a request for the 2nd opinion? Being able to do the opinions "out of order" would make the lives of the physicians easier.

Regarding the initiation of a BA32 Petition Initiating Involuntary Inpatient Placement, the law states the following:

> **394.467 Involuntary inpatient placement.--**
> **(2) ADMISSION TO A TREATMENT FACILITY.--**A patient may be retained by a receiving facility or involuntarily placed in a treatment facility upon the recommendation of the administrator of the receiving facility where the patient has been examined and after adherence to the notice and hearing procedures provided in s. 394.4599. **The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours,** that the criteria for involuntary inpatient placement are met.

There isn't any prohibition against a psychiatrist "ordering" an initiation for involuntary placement and completing the document later as long as he/she has personally examined the patient face-to-face prior to such an order or signing the petition form. However, it is unclear what is achieved by such an "order" – the two expert examinations and documentation of these opinions on the petition form, along with the administrator's signature and filing of the petition with the clerk of court must all be done within 72 hours of the patient's arrival at the facility (perhaps even earlier if the patient had waited at a medical hospital for transfer before arrival at the facility).

The above section from the law permits the second opinion to be conducted by electronic means, but only if visual and audio communication is maintained between psychiatrist and patient during the examination. See a continuation of the above section of the law as well as a new definition included in the law by the 2009 Legislature:

> Any **second opinion** authorized in this subsection may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation shall be entered on an involuntary inpatient placement certificate that authorizes the receiving facility to retain the patient pending transfer to a treatment facility or completion of a hearing.
>
> **394.455(38)** "Electronic means" means a form of telecommunication that requires all parties to maintain visual as well as audio communication.

It is unclear why a 2nd opinion would ever be conducted before a 1st opinion. The petition form elicits more extensive input from the psychiatrist conducting the 1st opinion and the 2nd opinion shouldn't differ from the first. The psychiatrist or psychologist providing the 2nd opinion is simply concurring with the first. Either of the psychiatrists is authorized to testify at the patient's hearing, as follows:

> **(6) HEARING ON INVOLUNTARY INPATIENT PLACEMENT.--**
> (a)2. …One of the professionals who executed the involuntary inpatient placement certificate shall be a witness….

It sounds as if your facility may have a procedure in place that may be creating a problem not created by the statute. The first opinion is more comprehensive – the second just supports the first opinion. Either expert can testify at the hearing.

Q. Any person that is admitted to our facility whether involuntary or voluntary two times within a 30 day period has to have a petition for involuntary placement filed for a court hearing. I can see doing this for individuals on frequent Baker Acts, but for someone who is voluntary and has 2 admissions within 30 days does not make much sense to me. Does this policy violate anyone's rights in any way?

There is no basis for requiring a petition to be filed solely because the person has had two admissions within a specified period of time. The two psychiatrists and the administrator are representing to the court that there is clear and convincing evidence that the person meets all criteria for involuntary inpatient placement when they file the petition with the court. It shouldn't be done solely to allow the staff time to conduct a meeting to discuss the circumstances. It is the patient's right not to be held over 72 hours unless all the legal criteria are met and the administrator intends the person to actually go to a court hearing.

Your facility is to be commended for looking closely at why certain persons are cycling through your facility and looking for new intervention strategies to prevent such acuity. They just need to do it within the 72 hours permitted by law as part of the examination and discharge planning. If the person does indeed meet criteria for involuntary placement and a petition is filed, there will be circumstances in which the person stabilizes before the hearing takes place and/or the final criteria that must be met no longer apply:

> **394.467 Involuntary inpatient placement.--**
> (b) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

In these circumstances a petition may be appropriately filed with the court but withdrawn before the hearing takes place if the person is willing and able to convert to voluntary status or is released from your facility.

Q. I'm a general magistrate handling BA hearings. We wanted to hear your opinion on whether a hearing is required when an Ex Parte Petition for Involuntary Examination is denied due to legal insufficiency. That is, should an order denying the request for examination provide a hearing date for a Petitioner to address his or her concerns?

A hearing is not needed to deny the petition for legal insufficiency and no such hearings are conducted at the time of or subsequent to a denial anywhere in the state. The Baker Act law and rule governing the ex parte process is as follows.

> **394.463(2) Involuntary Examination.--**

(a) An involuntary examination may be initiated by any one of the following means:
1. A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on sworn testimony, written or oral. 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 the nearest receiving facility for involuntary examination. The order of the court shall be made a part of the patient's clinical record. No fee shall be charged for the filing of an order under this subsection. Any receiving facility accepting the patient based on this order must send a copy of the order to the Agency for Health Care Administration on the next working day. The order shall be valid only until executed or, if not executed, for the period specified in the order itself. 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.

65E-5.280 Involuntary Examination.
(1) Court Order. Sworn testimony shall be documented by using recommended form CF-MH 3002, Feb. 05, “Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination,” which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or other form used by the court. Documentation of the findings of the court on recommended form CF-MH 3001, “Ex Parte Order for Involuntary Examination,” as referenced in subsection 65E-5.260(1), F.A.C., or other order used by the court, shall be used when there is reason to believe the criteria for involuntary examination are met. The ex parte order for involuntary examination shall accompany the person to the receiving facility and be retained in the person’s clinical record.

The law makes it discretionary on the part of a judge or a mental health professional to initiate an involuntary examination if there is reason to believe the criteria is met -- it is the duty of a law enforcement officer in such circumstances to do so.

If the law and rules governing this process only require an ex parte process (without a hearing) for a court to enter an order denying a person his or her liberty for the purpose of involuntary examination, a higher level of due process such as a hearing wouldn’t be required to deny such a petition. The sworn testimony in an affidavit should stand on it’s own as to whether the information is persuasive or not in convincing a judge that there’s reason to believe each of the criteria is met. Unless there are rules of judicial procedure that require such a hearing for denial, I don’t believe one is needed. There is no reason why a judge couldn’t conduct a hearing with a petitioner if he/she believed it was needed. Neither is there any reason why the petitioner couldn’t file a subsequent amended petition providing additional information for the judge’s consideration. Finally, if the patient’s condition escalated after the petition was filed / denied, the petitioner could contact law enforcement in an emergency to request initiation of the examination.

Q. A petition for involuntary inpatient placement was completed this morning and the patient immediately rescinded her request for release. I haven't even completed the remaining documents necessary to file the petition with the court.

The doctor authorized her to sign consent and she did. What do I now do with this petition? Just keep it in my files?

The patient appears to have been on involuntary status in order for the 1st and 2nd opinion to have been completed. She had no right to request release if on involuntary status – this right only applies to persons on voluntary status. However, if she requested to transfer from involuntary to voluntary status, the following would have to be done:

1. She would sign an application for voluntary admission
2. A physician or psychologist would document the completion of the initial mandatory involuntary examination as required in 65E-5.280(1), FAC
3. A physician would sign Form 3104 certifying the person's sustained ability to make well-reasoned, willful and knowing decisions about her medical and mental health care. This means she has the capacity and right to consent or refuse consent to treatment.

If she had just been certified by two psychiatrists that morning that she met the criteria for involuntary inpatient placement, it takes more than just her statement that she is willing to "rescind her right to release". The psychiatrist should indicate how her condition had changed over that short a period of time. If such an improvement of condition is documented, the signed petition must remain in the person's chart as it pertains to physician documentation of meeting criteria at a point in time of her hospitalization – it cannot be kept in any other place or destroyed just because it isn't actually filed with the court.

Q. If a psychiatrist who is asked to do a second opinion on a petition for involuntary placement did not agree, our facility would ask another psychiatrist. If that psychiatrist also didn't agree, would our only recourse be to discharge the person?

Yes. If there isn't a psychologist or a second psychiatrist in agreement with the 1st opinion, the person would have to be released within 72 hours, unless the person agreed to a voluntary status and was found to be competent to provide express and informed consent. There is no prohibition to seeking other psychologists or psychiatrists to provide a second opinion, even if a professional had previously disagreed.

Q. Can you tell me if a psychiatric ARNP can do a 2nd opinion for involuntary placement or it must be a psychiatrist or psychologist?

Only a psychologist or a 2nd psychiatrist can provide the second opinion. The only exception provided in statute is when the receiving facility is located in a county of less than 50,000 population, the law permits the administrator to so certify and obtain a second opinion from a licensed physician with postgraduate training and experience in diagnosis and treatment of mental and nervous disorders or by a psychiatric nurse as defined in the Baker Act (nurse with a masters or doctoralegree in psychiatric nursing+). No receiving facility in Florida is located in such a rural county and thus no psychiatric nurse can provide the second opinion. Please be aware that many nurse practitioners, even those working in the psychiatric field, don't meet the legal definition of "psychiatric nurse".

Q. When converting a person from voluntary to involuntary status and a Petition for Involuntary Placement and Request for Guardian Advocate will be filed, is the physician first required to complete a Certificate of Professional Initiating Involuntary Examination or Is filing the Petition it itself sufficient to convert a person from voluntary to involuntary status?

Completing the Petition for Involuntary Placement alone is sufficient to convert the person to involuntary status. The involuntary examination initiation form is only referenced in the law or rule as a method by which the person is taken into custody and delivered to a receiving facility. The proper procedure in the situation described is to initiate the BA-32, as found in Chapter 394.4625(5), FS and 65E-5.270(6), FAC. There is no purpose served in a Professional's Certificate for Involuntary Examination being signed after the person is already admitted to a designated receiving facility. Completion of the BA-32 and its timely filing with the clerk of court within two court working days of the determination is the appropriate action.

Q. If a person on voluntary status in a CSU subsequently was adjudicated incapacitated by the court, must the CSU file a petition for involuntary placement?

Yes. The Baker Act is very specific on this issue. Chapter 394.462(1)(d) states a facility may not admit on voluntary status a person who has been adjudicated incapacitated, unless the condition of incapacity has been judicially removed. If a facility admits as a person on voluntary status who is later determined to have been adjudicated incapacitated, and the condition of incapacity had not been removed by the time of the admission, the facility must either discharge the person or transfer the person to involuntary status.

Q. If a person on an Involuntary Inpatient Placement petition (BA32) requires admission to a medical facility for emergency medical treatment, is the BA32 put on medical hold or does the BA32 become void upon discharge of the patient from the psychiatric facility?

The only timeframe that is put on hold because of an emergency medical condition is the BA-52 involuntary examination. If a person is on a BA-32 involuntary placement petition or a BA-8 Involuntary placement order, the Baker Act doesn't permit any variation to the statutorily prescribed time frames. However, if at any time, the person no longer meets the criteria for involuntary placement, the administrator has a duty to convert the person to voluntary if competent and willing or to release the person. If the person continues to meet the criteria for involuntary placement, he/she can't be "discharged". The person would be "transferred" instead in order that the legal status and guardian advocate (if any) are retained. The person could then be transferred back upon stabilization with all the legal issues intact. While some type of administrative discharge would occur to avoid having two bills for the same day of care, the clinical record should reflect a transfer for medical purposes rather than a discharge.

Q. If a non-receiving facility initiates a BA32 by completing the first and second opinions, can that patient still be transferred to a receiving facility after the 72 hours has expired?

Only the administrator of a designated receiving facility has standing to **file** a petition for involuntary inpatient placement. In fact, one of the two psychiatrists signing the petition form would be required to attend the hearing and provide testimony. A petition could possibly be **initiated** by a receiving facility on a patient held in a non-receiving facility, if one of your psychiatrists performed the first or second opinion prior to a timely filing. This is an unusual procedure, but could potentially work with cooperation between the hospitals and physicians.

Q. What should be done when a person is awaiting a hearing on involuntary inpatient placement and the physician writes orders for the person to be discharged? When the family refused to take the person back, the physician cancelled the discharge order. Would the current BA-32 be nullified because of the order for discharge and another petition have to be filed?

If the physician documented that the person didn't meet criteria for involuntary inpatient or outpatient placement as a prerequisite for a discharge order, the facility couldn't go forward on an existing petition and couldn't file a new petition unless the person's condition had deteriorated after the discharge order was written. If the person is willing to apply for voluntary status and the physician has certified the person can make well-reasoned, willful and knowing decisions about his or her mental health and medical treatment, such a transfer to voluntary status can be done. If the person doesn't meet criteria for involuntary status and is unwilling or unable to consent to voluntary status, the Baker Act requires the person to be discharged. In that case, your discharge planners should investigate alternate discharge plans other than the family.

Q. I have a question regarding first and second opinions for a patient for whom involuntary proceedings have been initiated. The attending psychiatrist does the first opinion and a second opinion is done by a different psychiatrist or a psychologist. Can the second opinion be done by a psychiatrist that is in the same practice as the psychiatrist that does the first opinion?

There is no prohibition to two authorized professionals who are in the same practice from signing the two opinions required for an involuntary placement petition. As long as each professional exercises independent judgment and the opinions are in compliance with the criteria specified in the Baker Act, there isn't any problem. The only prohibition specified in the Baker Act is for conducting the evaluation of competence of a nursing home or ALF resident to be on voluntary status. The law requires that such a resident must be determined to be able to make well-reasoned, willful and knowing treatment decisions prior to removal from the long-term care facility on voluntary basis. The law prohibits any person who is employed by, under contract with, or has a financial interest in either the facility initiating the transfer or the receiving facility to which the transfer may be made from doing this evaluation. If the resident isn't able to make such competent decisions, an authorized professional who is associated with the facility may initiate an involuntary examination.

Q. A patient came to our psychiatry unit via a BA-52 that expired on a Saturday afternoon. The regular treatment teams are not here but there is a resident and an attending "on call." The resident is required to interview and write on every patient on weekends and holidays. The attending is supposed to do the same with anyone admitted on the previous evening or night shift. The resident wrote an order "Initiate BA-32" on the patient at noon. The attending arrives later in the day and when the charge nurse asks him to write an opinion for the new BA-32, he refuses, stating "it can wait until the treatment team is here on Monday." This happens because the attendings covering overnight, weekends, and holidays don't want to go to court on the patients. Should we insist that at the time the decision is made to keep a patient in the hospital the attending in charge of the unit write one of the opinions and a note? How should this be handled? This is not the first time it has happened, resulting in a delay of the hearing date.

The Baker Act requires that within the 72-hour period permitted for involuntary examination, the person be released, transferred to voluntary status, or a petition filed with the court. If the period runs out on a legal holiday or weekend, the filing of the petition can be filed on the next court working day. The law explicitly states that "a patient may not be held in a receiving facility for involuntary examination longer than 72 hours". If the 72-hour period expires, the law is clear that the person must be released. However it also states that the patient may not be released by the receiving facility without the documented approval of a psychiatrist, a clinical psychologist, or emergency physician.

> 394.463 **Involuntary examination.--**
> (2)(f) A patient shall be examined by a physician or clinical psychologist at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.
>
> (2)(i) Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:
> 1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;
> 2. The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;
> 3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or
> 4. A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary. When inpatient treatment

> is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(3)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

In the situation you describe, the psychiatrists aren't releasing the person, converting to voluntary status, or completing the petition for the court (for actual filing on the following Monday). Should a patient object, a petition for habeas corpus could be filed or the petition could be dismissed by the court for lack of timely filing. At worst, a charge of false imprisonment could be filed against the physician and the hospital. The BA-32 could have been completed with both experts and the facility administrator/designee before close of business on Friday since the person would have been at the hospital since Wednesday noon. The court would just delay the person's hearing, lengthening the deprivation of liberty, when a patient was held for examination longer than 72 hours. In most areas of the state, the public defender would have moved for dismissal of the petition.

Q. Once a Petition for Involuntary Placement has been filed by a receiving facility can that facility withdraw the petition when they transfer a patient to another psychiatric facility; then immediately Baker Act (BA-52) the patient to cover the legal status during transport to another treatment facility? In this scenario the patient is not returning to the original sending facility. We have one physician provide all of our expert testimony in Court. We don't want to risk having an acutely ill patient discharged because of a coordination problem that may occur with inviting a physician from another facility to testify at a hearing at our facility. In addition, we don't want to assume liability for another facility's 32 petition if it is out of compliance with the Baker Act law.

It would not be appropriate to withdraw the petition, once filed with the court, and start over with a new BA-52. This would result in the person being held longer than permitted under the law for involuntary examination. Such a deprivation of liberty would likely be frowned upon by the defense attorney once the person went to court. The practice around the state is that the transfer should occur prior to filing the petition or after the court hearing has taken place. That ensures that the person's due process rights are observed.

A receiving facility only has the power to discharge or release a person when a psychiatrist, psychologist or ER physician has determined the person doesn't meet the criteria for involuntary inpatient or involuntary outpatient placement. Other than that, only a transfer between receiving facilities is permissible as provided in 394.4685. A transfer maintains the legal status of the person.

The only alternative is if one of the two experts who signed the petition is willing to attend the hearing at the second facility to provide the legally required testimony. The attending psychiatrist at the second facility could provide supplemental testimony to that provided by one of the two signing experts as to the person's condition since arrival at the second facility. It is actually the duty of the assistant state attorney, as the real party in interest, to determine the legal sufficiency of each petition. If not sufficient, the petition should be withdrawn by the state attorney.

Q. I had a call this morning from the magistrate for this judicial circuit. She said that the Hospital has had a number of late filed petitions recently resulting in dismissals. They have then refilled the petitions, resulting in persons be detained beyond the period permitted by law. What should be done?

The only recourse is for the patients to file petitions for writs of habeas corpus. However, the public defender could call the hospital administrator and the hospital's attorney to advise them of this since there has been a change of in staff responsible for the petition filing. It is possible that the hospital administration doesn't even know a problem exists and will ensure it gets fixed immediately.

Q. Are local sheriffs required to serve documents related to the Baker Act? For example, notice of hearing, etc.

The Baker Act doesn't specify who is responsible for the actual service of documents other than the following:

394.4599 Notice.--

(2) INVOLUNTARY PATIENTS.--

(a) Whenever notice is required to be given under this part, such notice shall be given to the patient and the patient's guardian, guardian advocate, attorney, and representative.

1. When notice is required to be given to a patient, it shall be given both orally and in writing, in the language and terminology that the patient can understand, and, if needed, the facility shall provide an interpreter for the patient.
2. Notice to a patient's guardian, guardian advocate, attorney, and representative shall be given by United States mail and by registered or certified mail with the receipts attached to the patient's clinical record. Hand delivery by a facility employee may be used as an alternative, with delivery documented in the clinical record. If notice is given by a state attorney or an attorney for the department, a certificate of service shall be sufficient to document service.

(b) A receiving facility shall give prompt notice of the whereabouts of a patient who is being involuntarily held for examination, by telephone or in person within 24 hours after the patient's arrival at the facility, unless the patient requests that no notification be made. Contact attempts shall be documented in the patient's clinical record and shall begin as soon as reasonably possible after the patient's arrival. Notice that a patient is being admitted as an involuntary patient shall be given to the Florida local advocacy council no later than the next working day after the patient is admitted.

(c) The written notice of the filing of the petition for involuntary placement must contain the following:

1. Notice that the petition has been filed with the circuit court in the county in which the patient is hospitalized and the address of such court.
2. Notice that the office of the public defender has been appointed to represent the patient in the proceeding, if the patient is not otherwise represented by counsel.

3. The date, time, and place of the hearing and the name of each examining expert and every other person expected to testify in support of continued detention.
4. Notice that the patient, the patient's guardian or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the patient.
5. Notice that the patient is entitled to an independent expert examination and, if the patient cannot afford such an examination, that the court will provide for one.

(d) A treatment facility shall provide notice of a patient's involuntary admission on the next regular working day after the patient's arrival at the facility.

(e) When a patient is to be transferred from one facility to another, notice shall be given by the facility where the patient is located prior to the transfer.

394.467 Involuntary inpatient placement.--

(3) PETITION FOR INVOLUNTARY INPATIENT PLACEMENT.--The administrator of the facility shall file a petition for involuntary inpatient placement in the court in the county where the patient is located. Upon filing, the clerk of the court shall provide copies to the department, the patient, the patient's guardian or representative, and the state attorney and public defender of the judicial circuit in which the patient is located. No fee shall be charged for the filing of a petition under this subsection.

If the Sheriff's Office provides service of all other documents on behalf of the Clerk of Court, it would be required to do this as well. However, this isn't the case for most Baker Act notices.

Q. A patient on a BA52 in the ER is awaiting admission somewhere because we have no empty beds. The patient doesn't have capacity to sign voluntary. The ER staff is concerned that the BA52 will expire. The Psych MD will do a BA32 but should they do both opinions at our hospital because if the patient is transferred to another facility our MDs won't be there to testify? Can the other facility accept a patient on a BA32 with both opinions completed by another hospital's MDs? Do other facilities accept a patient with just the first opinion done or will they want to turn down the patient?

Your entire hospital is considered a receiving facility – not just the psychiatric unit. You have the option of placing the person on a medical unit with a sitter and providing a psychiatric overlay. You have just 72 hours in which the psychiatric examination of an involuntary patient is to be conducted, beginning at the time of the person's arrival at the ER. The only thing that stops this clock is the documentation of an emergency medical condition. Within the 72-hour period the person must be released or a petition filed with the court, unless the person is documented as both able and willing to provide express and informed consent to voluntary status/treatment.

If you can't locate another receiving facility to accept the person waiting in your ER, you may just have to initiate the BA-32 with your own psychiatrists (second opinion could be by a psychologist). You should admit the person to your first available bed on your psychiatric unit – there is generally some turnover during any 72-hour period. Remember that if you ever go over licensed census for any patient you must do so for

an indigent patient as well. One of the two experts signing the BA-32 must be available to testify at the person's hearing. You may want your attorney to check to see if the court and public defender would accept telephonic testimony in such a rare event.

There is no legal reason why another receiving facility couldn't accept the transfer with both opinions done by your physicians, but might have to have the petition actually signed by the administrator/designee of the facility to which the patient is being transferred. The destination facility would probably require, as a condition of accepting the transfer, that the issue of testimony be resolved.

Having just the first opinion done by the transferring facility, leaving the second opinion and administrator to sign at the destination facility, may be possible. However, this would have to be acceptable to the destination facility and there would have to be sufficient time remaining in the 72 hours to obtain the 2nd opinion and to process the petition with the Clerk of Court. If there is not sufficient time to file the petition in a timely way, your hospital may have to hold the person until after the hearing is conducted.

Q. When we have filed a first and second opinion with the courts and the patient misses the court date because they were admitted to our hospital's medical unit, when they come back do we have to start over and re-file or ask for a continuance?

The Baker Act requires the hearing to be conducted within 5 days of petition filing, unless the patient has requested a continuance. Therefore the continuance must be requested prior to the five day limit. Further, the 72-hour clock for involuntary examination is the only time period that can be stopped due to an emergency medical condition – not involuntary placement.

The petition for involuntary placement should probably be dismissed by the court since the patient and witnesses didn't show up for the scheduled hearing. Therefore, the only recourse that you would have is to re-file the BA-32 if the criteria for involuntary placement are still met.

The Baker Act would offer no basis for providing medical examination or treatment. If the patient was incompetent to consent, a health care surrogate or proxy should be sought, until such time as a guardian advocate could be appointed by the court

Public Defender & State Attorney

Q. What are the roles of the public defender and state attorney who conduct the Baker Act hearings?

The Baker Act involuntary placement sections [394.467) provides the following:

> (4) APPOINTMENT OF COUNSEL.--Within 1 court working day after the filing of a petition for involuntary inpatient placement, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of such appointment. Any attorney

representing the patient shall have access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.

(6) HEARING ON INVOLUNTARY INPATIENT PLACEMENT.--
(a)1... The state attorney for the circuit in which the patient is located shall represent the state, rather than the petitioning facility administrator, as the real party in interest in the proceeding.

The Supreme Court Commission on Fairness indicated that the State Attorney and Public Defender have the same obligation to their Baker Act clients as they do in any other form of legal representation.

An appellate case (Hugh T. Handley Public Guardian, Second Judicial Circuit of Florida, Guardian, et al. v. Britton B. Dennis, Administrator of Florida State Hospital and Nancy Daniels, Public Defender, Second Judicial Circuit of Florida, 642 So. 2d 115 (Fla. 1st DCA 1994). said the following about the role of the Public Defender:

> "the duty of the Public Defender is a legal and professional duty that is owed to the patient as a client.. The Public Defender serves as an independent advocate for the patient, not as a neutral party charged with the responsibility of determining the best interests of the patient or the needs of society." It also stated that "If the patient wishes to be released or transferred and if there is a basis for that request, the Public Defender has a duty to advocate the cause of the patient."

There are a number of appellate cases that relate to the notification and participation of the state attorney in Baker Act hearings -- most circuit court orders for involuntary placement were reversed for failure to participate. One 6th circuit court order (not appealed) was interesting in defining the role of the state attorney in these cases:

> Regarding the participation of attorney for a receiving facility in a Baker Act involuntary placement hearing. A receiving facility has every right to employ legal counsel to represent their legal interests in any proceeding where the facility's legal rights, liabilities or corporate interests are implicated. Since future actions of the facility, either in providing ordered treatment, or arranging for discharge of the patient, are predicated on the outcome of the hearing, the facility is entitled to have counsel present during the adjudicatory process. Counsel for the facility, although present at the hearing, may not interpose evidentiary objections or participate in questioning witnesses. This is the assigned role of the state attorney. While the facility may be a party in interest for the purpose of placing the controversy before the court, they do not have a legally protectible interest in the outcome of an adjudication of the need for involuntary mental health treatment. The statute permits the facility administrator to throw out the first ball, but the constitutional rights of the patient require that the state attorney pitch the game.

Q. I have several questions about involuntary inpatient placement procedures. In preparing for a Baker Act hearing would the PD be correct in asserting/demanding that they have the right to interview a FACT team leader prior to the hearing that

serves the client who is under the 32? I had understood that the FACT team leader would actually be a witness for the State Attorney and if the PD wanted to interview they would have to do a deposition or just question the team leader during the hearing. Other than the CSU record, would the PD have a right to review the FACT record(different provider) and require that the FACT team bring it to her office? Would this only be able to happen via a court order? This particular PD does not allow anyone in the hearing room except the person who is testifying, and of course the Magistrate and client. They also have been known to question team leaders for over an hour and in some instances their baker act hearings have run on from 8:30 to 6:00pm or later. What responsibility does the State Attorney's office have in sending informed SA to these hearings to represent the interests of the state and be able to challenge certain unfair practices of the PD?

The Baker Act is very explicit about the Public Defender's right to access the patient, medical records, and any witnesses in defending his/her client in the Baker Act proceedings. In terms of the record, the confidentiality section of the law states:

> **394.4615 Clinical records; confidentiality.**
> (2)The clinical record shall be released when:
> (b)The patient is represented by counsel and the records are needed by the patient's counsel for adequate representation.

The Baker Act defines the clinical record as follows:

> **394.455 Definitions.**
> As used in this part, unless the context clearly requires otherwise, the term:
> **(3)"Clinical record" means** all parts of the record required to be maintained and includes all medical records, progress notes, charts, and admission and discharge data, and all other information **recorded by a facility** which pertains to the patient's hospitalization or treatment.

It is unlikely that this definition would include medical records of the client other than those at the receiving facility. However, the patient always has the right to authorize release of his/her records at any facility unless adjudicated incapacitated and a guardian has been appointed by the court. In such cases, if the guardian didn't release the records, a good cause hearing could be conducted by the court in order to provide the records or any part of the records to the public defender in preparation for hearing. There isn't a requirement that you take these FACT records off site for the convenience of the Public Defender unless ordered to do so by the court.

In the Involuntary Inpatient Placement provisions, the law extends from the Public Defender just accessing the records to accessing his/her client and any witnesses in the proceedings:

> **394.467(4) APPOINTMENT OF COUNSEL**.—Within 1 court working day after the filing of a petition for involuntary inpatient placement, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of such appointment. **Any attorney representing the patient shall have access to the patient, witnesses, and**

records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.

Unfortunately, the Assistant State Attorney as the "real party in interest" doesn't have the same access to the records and to the witnesses in preparation for the Baker Act hearing and usually has to wait until the hearing to access these resources. DCF staff and I have drafted amendments to the Baker Act to extend this same access to the State Attorney to provide a level playing field in the court hearing. However, this would require legislative action to enact these amendments.

It is the responsibility of the petitioning facility to list the names of all potential witnesses for the State in the BA-32:

394.4599 Notice.
(2)INVOLUNTARY PATIENTS.—
(c)The written notice of the filing of the petition for involuntary placement must contain the following:
3.The date, time, and place of the hearing and **the name of** each examining expert **and every other person expected to testify in support of continued detention.**

It is from the BA-32 filed by the receiving facility that the Clerk of Court knows who may be called by the State Attorney as witnesses in the hearing. If such names aren't listed on the Notice of Hearing, the Public Defender would have every right to object to testimony sought from such witnesses at the time of hearing.

It is the State Attorney's responsibility to elicit clear and convincing evidence from noticed witnesses that each of the criteria for involuntary inpatient placement is fully met. One of those criteria is that "all available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate". This generally requires testimony from any case manager about why less restrictive alternatives in the community aren't available and appropriate.

394.467 Involuntary inpatient placement.
(1)CRITERIA.—A person may be placed in involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:
(a)He or she is mentally ill and because of his or her mental illness:
1.a.He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or
b.He or she is unable to determine for himself or herself whether placement is necessary; and
2.a.He or she is manifestly 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 himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; **and**

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

If state hospitalization is sought, a Transfer Evaluation is required by law from the community mental health center designated by DCF to confirm the patient meets criteria for admission to the state facility and that no less restrictive alternative is available and appropriate in the community. This evaluation must be provided to the court in advance of the hearing and the evaluator must be available to testify if desired by the court.

It would be very rare for a witness to require a subpoena to provide testimony for the state or for the defense in a Baker Act hearing. The "Exclusionary Rule" is usually invoked to prevent any witness from hearing the testimony of any other witness. This isn't specific to Baker Act hearings – it is a usual procedure in most any type of court hearing. Further, the information elicited in the hearing is of a confidential nature and anyone without the legal right to access this confidential information wouldn't be allowed to be in the hearing without the consent of the patient with concurrence of counsel.

Due to the liberty interests of the patient, the courts would uphold whatever length of time was needed for the State Attorney to elicit material and relevant testimony to support continued detention as well as for the defense attorney to challenge that testimony through cross examination as well as presenting any defense witnesses. These hearings are intended to be adversarial in the best sense of the term – not a staffing to determine best interest of the patient. I maintain a compendium of appellate cases in which dozens of orders for involuntary inpatient placement were reversed on procedural or evidentiary grounds. I'm sure the Magistrate and Circuit Court Judge would prefer to minimize the number of appeals and reversals.

The role of the Public Defender in a Baker Act hearing was defined by the 1st DCA in Handley vs. Dennis (attached). The court stated that

- The duty of the Public Defender is a legal and professional duty owed to the patient as a client.
- The Public Defender serves as an independent advocate for the patient, not as a neutral party charged with the responsibility of determining the best interests of the patient or the needs of society.
- If the patient wishes to be released or transferred and if there is a basis for that request, the Public Defender has a duty to advocate the cause of the patient.

The Florida Supreme Court Commission on Fairness concluded the duty of the State Attorney and the Public Defender was the same in a Baker Act proceeding as in any other representation. Failure to uphold this legal and ethical duty by the attorneys could constitute action against them with the Bar Association.

Many people around the state share your concern about having Assistant State Attorneys being as well trained in Baker Act matters and who remain in the role long enough to provide equal representation to the State as the Public Defender does for his/her client. An Assistant State Attorney in Broward prepared an excellent document related to the preparation and presentation of Baker Act hearings by the State. This might be helpful in the circuits you cover.

Q. What is the responsibility of the Public Defender to represent the client's wishes vs. the best interest of the client and the community?

The First District Court of Appeals found that the Public Defender has a legal and professional duty to the patient as a client. The Public Defender serves as an independent advocate for the patient, not as a neutral party charged with the responsibility of determining the best interests of the patient or the needs of society. If the patient wishes to be released or transferred and if there is a basis for that request, the Public Defender has a duty to advocate the cause of the patient.

Q. What is the role of the State Attorney in an involuntary placement hearing?

The State Attorney's role is to represent the state, rather than the petitioning facility, as the real party in interest in the proceeding. The Florida Supreme Court Commission on Fairness stateed each state attorney should place a high priority on involuntary placement proceedings and properly prepare the cases on behalf of the state. Assistant state attorneys representing the state in involuntary placement proceedings must be bound to the same legal and ethical obligations as they do prosecuting other cases. The Commission also stated that the state attorney's office should independently evaluate and confirm the allegations set forth in the petition for involuntary placement. If the information is found to be correct, the state attorney should vigorously prosecute the petition. If the allegations are not substantiated, the state attorney should withdraw the petition. The Commission further stated the state attorney's office must be represented at and actively participate in every hearing. If a representative of the state attorney's office is not present at the hearing, the Commission urged the court to halt the proceeding while the state attorney was summoned.

Q. Can you explain more about the role of Assistant State Attorneys in preparing and presenting Baker Act cases at involuntary placement hearings?

An excellent document titled "Preparation & Presentation of Baker Act Hearings by Assistant State Attorneys" has been prepared by Mari S. Blumstein, Assistant State Attorney Office of the State Attorney, Seventeenth Judicial Circuit, 201 SE Sixth Street, Fort Lauderdale, Fl 33301, (954) 831-6965.

Q. Recently, we have encountered a speed bump with the Sate Attorney's office feeling "unsafe" when doing hearings at the receiving facility. We have a dedicated room for the hearings and have never had this problem before. I agreed to have an additional Technician sit directly behind the clients while in hearing. Subsequently, the States Attorney's Office has sent us letter stating they will "cease" all BA hearings at the facility unless we can change the venue. I have read the Statute in the 2008 BA manual and find very little regarding this issue. Can you shed some light, as having to bring our clients to the County Courthouse would be most traumatic?

This reason being given for an assistant state attorney to not attend a hearing may be unique. If it is safe enough for the Magistrate, Public Defender and staff, especially with the addition of another well-trained staff person, it's difficult to believe that safety should

be an issue. The Baker Act addresses the location of the hearing in the following provision:

> **394.467 Involuntary inpatient placement.--**
> (6) HEARING ON INVOLUNTARY INPATIENT PLACEMENT.--
> (a)1. The court shall hold the hearing on involuntary inpatient placement within 5 days, unless a continuance is granted. The hearing shall be held in the county where the patient is located and shall be as convenient to the patient as may be consistent with orderly procedure and shall be conducted in physical settings not likely to be injurious to the patient's condition.

While historically, Baker Act hearings were often held at courthouses, this is generally a thing of the past. Hearings usually occur at the receiving facilities. The safety of the patient in transporting is a very real concern as is the privacy and dignity of moving such a person in the most acute phases of his/her illness through public places. Providing for the personal care of the patient in a courthouse is also incredibly difficult.

Regarding the participation of the state attorney at hearings, the following information may assist. The Baker Act (involuntary inpatient as well as involuntary outpatient) requires that the state attorney be the "real party in interest"

> **394.467 Involuntary inpatient placement.--**
> (6) Hearing on Involuntary Inpatient Placement.--
> (a)1. The court shall hold the hearing on involuntary inpatient placement within 5 days, unless a continuance is granted. The hearing shall be held in the county where the patient is located and shall be as convenient to the patient as may be consistent with orderly procedure and shall be conducted in physical settings not likely to be injurious to the patient's condition. If the court finds that the patient's attendance at the hearing is not consistent with the best interests of the patient, and the patient's counsel does not object, the court may waive the presence of the patient from all or any portion of the hearing. <u>The state attorney for the circuit in which the patient is located shall represent the state, rather than the petitioning facility administrator, as the real party in interest in the proceeding.</u>

In addition, there have been some appellate decisions, such as:

> **Michael WICKLAND v. STATE of Florida,** 642 So. 2d 670 (Fla. 1st DCA 1994). Appellate Judge Allen wrote the opinion with Appellate Judges Webster and Lawrence concurring. The First District Court of Appeals held that trial court failed to comply with the requirements of the Baker Act where the trial court did not serve notice of an involuntary placement hearing on the state attorney's office, the state attorney did not appear at the hearing, the state's psychiatrist did not testify as to having personal knowledge of the underlying facts of the case, and the trial court's order of involuntary placement for treatment recited the contents of the petition for involuntary placement. The First District Court of Appeals reversed the trial court's order of involuntary placement for treatment under the Baker Act, section 394.467, Fla. Stat.

Finally, the Florida Supreme Court Commission on Fairness addressing the Baker Act had much to say about the venue of such hearings:

Issue: Should involuntary placement hearings be conducted in the courthouse or at the mental health facility? If the hearings are held in the facilities, are measures being taken to ensure that the patients understand the seriousness of the proceeding?

A balanced approach may be the most desirable resolution of this issue. The receiving facility may be the location that is both the most convenient to the patient and the safest. However, all involuntary placement hearings held in receiving facilities should include formalities consistent with a court hearing, to ensure that everyone understands the seriousness of the proceeding. When liberty interests are at stake, they should be addressed in a formal and appropriate manner. Food, drink, and side conversations at hearings, coupled with lax observance of procedures and rules of evidence, give the appearance that the system is trivializing involuntary placement cases.

Recommendations:

1. The Subcommittee recommends that the chief judge of each circuit court require involuntary placement hearings held at mental health receiving facilities to be conducted in a room that is set up in the manner of a courtroom. If possible, that room should not be used for any other patient purposes. The presiding officer should wear a robe. United States and Florida flags should be present. Formal courtroom decorum should be observed.

2. Patients should be dressed in street clothing. Food, drink, and side conversations should be prohibited. The presiding officer, state attorney, public defender, and other participants should introduce themselves prior to each case. Moreover, rules of evidence and procedure should be observed.

Issue: Should involuntary placement hearings be conducted by video?

Discussion: Some court proceedings are conducted by video. An example is video arraignments, in which the judge remains at the courthouse while the defendant participates by live video link-up from the jail. At the November 12, 1998, meeting it was suggested that video hearings may be a convenient and less costly alternative for involuntary placement hearings. One of the judges who responded to the survey observed that allowing patients to attend hearings by video would alleviate the need for them to be transported to the courthouse.

Recommendation
The Subcommittee strongly recommends against the use of video for involuntary placement hearings.

The Florida Supreme Court Commission on Fairness addressing the Baker Act also had the following to say about Assistant State Attorneys in such hearings:

V. Ensure Public Safety and Represent The State's Interests

Some state attorneys are not fully participating in the Baker Act process. In some instances the state attorney's office is not even represented at involuntary placement hearings. Involuntary mental health examination and placement

involve a balancing of individual rights with the state's parens patriae authority and police power. The state is the only entity with the authority to restrict a person's liberty. Active participation by the state attorney's office is an integral part of the proceeding, according to Florida statutes and case law. The Subcommittee found that the office of the state attorney must be present at every involuntary placement proceeding in order to comply with the statutory mandate and to appropriately, adequately, and competently represent the state's interests.

Moreover, the Subcommittee learned that state attorneys are not always properly preparing their cases prior to the involuntary placement hearing. In an adversarial proceeding, the state attorney is required to meet a burden of proof for involuntary placement. The state has the responsibility to present evidence and testimony as to the elements and requirements of the applicable statutes.

It appears, however, that state attorneys generally take little action to prepare Baker Act cases. The Subcommittee heard testimony about instances where individuals who were believed to be dangerous were discharged because the state attorney did not subpoena witnesses and conduct other pre-trial preparations necessary to sustain the petition. The court was left with no alternative but to dismiss the petition and discharge the patient. This conduct may place the public's safety at risk. Meanwhile, the individuals do not receive necessary treatment.

The state attorney should gather information independently, and evaluate and confirm the information contained in the petitions. It is incumbent upon the state attorney to vigorously investigate and prosecute the petition. Further, if the state attorney's independent review does not show the statutory criteria are provable, then the state attorney should withdraw the petition.

Chapter 394 specifically authorizes the attorney representing the patient to have access to the clinical record, facility staff, and other pertinent information. However, the law is silent as to whether the state attorney has the authority to access the same information. Thus, a study should be conducted on whether the law should be amended to allow the state attorney access this information in order to evaluate the petition and prepare for the hearing.

Related Recommendations

1. The state attorney's office must be represented at and actively participate in every hearing. The court should require the presence of the state attorney's office at every involuntary placement hearing. If a representative of the state attorney's office is not present at the hearing, the court should halt the proceeding while the state attorney is summoned.

2. Each state attorney's office should independently evaluate and confirm the allegations set forth in the petition for involuntary placement. If the information is found to be correct, the state attorney should vigorously prosecute the petition. If the allegations are not substantiated, the state attorney should withdraw the petition.

3. Each state attorney should place a high priority on involuntary placement proceedings and properly prepare the cases on behalf of the state. The Florida Legislature should provide adequate resources to enable state attorneys to provide quality representation for the state in involuntary placement.

4. The Florida Association of Prosecuting Attorneys should develop a model curriculum and/or training videotape on involuntary examination and placement procedures and associated issues. The Florida Association of Prosecuting Attorneys and The Florida Bar should ensure that continuing legal education programs on elder, mental health, and disability laws and issues are made available on an on-going basis.

5. Assistant state attorneys representing the state in involuntary placement proceedings must be bound to the same legal and ethical obligations of assistant state attorneys prosecuting other cases.

6. The bar should be educated as to attorneys' roles and responsibilities in handling involuntary placement proceedings.

7. Each state attorney should ensure that experienced and trained attorneys are assigned to involuntary placement cases.

8. The Florida Legislature should direct and fund an interdisciplinary study on whether state attorneys should be authorized to have access to clinical records, facility staff, and other pertinent information.

9. The Florida Department of Law Enforcement and the Department of Children and Families should jointly initiate a comprehensive training program for law enforcement officers, incorporating a minimum:

    - A videotaped orientation to the Baker Act for statewide use, which emphasizes the criteria for initiating an involuntary examination; and

    - Crisis intervention training for appropriate interaction with persons with mental illnesses.

10. State attorneys and public defenders should be provided with training on jail diversion programs for individuals with mental illnesses.

While the Supreme Court Commission's recommendations have, for the most part, not been enacted by the Legislature, the recommendations should be persuasive in improving the administration of justice by Florida courts.

Q. What specific language in 394 requires the State Attorney to represent \ make case for involuntary commitment?

The Baker Act (involuntary inpatient as well as involuntary outpatient) requires that the state attorney is the "real party in interest"

394.467 Involuntary inpatient placement.--

6) Hearing on Involuntary Inpatient Placement.--

(a)1. The court shall hold the hearing on involuntary inpatient placement within 5 days, unless a continuance is granted. The hearing shall be held in the county where the patient is located and shall be as convenient to the patient as may be consistent with orderly procedure and shall be conducted in physical settings not likely to be injurious to the patient's condition. If the court finds that the patient's attendance at the hearing is not consistent with the best interests of the patient, and the patient's counsel does not object, the court may waive the presence of the patient from all or any portion of the hearing. The state attorney for the circuit in which the patient is located shall represent the state, rather than the petitioning facility administrator, as the real party in interest in the proceeding.

Chapter 27, FS establishes the duties of Public Defenders and State Attorneys. The provision on Public Defenders is as follows;

27.51 Duties of public defender.--

(1) The public defender shall represent, without additional compensation, any person determined to be indigent under s. 27.52 and:

(d) Sought by petition filed in such court to be involuntarily placed as a mentally ill person under part I of chapter 394, involuntarily committed as a sexually violent predator under part V of chapter 394, or involuntarily admitted to residential services as a person with developmental disabilities under chapter 393. A public defender shall not represent any plaintiff in a civil action brought under the Florida Rules of Civil Procedure, the Federal Rules of Civil Procedure, or the federal statutes, or represent a petitioner in a rule challenge under chapter 120, unless specifically authorized by statute;

There doesn't seem to be any corresponding provision in Chapter 27 about the duties of the State Attorney regarding the Baker Act. However, the provision in Chapter 394 above seems to suffice.

In addition, there have been some appellate decisions, such as:

Larry Donald JONES v. STATE of Florida, 611 So. 2d 577 (Fla. 1st DCA 1992). Appellate Judges Shivers and Webster concur and Appellate Judge Joanos specially concurred in the result with the written per curiam opinion. The First District Court of Appeals reversed the trial court's order for involuntary placement for treatment of a former patient to a mental health facility where the former patient's due process rights were violated by the fact there was no proof of service that the state attorney was notified about the involuntary placement hearing, by the fact that only one witness, the treating psychiatrist testified and his testimony did not support an order of involuntary placement, and by the fact that the trial court's order for involuntary placement recited facts set forth in the petition for involuntary placement for treatment that were not addressed or developed at the involuntary placement hearing.

Michael WICKLAND v. STATE of Florida, 642 So. 2d 670 (Fla. 1st DCA 1994). Appellate Judge Allen wrote the opinion with Appellate Judges Webster and Lawrence concurring. The First District Court of Appeals held that trial court failed to comply with the requirements of the Baker Act where the trial court did

not serve notice of an involuntary placement hearing on the state attorney's office, the state attorney did not appear at the hearing, the state's psychiatrist did not testify as to having personal knowledge of the underlying facts of the case, and the trial court's order of involuntary placement for treatment recited the contents of the petition for involuntary placement. The First District Court of Appeals reversed the trial court's order of involuntary placement for treatment under the Baker Act, section 394.467, Fla. Stat.

While never appealed, the following circuit judge's order is interesting:

> **IN RE: THE MATTER OF V.S..** Order by 6th Judicial Circuit Court Judge Thomas Penick regarding the participation of attorney for a receiving facility in a Baker Act involuntary placement hearing. A receiving facility has every right to employ legal counsel to represent their legal interests in any proceeding where the facility's legal rights, liabilities or corporate interests are implicated. Since future actions of the facility, either in providing ordered treatment, or arranging for discharge of the patient, are predicated on the outcome of the hearing, the facility is entitled to have counsel present during the adjudicatory process. Counsel for the facility, although present at the hearing, may not interpose evidentiary objections or participate in questioning witnesses. **This is the assigned role of the state attorney.** While the facility may be a party in interest for the purpose of placing the controversy before the court, they do not have a legally protectible interest in the outcome of an adjudication of the need for involuntary mental health treatment. **The statute permits the facility administrator to throw out the first ball, but the constitutional rights of the patient require that the state attorney pitch the game**.

Finally, the Florida Supreme Court Commission on Fairness addressing the Baker Act had the following to say about Assistant State Attorneys:

> **V. Ensure Public Safety And Represent The State's Interests**
>
> Some state attorneys are not fully participating in the Baker Act process. In some instances the state attorney's office is not even represented at involuntary placement hearings. Involuntary mental health examination and placement involve a balancing of individual rights with the state's parens patriae authority and police power. The state is the only entity with the authority to restrict a person's liberty. Active participation by the state attorney's office is an integral part of the proceeding, according to Florida statutes and case law. The Subcommittee found that the office of the state attorney must be present at every involuntary placement proceeding in order to comply with the statutory mandate and to appropriately, adequately, and competently represent the state's interests.
>
> Moreover, the Subcommittee learned that state attorneys are not always properly preparing their cases prior to the involuntary placement hearing. In an adversarial proceeding, the state attorney is required to meet a burden of proof for involuntary placement. The state has the responsibility to present evidence and testimony as to the elements and requirements of the applicable statutes.
>
> It appears, however, that state attorneys generally take little action to prepare Baker Act cases. The Subcommittee heard testimony about instances where

individuals who were believed to be dangerous were discharged because the state attorney did not subpoena witnesses and conduct other pre-trial preparations necessary to sustain the petition. The court was left with no alternative but to dismiss the petition and discharge the patient. This conduct may place the public's safety at risk. Meanwhile, the individuals do not receive necessary treatment.

The state attorney should gather information independently, and evaluate and confirm the information contained in the petitions. It is incumbent upon the state attorney to vigorously investigate and prosecute the petition. Further, if the state attorney's independent review does not show the statutory criteria are provable, then the state attorney should withdraw the petition.

Chapter 394 specifically authorizes the attorney representing the patient to have access to the clinical record, facility staff, and other pertinent information. However, the law is silent as to whether the state attorney has the authority to access the same information. Thus, a study should be conducted on whether the law should be amended to allow the state attorney access this information in order to evaluate the petition and prepare for the hearing.

Florida Statutes require a law enforcement officer to take a person who appears to meet the criteria for involuntary examination into custody and deliver the person to the nearest receiving facility for examination. Testimony indicated that some law enforcement officers inappropriately arrest persons with mental illnesses rather than taking them to a receiving facility. Near the end of the study, the Subcommittee received reports that improvements are occurring in regard to law enforcement's understanding of and response to mental health matters. Nevertheless, there needs to be more training for them on mental illnesses. It may also be beneficial for state attorneys and public defenders to be provided with training on jail diversion programs for individuals with mental illnesses.

Related Recommendations

11. The state attorney's office must be represented at and actively participate in every hearing. The court should require the presence of the state attorney's office at every involuntary placement hearing. If a representative of the state attorney's office is not present at the hearing, the court should halt the proceeding while the state attorney is summoned.

12. Each state attorney's office should independently evaluate and confirm the allegations set forth in the petition for involuntary placement. If the information is found to be correct, the state attorney should vigorously prosecute the petition. If the allegations are not substantiated, the state attorney should withdraw the petition.

13. Each state attorney should place a high priority on involuntary placement proceedings and properly prepare the cases on behalf of the state. The Florida Legislature should provide adequate resources to enable state attorneys to provide quality representation for the state in involuntary placement.

14. The Florida Association of Prosecuting Attorneys should develop a model curriculum and/or training videotape on involuntary examination and placement procedures and associated issues. The Florida Association of Prosecuting Attorneys and The Florida Bar should ensure that continuing legal education programs on elder, mental health, and disability laws and issues are made available on an on-going basis.

15. Assistant state attorneys representing the state in involuntary placement proceedings must be bound to the same legal and ethical obligations of assistant state attorneys prosecuting other cases.

16. The bar should be educated as to attorneys' roles and responsibilities in handling involuntary placement proceedings.

17. Each state attorney should ensure that experienced and trained attorneys are assigned to involuntary placement cases.

18. The Florida Legislature should direct and fund an interdisciplinary study on whether state attorneys should be authorized to have access to clinical records, facility staff, and other pertinent information.

19. The Florida Department of Law Enforcement and the Department of Children and Families should jointly initiate a comprehensive training program for law enforcement officers, incorporating a minimum:

    - A videotaped orientation to the Baker Act for statewide use, which emphasizes the criteria for initiating an involuntary examination; and

    - Crisis intervention training for appropriate interaction with persons with mental illnesses.

20. State attorneys and public defenders should be provided with training on jail diversion programs for individuals with mental illnesses.

Q. Can you give me information about the legal responsibilities of the State Attorney regarding Baker Act hearings?

The burden of proof for involuntary placement is by Clear and Convincing Evidence. The following is the only definition I've been able to come up with is:

> Evidence that is precise, explicit, lacking in confusion, and of such weight that it produces a firm belief or conviction, without hesitation, about the matter at issue (Standard Jury Instructions – Criminal Cases, published by the Supreme Court of Florida, No. SC95832, June 15, 2000).

It's the duty of the state attorney to ensure the petition appears sufficient to meet this level of proof. In the compendium I've attached show nearly 20 cases that were reversed by appellate courts for failure to meet this legal threshold. The compendium

also includes cases that were reversed due to the failure to notice the state attorney or when the state attorney failed to participate in the hearings.

We also discussed the issue of conducting Baker Act hearings by video conference. The Florida Supreme Court Subcommittee on Case Administration conducted a major study of the Judicial Administration of the Baker Act. The Commission's report includes the following on use of video conferencing:

> **II. IMPROVE THE ADMINISTRATION OF JUSTICE IN BAKER ACT CASES (page 14)**
>
> The location and formality of hearings are also somewhat controversial. In Florida, the majority of involuntary placement hearings are held in receiving facilities. According to testimony, conducting hearings in the facilities may confuse patients, particularly elder patients, who may be unaware that a court proceeding is underway at which their liberty interests are being determined. Certain jurisdictions are also considering conducting involuntary placement hearings by video. The Subcommittee learned that some individuals may react negatively to video hearings because of their mental illnesses. When individuals do not understand that a hearing has been held, they believe they have not been afforded their rights and are being held contrary to law.
>
> Recommendations (page 19)
> When involuntary placement hearings are held in receiving facilities, steps should be taken to increase the probability that patients understand that a formal court hearing is taking place:
> • **the proceedings should not be conducted by video;**
> • courtroom formalities should be observed; and
> • the presiding officer should wear a robe.
>
> *Issue page 31& 32*
> ***Should involuntary placement hearings be conducted by video?***
> Discussion:
> Some court proceedings are conducted by video. An example is video arraignments, in which the judge remains at the courthouse while the defendant participates by live video link-up from the jail. At the November 12, 1998, meeting it was suggested that video hearings may be a convenient and less costly alternative for involuntary placement hearings. One of the judges who responded to the survey observed that allowing patients to attend hearings by video would alleviate the need for them to be transported to the courthouse. However, Martha Lenderman pointed out that some individuals' mental health problems include symptoms of paranoia. These persons may react negatively to video hearings. Some individuals with mental illnesses may be too confused to understand a procedure involving a video hearing. Further, the presiding officer may be limited in observing the situation when confined to viewing only what a camera is focused on. Ms. Lenderman warned that video be used with caution, if at all, for involuntary placement hearings. Vince Smith, of the Mental Health Program Office in the Department of Children and Families, was concerned that use of video may increase the number of individuals who decline to participate in their involuntary placement hearing. Winifred Sharp, a Judge on the Fifth District Court of Appeal, observed that it would be very difficult to make a video proceeding

look or feel like a formal court hearing, and therefore the chance that a patient might not understand a court proceeding is occurring would continue to present a challenge.

Recommendation

The Subcommittee strongly recommends against the use of video for involuntary placement hearings.

While the Supreme Court Commission's recommendations have, for the most part, not been enacted by the Legislature, the recommendations should be persuasive in improving the administration of justice by Florida courts.

Q. Can a receiving or treatment facility's attorney act in place of the State Attorney in initial involuntary inpatient or outpatient placement hearings?

No. The state attorney is named as the "real party in interest". One circuit court case dealing with a hospital attorney rather than the state attorney acting as the real party in interest is a 6th circuit case that was never appealed. An abbreviated version of it is as follows:

IN RE: THE MATTER OF V.S.. Order by 6th Judicial Circuit Court Judge Thomas Penick regarding the participation of attorney for a receiving facility in a Baker Act involuntary placement hearing. A receiving facility has every right to employ legal counsel to represent their legal interests in any proceeding where the facility's legal rights, liabilities or corporate interests are implicated. Since future actions of the facility, either in providing ordered treatment, or arranging for discharge of the patient, are predicated on the outcome of the hearing, the facility is entitled to have counsel present during the adjudicatory process. Counsel for the facility, although present at the hearing, may not interpose evidentiary objections or participate in questioning witnesses. This is the assigned role of the state attorney. While the facility may be a party in interest for the purpose of placing the controversy before the court, they do not have a legally protectible interest in the outcome of an adjudication of the need for involuntary mental health treatment. The statute permits the facility administrator to throw out the first ball, but the constitutional rights of the patient require that the state attorney pitch the game.

Q. Does the state attorney ever represent the state as the "real party in interest" at continued involuntary placement hearings?

The state attorney in one area of the state has performed this role for years, but may discontinue this practice since there is no reference in 394 for the state attorney's participation in continued involuntary inpatient or involuntary outpatient placement hearings (it is only mentioned in the initial hearings); nor is there specific reference to it in chapter 27. The public defenders' role is specified in 394 (initial and continued hearings) as well as chapter 27.

However, chapter 394.467(7) requires in the continued hearings that there be clear and convincing evidence that all criteria for involuntary inpatient placement continue to be met. Some attorneys question how this evidence will get into the record if not by the state attorney. This may be of particular concern when a state hospital has been privatized and the "state" isn't present to determine sufficiency of the petition or be

concerned with the deprivation of a person's liberty as they would be in other such cases.

There are many appellate cases that have been reversed due to the state attorney not being noticed or not participating in the initial involuntary placement hearings.

Q. Can the Public Defender and State Attorney access the clinical record?

The Public Defender can have access to the clinical record, the person, and the staff in preparing for the involuntary placement hearing. The law doesn't expressly permit this same access to the State Attorney prior to a hearing for involuntary inpatient placement (is expressly permitted for involuntary outpatient placement). In some circuits, the State Attorney has access, while not in others. In any case, the clinical record is always available at the time of the hearing and is, at that time, available to the State Attorney.

Independent Expert Examination

Q. Who is responsible for paying the independent expert examiner under 394.467(6)(a)2? I know the court is responsible for providing such an expert, but didn't know if this equates to the court paying for one. What specific authority has addressed the responsibility of the court paying for the expert?

A memorandum was sent to the Chief Judges from Judge Stan Morris, Chair of the Trial Court Budget Commission dated August 3, 2005. The paragraph in question is on page two of the memorandum, which states the following:

> More problematic are Baker Act evaluations under section 394.467(6)(a)2, Florida Statutes. In Baker Act situations, the patient has the statutory right to request an independent expert evaluation. This right arises after a professional has executed an involuntary inpatient placement certificate and the involuntary commitment process has started. The statute says: "If the patient cannot afford such an examination, the court shall provide for one." Thus, the statute clearly evidences legislative intent that if the person is not indigent, this cost is not paid by the public. However, when the person is indigent, section 394.473, Florida Statutes, states that the expert should be paid pursuant to section 27.5304, Florida Statutes. That section provides for payment by the Justice Administrative Commission.[3] As a person subject to Baker Act commitment, the patient has the right to the appointment of the public defender or court-appointed counsel if indigent. Both section 29.006, Florida Statutes, (public defender) and section 29.007, Florida Statutes, (court-appointed counsel) specifically reference mental health professionals appointed pursuant to section 394.473, Florida Statutes. Clearly these witnesses are defense witnesses; they are appointed only if requested by the patient and any report issued is confidential and not discoverable. See: section 394.467(6)(a)2, Florida Statutes. The language found in section 394.467(6)(a)2, Florida Statutes, {"the court shall provide for one"} does not transform what is essentially a defense witness into a state court expense when there is clear statutory guidance to the contrary.

Witnesses

Q. I am a new psychiatrist at a receiving facility. We are running into a problem with the BA-32 psychiatrist opinions and are finding a need for the option of a "Third Opinion" for the 32 as there might be occasions the first and second opinion psychiatrists may not be available. When this situation arose at a previous hospital, a third psychiatrist would complete a third opinion (on another "second opinion" portion), file it with the court, and present testimony at the hearing. When this was suggested as an alternative here I discovered there is no ruling in the Baker Act statutes regarding this. The statute still explicitly states one of the psychiatrists who initiated the first or second opinion be present in court. Can the law be amended to allow for a third opinion in the situation where neither the first or second opinion psychiatrists are available? What do you advise?

The law is quite specific that one of the two doctors must provide testimony at the involuntary placement hearing.

> **394.467(6) HEARING ON INVOLUNTARY INPATIENT PLACEMENT.--**
> (a) 2. The court may appoint a general or special magistrate to preside at the hearing. **One of the professionals who executed the involuntary inpatient placement certificate shall be a witness.**

As you can see, the statute requires one of the two professionals to be a witness, but is silent as to whether the testimony must be done in court or through other methods. While the doctors know when the hearings are scheduled and usually make plans to attend as required by law, the statute wouldn't preclude such testimony from being done telephonically in exceptional circumstances. This might involve having someone available to swear in the doctor as a witness when done off site.

If neither of the two doctors signing the petition form is able to testify, the court would have no choice but to release the patient because there would be no clear and convincing testimony elicited to support the petition. It is the patient's right to a hearing within the 5 day period of the filing of the petition, unless the patient requests a continuance of the hearing – a Baker Act equivalent of a "speedy trial" under criminal law.

Q. Is there any provision in the Baker Act that prohibits psychiatrists who complete the 1st and 2nd opinion for involuntary placement from being professionally affiliated, i.e. work in the same practice in the community?

There is no prohibition against psychiatrists who practice with each other from signing the 1st and 2nd opinions on the same Petition for Involuntary Inpatient Placement (BA 32). One would presume, unless there is evidence to the contrary, that each psychiatrist performed an evaluation independent from each other and reached their respective conclusions based on these evaluations.

The only conflict of interest referenced in the Baker Act is the assessment of capacity for persons in long-term care facilities to be voluntary, as follows:

> **394.4625 Voluntary admissions**.--
> (1) AUTHORITY TO RECEIVE PATIENTS.--

(b) A mental health overlay program or a mobile crisis response service or a licensed professional who is authorized to initiate an involuntary examination pursuant to s. 394.463 and is employed by a community mental health center or clinic must, pursuant to district procedure approved by the respective district administrator, conduct an initial assessment of the ability of the following persons to give express and informed consent to treatment before such persons may be admitted voluntarily:
1. A person 60 years of age or older for whom transfer is being sought from a nursing home, assisted living facility, adult day care center, or adult family-care home, when such person has been diagnosed as suffering from dementia.
2. A person 60 years of age or older for whom transfer is being sought from a nursing home pursuant to s. 400.0255(12).
3. A person for whom all decisions concerning medical treatment are currently being lawfully made by the health care surrogate or proxy designated under chapter 765.
(c) When an initial assessment of the ability of a person to give express and informed consent to treatment is required under this section, and a mobile crisis response service does not respond to the request for an assessment within 2 hours after the request is made or informs the requesting facility that it will not be able to respond within 2 hours after the request is made, the requesting facility may arrange for assessment by any licensed professional authorized to initiate an involuntary examination pursuant to s. 394.463 who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made.

Q. What do we do if neither of the two psychiatrists who signed opinions supporting a petition for involuntary inpatient placement are available to testify at the hearing?

The Baker Act requires that a petition for involuntary inpatient or outpatient placement must have the opinions of two psychiatrists or a psychiatrist and a psychologist. The law requires that one of the two professionals signing the petition must testify at the involuntary placement hearing. The law also requires that the clerk of court list the names of the two examiners in a notice of hearing. These statutory provisions are as follows:

394.467(6) FS Hearing On Involuntary Inpatient Placement.--
(a)2. The court may appoint a general or special magistrate to preside at the hearing**. One of the professionals who executed the involuntary inpatient placement certificate shall be a witness**.
394.4599(c)3, FS states that The **written notice of the filing of the petition for involuntary placement must contain** The date, time, and place of the hearing and **the name of each examining expert** and every other person expected to testify in support of continued detention.

The Florida Supreme Court Commission on Fairness addressing the Baker Act recommended that the State Attorney's office should withdraw the petition if the allegations in the petition are not substantiated. This means that if one of the two experts who prepared the petition is not available to testify, the petition must be withdrawn by the state attorney or dismissed by the court. The only provision for a "third opinion" is when

the patient has requested an independent expert examination. The findings of this examination are confidential and not discoverable unless the expert is called as a witness for the patient at the hearing. One situation in which a psychiatrist failed to appear at Baker Act hearings to testify in support of petitions for involuntary placement resulted in her being reported to the Florida Board of Medicine which reached a probable cause finding against her license.

Q. Regarding a hearing on Involuntary Inpatient Placement, can an ARNP testify on behalf of the psychiatrist who provided one of the two expert opinions? I told them that they could not send an ARNP. However in our county, a clinical psychologist is authorized to provide the second opinion supporting the petition and "One of the two professionals who executed the involuntary placement certificate must be a witness. This role cannot be delegate to others."
I would like to know your opinion as to whether or not a clinical psychologist (the one giving the second opinion) could replace the MD in the court?

You are correct regarding the ARNP being unable to provide the testimony. Only psychiatrists and psychologists are authorized to perform the involuntary inpatient placement examination and provide the statutorily required court testimony. Psychologists can provide the court testimony instead of the psychiatrist, but they may have questions thrown at them by the state attorney or public defender about co-existing medical conditions as well as the medications that wouldn't be within the psychologists' area of expertise. However, the psychologist, if one is used for one of the two opinions, is authorized by law to examine and to testify as to the conclusions from that examination -- an ARNP is not.

Continuances

Q. The receiving facilities in our circuit have noticed that lately the Public Defender does automatic continuances on almost all folks...many times 2 or 3 times. According to the CSU, the PD doesn't see or talk to the patient prior to requesting a continuance. We believe this may be adding to our capacity issues, as when folks finally get court ordered to the state hospital, they often have to wait an additional 4-6 weeks for admission, meaning they are on the units for several months (following the above mentioned continuances). I know there are often legitimate reasons for continuance, but this seems excessive. Assuming the research supports this what would your recommendation be for addressing with the PD? I was wondering if it would be beneficial to have reps from the receiving facilities as well as myself meet with PD to explain our situation,

Actually, only the patient has the standing to request a continuance -- with concurrence of counsel. No one else has such a right. There has been some criticism of defense counsels making such requests for continuances unless consistent with their client's wishes.

> **394.467(5) CONTINUANCE OF HEARING.--**The patient is entitled, with the concurrence of the patient's counsel, to at least one continuance of the hearing. The continuance shall be for a period of up to 4 weeks.

The law requires the hearing to take place within 5 days, unless a continuance is requested by the patient. This is the equivalent of a speedy trial in a criminal setting and a deprivation of the person's liberty is at stake should a person's hearing be delayed. An appellate case (Handley v. Dennis) clearly stated that the role of the public defender is to "serve as an independent advocate for the patient, not as a neutral party charged with the responsibility of determining the best interests of the patient or the needs of society." The attorney is the voice of the patient at a time when the patient's lack of capacity makes him/her unable to speak for himself.

While some defense attorneys take the position they can act for their clients without the client's agreement for purposes of trial strategy, the language of the law clearly indicates that the "patient" is the one with standing to request such a continuance – with the concurrence of counsel. The Florida Supreme Court Commission on Fairness on which I sat emphasized that only the patient has the power to do this. The Commission also indicated that an attorney's duty to his client is the same as in any other type of case. I served three years on a Florida Bar Grievance Committee and we found probable cause in a number of cases where the attorney didn't represent the wishes of his/her client, although none of these grievances arose from a Baker Act situation.

The Supreme Court's Commission also strongly recommended that whenever a continuance of a hearing on involuntary placement is considered, the court should proceed with a hearing to consider the person's competence to consent to treatment and the appointment of a guardian advocate if the person is found to be incompetent. The actual placement hearing would then take place at a later time

One Public Defender often makes such requests to avoid a hearing in which a commitment to a state hospital might result, believing that another week or two of treatment might result in improved clinical condition. He says he always talks to his clients in advance of filing such a request for a continuance and lets the client know of the benefit to a delay. However, he says that if his client still wants his/her "day in court", they go forward with the hearing as scheduled. If the court conducts a hearing to appoint a GA, this might relieve part of the problem in some situations.

You may want to talk with the PD in your circuit first to find out her reason for routine continuances. While her sole priority must be representing her client's interests, she may not know that her practice is an anomaly around the state. She also may not know that routine use of continuances results in serious service system issues for others that might need acute care examination or treatment. If this doesn't work, you might have to talk with her supervisor.

If it appears that any of individuals who are detained past the 5 working days following petition filing are unhappy about the delay in hearing, this really needs to be brought to the Bar Association grievance process. This delay could potentially result in an unwarranted deprivation of liberty without due process. You might want to speak with the circuit DCF legal counsel about the situation.

Q. We've received a couple of complaints regarding lack of Baker Act hearings in one county. We've been told that the Court, the State Attorney and the Public Defender frequently continue hearings – sometimes for months at a time. Who should resolve this problem?

Actually, only the patient has the standing to request a continuance -- with concurrence of counsel. No one else has such a right. There has been some criticism of defense counsels making such requests for continuances unless consistent with the client's wishes.

The only reference to standing for the State Attorney or others regarding the involuntary placement process is related to venue, as follows:

> **394.4599 Notice.**
> (2)INVOLUNTARY PATIENTS.—
> (c)The written notice of the filing of the petition for involuntary placement must contain the following:
> 4. Notice that the patient, the patient's guardian or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the patient.

Change of venue doesn't equate to waiving "speedy trial" or delay in potential release. Only the patient with concurrence of counsel can do this. One Assistant Public Defender tells me that he frequently sits the client down and explains the benefit of a "continuance" in words understandable to a lay person. He strongly encourages them to agree to a delay in hearing as trial strategy to avoid an order for involuntary placement that might result while the client is still acutely ill. However, he states that if the client insists on going forward with a hearing within the 5 working days required by law, that's what happens.

The role of a Public Defender in a Baker Act case is well described in the Handley v. Dennis 1st DCA case that defined the role of the Public Defender as follows:

> "In such cases, the duty of the Public Defender is a legal and professional duty that is owed to the patient as a client." "The Public Defender serves as an independent advocate for the patient, not as a neutral party charged with the responsibility of determining the best interests of the patient or the needs of society." The court stated that "if the patient wishes to be released or transferred and if there is a basis for that request, the Public Defender has a duty to advocate the cause of the patient".

One attorney who served as an assistant public defender for a period of time states that the PDs have to assess whether it is in their client's best interest whether they should go forward at a hearing or wait a week or two. That begs the question of whether the patient is competent or not, but usually when they have not been on their meds for a long time, this is iffy. From her experience, very few patients actually make a request for a continuance, as it is usually strategic on the part of their attorney.

Q. The Baker Act statute only provides for the defense to continue the hearing. Sometimes our magistrate wants to continue the hearing to "get more information" or the state attorney wants to argue that the state can continue in order to provide the psychiatrist more time to re-petition. I think this violates the clients' due process and liberty. Is there any case law or opinions on this issue? Is there any case law on the hospital just turning around and re-petitioning after

the first petition is dismissed due to it being untimely? Can the facility get around the initial bad petition and keep the client for a new examination / petition?

A "speedy trial" in a criminal case is an analogy to allowing only the patient, with concurrence of counsel to request a continuance in a Baker Act case. The Florida Supreme Court Commission on Fairness also reinforced this position.

Some hospitals do re-petition if the original petition is dismissed due to lack of timely filing or a disagreement with the action of the judge or magistrate. The facility administrator doesn't have standing to file an exception or appeal the decision and if the state attorney is unwilling to do so, such facilities occasionally take it on themselves to secure the safety of the patient. In such cases, they may not even intend to keep the patient as long as it would take to get to another hearing, believing just a few more days would suffice. If the public defender doesn't file a petition for a writ on behalf of his/her client, there may be few other remedies. The PD wouldn't have a judicial order to appeal since the original petition had been dismissed.

Q. Can the receiving facility or a doctor testifying at an involuntary placement hearing request a continuance?

NO. Only the person is entitled, with the concurrence of counsel, to request a continuance. The Florida Supreme Court Commission on Fairness urges courts, when considering a motion for continuance, to conduct a hearing and make a finding as to the capacity of the person to consent to treatment if there is a pending request. If the court finds that the capacity to consent to treatment is lacking, a guardian advocate should be appointed at the time the involuntary placement hearing is continued.

Q. Does the doctor need to be present when there is a stipulation for continuance between the State and Public Defender?

There is no purpose served in the doctor being present. The request for a continuance is solely decided by the patient, with concurrence of counsel. The person's counsel shouldn't delay a hearing unless that is what the person desires – sort of the probate equivalent of a speedy trial in a criminal proceeding. There doesn't even need to be a stipulation by the State as no role for the State is specified in the Baker Act law or rules governing continuances

Transfers for Medical Care

Q. I'm a Baker Act Magistrate. I recently found a person to meet Baker Act criteria and entered a recommended order for her involuntary placement in a state mental health facility. The circuit judge entered his order accepting the recommendation the next day. The receiving facility (a general hospital) became medically concerned over the patient's heart rhythms and admitted her to the med/surg unit of the hospital. There's a Notice of Release or Discharge in the file. The receiving facility regards the above as a discharge, so it has filed a new petition for involuntary placement. This new petition shows up on my docket for tomorrow.

Was the receiving facility correct in treating the medical admission to the hospital as a discharge under the Baker Act? If so, do you believe a new petition and a new hearing is necessary?

The receiving facility should have "transferred" the person for medical treatment instead of "discharging". They only have the power to discharge when the person no longer meets the involuntary criteria. Everyone knows that there is a back office financial or administrative discharge to prevent dual billing for the same day of care, but the notation of "transfer" in the doctor's order in the medical record keeps the legal status and the guardian advocate intact. This is why persons are "transferred" to the state mental health facility – not "discharged". Unfortunately, once the patient was "discharged" and a notice of discharge filed, there may be no alternative to refilling a new petition. It's possible that the state and defense can just stipulate to much of the evidence presented at the earlier hearing, but you still have to have a record that the hearing was conducted and that clear and convincing evidence was presented prior to entering a new order. Hopefully, this won't happen again if you inform the receiving facility personnel at the hearing tomorrow of the proper procedure. It's unfortunate that it happened because it has the potential of resulting in an extended period of confinement.

Q. We are having a dispute over the clock stopping for a medical condition that arises during the 72 hours. If within the 72 hours we start the 1st opinion but before the 2nd opinion and filing is complete (within the 72 hours) a medical condition arises that requires medical treatment, the petition for 32 is no good, because the 1st and 2nd opinion must occur within 72 hours of the administrator filing the petition; even though the 72 hour period stopped for a valid medical condition? So what, re-do the first opinion? It seems if the clock stopped the clock stopped. If the individual still meets criteria for the Baker Act after the medical condition is resolved, the process that is authorized to occur during the 72 hour period resumes for the time remaining?

This is a difficult question because it isn't specifically covered in the Baker Act law or rules. The provision for the tolling of the 72-hours permitted for the involuntary examination is based on the presumption that an individual's psychiatric condition can't be adequately evaluated while undergoing an emergency medical condition. This provision simply allows a delay until the emergency medical condition has been stabilized or determined by a physician not to exist.

The first issue is that the 72-hour period for involuntary examination begins upon arrival at the first hospital or receiving facility – if initially at a non-receiving facility hospital, any time awaiting transfer after the individual is considered medically stable is counted against the 72-hours, even before his/her arrival at the receiving facility.

> **394.463(2)(g), FS** A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an **emergency medical condition specified in s. 395.002** must be examined by a receiving facility within 72 hours. **The 72-hour 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 *(physician or clinical psychologist)* and is

found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record.

The law doesn't actually specify when the 72-hour clock begins again after stabilization of the medical condition, but it is only reasonable to assume that it is upon documentation by the physician of medical stability. It is the individual's right not to be confined for the involuntary psychiatric examination more than 72 hours, not the right of a facility to have a full 72 hours in which to conduct the examination. This comes up when transfers between facilities takes place.

Further, the clock isn't stopped for just any type of medical treatment—only for an "emergency medical condition" as defined in the hospital licensing statute. This definition is as follows:

395.002(8)"Emergency medical condition" means:
(a)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.
(b) With respect to a pregnant woman:
1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;
2. That a transfer may pose a threat to the health and safety of the patient or fetus; or
3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

As you can see, the Baker Act provision was originally intended to apply when a person under Baker Act involuntary status was taken first to an ED in the belief that he/she had an emergency medical condition, rather than a transfer subsequent to the person's arrival at or admission to a designated receiving facility. However, since the subsequent transfer from a receiving facility to an ED is not precluded by the statutory language and the same inability to psychiatrically evaluate during a medical emergency would exist, the stopping of the clock at any time during the examination period has been adopted by practice.

As you noted in your inquiry, the tolling of the 72-hour period only applies to the involuntary examination period. However, it was mentioned in your message that it only applies to the period prior to the 2nd opinion – I believe it would actually apply through the signature of the facility administrator and filing with the Clerk of Court. Only the facility administrator has standing to decide whether to file, based upon the recommendations of the two experts.

394.463 (2)Involuntary examination.
(f)A patient shall be examined by a physician or clinical psychologist at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others. The patient may **not be released by the receiving facility** or its contractor without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. **However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.**

If you transfer the individual for medical treatment to a hospital that isn't designated as a receiving facility, that time doesn't appear to count against the 72-hour limit. However, this issue may be different if the individual is transferred to Florida Hospital for the medical treatment as it is a designated receiving facility vs. to other general hospitals that have no psychiatric capability.

A general hospital with psychiatric capability should be the preferred facility to which individuals are sent for medical care since their psychiatric, medical, and legal needs can be addressed concurrently at the same site. If at such a hospital, the 2nd opinion (and a different 1st opinion if needed), the signature of its administrator on the petition and filing the petition with the Clerk of Court could be arranged. Only one of the two experts is required to provide testimony at the hearing and even if both opinions were done at the first facility, the court might allow for telephonic testimony by one of the two experts providing recommendations.

394.467 Involuntary inpatient placement.
(2)ADMISSION TO A TREATMENT FACILITY.—A patient may be retained by a receiving facility or involuntarily placed in a treatment facility **upon the recommendation of the administrator** of the receiving facility where the patient has been examined and after adherence to the notice and hearing procedures provided in s. 394.4599. **The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary inpatient placement are met**. ..Any **second opinion** authorized in this subsection may be conducted through a face-to-face examination, in person or by **electronic means**. (*a form of telecommunication that requires all parties to maintain visual as well as audio communication*) Such recommendation shall be entered on an involuntary inpatient placement certificate that authorizes the receiving facility to retain the patient pending transfer to a treatment facility or completion of a hearing.

While the above paragraph states that both experts have to examine the individual within the preceding 72 hours, it makes no sense to take this out of context of the original premise that a valid psychiatric evaluation cannot be done in the midst of an emergency medical condition. The psychiatrist that conducts the first examination could document upon the individual's return from the hospital providing medical treatment that the psychiatric condition remained the same as on the previous date, the 2nd opinion could

then be done, signed by the administrator/designee, and filed with the court within the 72 hours plus the period of the medical emergency.

You correctly refer to this as a "transfer" for medical purposes instead of a "discharge"; this allows for the legal status to remain in place and avoids the person from being held for psychiatric evaluation longer than the 72 hours permitted by law.

An additional option in some cases would be to have a psychiatrist or psychologist at the medical hospital provide the second opinion – it wouldn't have to be one of the doctors at your facility. You could have your administrator then sign the petition and request a change of venue for the hearing to take place at the medical hospital where the patient will be located.

> **394.4599 Notice.**
> **(2)INVOLUNTARY PATIENTS.—**
> (c)The written notice of the filing of the petition for involuntary placement must contain the following:
> 4.Notice that the patient, the patient's guardian or representative, or the administrator may apply for a **change of venue** for the convenience of the parties or witnesses **or because of the condition of the patient**.

You are correct that both opinions and the signature of the administrator/designee must be completed within the 72 hour period plus the period in which an emergency medical condition has been documented. If this period ends on a weekend or legal holiday, the law requires the filing of the petition on the next working day. It doesn't specify that it must be done the first thing in the morning of that next working day, although it would be preferable especially if it would make a difference in the date of the hearing itself. Once the petition is filed, the patient, with concurrence of counsel, can request a continuance of the hearing.

There are gaps in the law that hamper our ability to know legislative intent. However, absent such intent and in the face of conflict in differing provisions, good sense should prevail

Q. Does a petition for involuntary placement still stand if the patient is sent for medical clearance and ends up being admitted for several days?

Your question will have to be decided by the court. While the law requires the hearing to be conducted within 5 court working days following the filing of the petition, it allows the patient to request a continuance of the hearing with concurrence of counsel. The only other alternative is for the court to provide for a change of venue so the hearing can be conducted at the medical hospital because of the patient's medical condition.

The mere filing of a petition allows for the individual to be held by a receiving facility until the hearing. If you have "transferred" the person to the medical hospital and haven't formally "discharged" the individual, this would probably still authorize retention of the individual on an involuntary status pending the hearing. The statutory provisions that may apply to your question are as follows:

> **394.467 Involuntary inpatient placement.**

(2)ADMISSION TO A TREATMENT FACILITY.—A patient may be retained by a receiving facility or involuntarily placed in a treatment facility upon the recommendation of the administrator of the receiving facility where the patient has been examined and after adherence to the notice and hearing procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary inpatient placement are met. However, in a county that has a population of fewer than 50,000, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental and nervous disorders or by a psychiatric nurse. Any second opinion authorized in this subsection may be conducted through a face-to-face examination, in person or by electronic means. **Such recommendation shall be entered on an involuntary inpatient placement certificate that authorizes the receiving facility to retain the patient pending transfer to a treatment facility or completion of a hearing.**

(4)APPOINTMENT OF COUNSEL.—Within 1 court working day after the filing of a petition for involuntary inpatient placement, **the court shall appoint the public defender** to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of such appointment. Any attorney representing the patient shall have access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.

(5)CONTINUANCE OF HEARING.—The **patient is entitled, with the concurrence of the patient's counsel, to at least one continuance of the hearing**. The continuance shall be for a period of up to 4 weeks.

(6)HEARING ON INVOLUNTARY INPATIENT PLACEMENT.—

(a)1.The court shall hold the hearing on involuntary inpatient placement within 5 days, unless a continuance is granted. The hearing shall be held in the county where the patient is located and shall be as convenient to the patient as may be consistent with orderly procedure and shall be conducted in physical settings not likely to be injurious to the patient's condition.

394.4599 Notice.

(2)INVOLUNTARY PATIENTS.—

(c)The written notice of the filing of the petition for involuntary placement must contain the following:

4.Notice that the patient, the patient's guardian or representative, or the administrator may apply for a **change of venue** for the convenience of the parties or witnesses or because of the condition of the patient.

Since the filing of a petition results in an attorney being appointed for the individual, you're probably OK as long as the attorney is OK with the delay in hearing.

Q. A patient is admitted to a freestanding psychiatric hospital and is under a petition. During their stay, the patient is sent to a med/surg hospital and is admitted due to a medical emergency. At our facility, we document the petition is

on "medical hold." However, technically, the patient has been discharged from our facility thereby "ending" the petition. Legally, what can our MD's do to ensure the patient comes back for further psychiatric treatment?

When sending a person held on involuntary status out of your free-standing hospital for medical care, you should “transfer” the patient, not “discharge”. It is understood that some sort of a back office administrative/financial discharge must take place to avoid the risk of two facilities billing for the patient’s care on the same day. However, your clinical record should reflect a transfer in order to retain the person’s legal status as well as any guardian advocate who may have been appointed by the court as a substitute decision-maker.

This process is the same as “transferring” a person to the state hospital or transferring to another receiving facility. This maintains the legal standing and guardian advocate.

The clock doesn’t stop for a medical emergency in the circumstance you describe. The patient still has the right to a hearing within the 5 day period after the filing of the petition that is permitted by law unless the patient, with concurrence of counsel, requests a continuation of the hearing. The Baker Act does guarantee the patient a right to a change of venue to have the location of the hearing changed. This might end up taking place at the medical hospital in which case, one of the two experts who signed the petition may have to testify at a different location.

Q. When we have an individual on our CSU under a court petition awaiting their court hearing and they develop medical problems that require us to transfer them to a medical facility for treatment and they are admitted to the medical hospital then historically we have discharged the patient from our CSU census. When the court is notified of this administrative discharge then the petition is dropped. When the individual is medically stable and continues to meet the criteria for a Baker Act then a new Baker Act is initiated by the referring hospital for return to the CSU. Is there anyway to avoid the dismissal of the first petition and avoid creating delays in getting to the individual to a hearing?

The Baker Act gives a receiving facility the authority to discharge persons who no longer meet the criteria for involuntary placement. Just as you “transfer” people to the State Hospital for purpose of maintaining the person’s legal status and any guardian advocate that may have been appointed by the court (doing a back office financial/administrative discharge), you reflect a transfer instead of a discharge in the treatment notes.

You can do the same “transfer” note for a person held in your facility awaiting an involuntary placement hearing. However, there isn’t any provision during the 5-day period in which a hearing must take place for the clock to stop for an emergency medical condition like there is for involuntary examination purposes. The only alternatives that exist are:

- The patient can request with the concurrence of counsel for a continuance (delay) in his/her hearing.
- The court can grant a change of venue for the hearing to take place at the medical hospital.

If none of the above is possible, the petition can be withdrawn by the facility or dismissed by the court and new BA-32 can be filed upon the patient's return to your facility, if still meeting involuntary placement criteria.

Q. Can a CSU "transfer" an involuntary patient under a petition for involuntary placement to a medical facility with a petition accompanying them and then accept him or her back once medically stable and continue the process with the same petition? If we avoid the "discharge" then we can utilize the same petition?

Yes – that is correct. As long as the person was transferred for medical reasons (not discharged) and the hearing was conducted in a timely way, the original petition is still valid. It is recognized that some form of back office financial or administrative discharge will occur during the patient's absence from your facility, but the clinical notes in the record will reflect a transfer. This should be similar to your transfers to the state hospital.

Waiver of Hearings & Waiver of Patient Presence at Hearing

Q. Can the involuntary inpatient placement hearing be waived?

NO. While the hearing cannot be waived, the person's attendance at the hearing can be waived if it is consistent with the best interests of the person and the person's counsel does not object, the court can waive the person's presence from all or any part of the hearing.

Q. I have a question regarding patients' rights in our receiving facility. We have a patient here who had his court hearing yesterday, but he did not attend due to being restrained at the time. He is requesting to appeal the decision. To my knowledge there is no provision in the Baker Act for an appeals process. What are this patient's options, if any, regarding being court ordered to receive treatment at this facility?

The appellate courts have found that involuntary placement under the Baker Act is such a substantial deprivation of liberty, any limitation on a person's ability to be present at or testify at his or her own hearing is grounds for reversal of the court order. The courts have said that a person's refusal to attend or testimony by his/her attorney of such refusal is an insufficient waiver of the right to be present without a separate independent inquiry by the court to confirm that such a refusal was knowing, intelligent and voluntary. In your situation, the individual wasn't refusing to attend -- he was denied his strong desire and right to attend due to his/her acuity. The hearing should have been conducted if necessary in the restraint room to allow the person to attend/participate while preserving the safety of the person and others.

The person's public defender has the standing to appeal an order for involuntary placement if the hearing was conducted by the circuit court judge. If the hearing was conducted by a magistrate instead of by a judge, the public defender has the right to file an "exception" to the Magistrate's recommended order. According to the 1st DCA, the public defender has the duty to be "an independent advocate for the client, not as a

neutral party charged with the responsibility of determining the best interests of the patient or the needs of society". The 1st DCA also said that "if the patient wishes to be released or transferred and if there is a basis for that request, the Public Defender has a duty to advocate the cause of the patient".

The cases referenced above are:

> Jonathan F. IBUR v. STATE of Florida, 765 So. 2d 275 (Fla. 1st DCA 2000). Appellate Judge Barfield wrote the opinion with Appellate Judges Miner and Padovano concurring. The First District Court of Appeals decided that a hearing officer committed reversible error by not permitting a Baker Act patient to testify at the patient's hearing for involuntary hospitalization. The First District Court of Appeals held that since an involuntary commitment is a substantial deprivation of liberty at which fundamental due process protections must attach, the patient can not be denied the right to be present, to be represented by counsel, and to be heard. The First District Court of Appeals reversed the order of commitment and remanded the case for further proceedings.
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> Ryan JOEHNK v. STATE of Florida, 689 So. 2d 1179 (Fla. 1st DCA 1997). Appellate Judge Wolf wrote the opinion with Appellate Judges Joanos and Van Nortwick concurring. The First District Court of Appeals held that the respondent's lawyer informing the trial court that the respondent did not wish to appear at an involuntary commitment hearing was an insufficient waiver of the respondent's fundamental right to be present at an involuntary commitment hearing and while a respondent may waive his/her rights to be personally present and be constructively present through counsel, the trial court must certify through proper inquiry that a respondent's waiver of his/her right to be personally present at an involuntary commitment proceeding be knowing, intelligent, and voluntary. The First District Court of Appeals reversed the trial court's final order of involuntary commitment and remanded the case for further proceedings.
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> Clarence WILLIAMS v. STATE of Florida, 692 So. 2d 257 (Fla. 1st DCA 1997). Appellate Judges Booth, Wolf, and Van Nortwick in a per curiam decision held that in a Baker Act commitment proceeding the defendant has a fundamental right to be present at the commitment proceeding and while a defendant may waive his/her rights to be personally present and be constructively present through counsel, the court must certify through proper inquiry that the waiver is knowing, intelligent, and voluntary. The First District Court of Appeals reversed and remanded the case for a new commitment hearing since the record did not reflect if the Baker Act patient waived his right to be present at the commitment hearing.

DCF circuit office staff may be able to assist you in contacting the Public Defender's Office to ensure that the due process right of the individual have been protected. If the Public Defender's Office is unwilling to file such an appeal/exception, you should assist the individual to connect with a Legal Aid organization or ACLU to obtain legal representation. Finally, you may wish to refer this matter to your corporate attorney for assistance.

Conversion from Voluntary to Involuntary Status

Q. If we have a patient who is voluntary and the MD wants to initiate a BA-32 for involuntary placement, do they also need to do a BA-52 or is initiating the BA-32 sufficient and just send that in to the court with the notice of the petition?

No BA-52 is needed to transfer a person from voluntary to involuntary status. The BA-32 must be filed with the court within two court working days of the person's refusal of treatment, request for discharge, or determination by a physician that the person is incompetent to consent to treatment. It is the court's responsibility to prepare the notice of petition unless the hospital has some different understanding with the Clerk of Court.

Q. The doctors in our hospital think it is okay to BA 32 patients directly without benefit of a BA 52 first. The recent circumstance happened when a patient was on a medical unit for a time and then needed to come to the psychiatric unit. I explained to the doctor that the patient had to have a BA status first-- ie. voluntary or BA 52. If it is possible to directly BA 32 patients?

Actually, the doctor may be correct on this issue. People arrive at receiving facilities on a voluntary basis, but have to be transferred to involuntary status

> **394.4625, FS Voluntary admissions.—**
> (5) TRANSFER TO INVOLUNTARY STATUS.--When a voluntary patient, or an authorized person on the patient's behalf, makes a request for discharge, the request for discharge, unless freely and voluntarily rescinded, must be communicated to a physician, clinical psychologist, or psychiatrist as quickly as possible, but not later than 12 hours after the request is made. **If the patient meets the criteria for involuntary placement, the administrator of the facility must file with the court a petition for involuntary placement, within 2 court working days after the request for discharge is made**. If the petition is not filed within 2 court working days, the patient shall be discharged. Pending the filing of the petition, the patient may be held and emergency treatment rendered in the least restrictive manner, upon the written order of a physician, if it is determined that such treatment is necessary for the safety of the patient or others.

The Baker Act law only references an ex parte order, a report of a law enforcement officer, or a certificate of a professional to take the person into custody for delivery to the nearest designated receiving facility. Once at a receiving facility, there is no particular purpose for such documentation, although many receiving facilities have a practice of creating such documentation No harm is done by a professional doing a Certificate as an alternate way of documenting that a person is now being held under the involuntary provisions of the law as long as the petition is filed within the two working day time limit as opposed to the 72-hour time limit. Most facilities would use the BA-52 method, even if not required, instead of just documenting this is the chart.

The bigger issue is when a person comes to a receiving facility and hasn't yet signed an application for voluntary admission. This may be because of refusal or because the staff identifies the person's condition makes him/her clearly incompetent to consent. In this case, the statute and rules are silent as to the appropriate procedure. CSU's used to call law enforcement to come to the facility to initiate an involuntary exam if no mental health

professional was available to do so. The alternative was to have an on-call professional come to the unit to evaluate the person and initiate involuntary examination. A receiving facility, by virtue of its designation is authorized to accept and hold a person on involuntary status, assuming all due process rights of the person are observed.

394.455, FS Definitions

(26) "Receiving facility" means any public or private facility designated by the department to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment. The term does not include a county jail.

The Florida Administrative Code has the following provisions governing this issue:

65E-5.170, FAC Right to Express and Informed Consent.

(1) Establishment of Consent.

(d) In the event there is a change in the ability of a person on voluntary status to provide express and informed consent to treatment, the change shall be immediately documented in the person's clinical record. A person's refusal to consent to treatment is not, in itself, an indication of incompetence to consent to treatment.

1. If the person is assessed to be competent to consent to treatment and meets the criteria for involuntary inpatient placement, the facility administrator shall file with the court a petition for involuntary placement. Recommended form CF-MH 3032, Feb. 05, "Petition for Involuntary Inpatient Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E- 5.120, F.A.C., of this rule chapter may be used for this purpose.

2. If the person is assessed to be incompetent to consent to treatment, and meets the criteria for involuntary inpatient or involuntary outpatient placement, the facility administrator shall expeditiously file with the court both a petition for the adjudication of incompetence to consent to treatment and appointment of a guardian advocate, and a petition for involuntary inpatient or involuntary outpatient placement. Upon determination that a person is incompetent to consent to treatment the facility shall expeditiously pursue the appointment of a duly authorized substitute decision-maker that can make legally required decisions concerning treatment options or refusal of treatments for the person. Recommended forms CF-MH 3106, Feb. 05, "Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate," which is incorporated by reference may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, and CF-MH 3032, "Petition for Involuntary Inpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)1., F.A.C., or CF-MH 3130, "Petition for Involuntary Outpatient Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

65E-5.270, FAC Voluntary Admission.

(6) When a person on voluntary status refuses treatment or requests discharge and the facility administrator makes the determination that the person will not be discharged within 24 hours from a designated receiving or treatment facility, a petition for involuntary inpatient placement or involuntary outpatient placement shall be filed with the court by the facility administrator. Recommended form CF-MH 3032, "Petition for Involuntary Inpatient Placement," as referenced in

subparagraph 65E- 5.170(1)(d)1., F.A.C., or recommended form CF-MH 3130, "Petition for Involuntary Outpatient Placement", as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., may be used for this purpose. The first expert opinion by a psychiatrist shall be obtained on the petition form within 24 hours of the request for discharge or refusal of treatment to justify the continued detention of the person and the petition shall be filed with the court within 2 court working days after the request for discharge or refusal to consent to treatment was made.

As you can see from the above provisions, the person would be transferred from voluntary status directly to involuntary via a petition for involuntary placement. No involuntary examination is initiated in such circumstances. In any case, you should always follow advice of your facility's attorney

Conversion from involuntary to Voluntary Status

Q. If a petition for involuntary inpatient placement has been filed, but the patient was subsequently deemed competent (prior to court date), do we need to ask him/her to sign a whole new consent?

If a person has first been found to meet the criteria for involuntary inpatient placement and incompetent to consent to treatment, resulting in a BA-32 petition form being filed with the circuit court and, subsequently stabilizes before the scheduled hearing, you would indeed request withdrawal of the petition. The person would sign an application for voluntary admission and other forms required for voluntary status only after a physician had documented that the person is competent to provide express and informed consent by use of the 3104 Certificate form.

Q. We have a large volume of 2nd opinions for Psychiatrists to move forward with BA court hearings. The clinicians raise CONCERN because the attending Psychiatrist is checking the incompetent box on the 24 hour competency even when the patients seem able to make well reasoned decisions, seemingly competent to sign in voluntarily. As a result of the psychiatrist's determination, they don't even ask the patient if they are willing to sign in voluntarily. So then we go through a detailed process to properly prepare for the hearings. Then the day of the scheduled court hearing the Psychiatrist allows the patient to sign in. We presented this as a concern/question to our Psychiatrists. They indicated they feel legally protected if they DON'T allow the patient's to sign in. They indicated that the patient's competency changed from day one to day four, therefore allowing for them to sign in a few days later. Psychiatrists state that it protects the doctor/facility to take the patient to court because the judge can't be sued if something happens after discharge. My stance on this is that it's our responsibility to honor the patient and his/her rights above all else. Can you provide me with additional guidance or recommendations to address this concern?

This is an issue that may need to be handled through a peer review or through your hospital's medical chain of command. There seem to be several separate issues here, including:

1. Only a physician is authorized by the Baker Act to determine which individuals are competent to make "well-reasoned, willful, and knowing decisions about their medical or mental health treatment". Any individuals determined to be incompetent to consent to admission or treatment must be retained on involuntary status to ensure their due process rights are protected. Some individuals might be "willing" to consent to admission / treatment, but not be clinically competent to do so.

2. While an individual might have stabilized sufficiently between the time the petition is filed and the day of the hearing to allow that particular individual to convert to voluntary status, this should not be a regular occurrence. If this is a regular occurrence, such a pattern would make it appear that individuals are being retained for longer than the 72 hours permitted by law for examination. The law doesn't allow further deprivation of liberty solely because the individual may be in need of treatment – only when the specific legal criteria are met by clear and convincing evidence.

3. It would be totally inappropriate (illegal) to misrepresent an individual's clinical condition to the court through a wrongful court affidavit. If the entries in the clinical record didn't fully support the two psychiatric opinions at the time of filing or at any time following that time prior to a hearing, the psychiatrists could be subject to legal or administrative action. It would be totally inappropriate to routinely file petitions for the sole purpose of shifting responsibility from the physician to the judge.

Representative Maxine Baker was quoted on the day her bill passed the Legislature in 1971 that "in the name of mental health, we deprive them of their most precious possession – their liberty". Retaining persons against their will without meeting the legal standards is not only a violation of rights enumerated in the Baker Act but could be considered fraudulent if disparate information was provided to insurers to obtain authorization for continued stay.

Q. If a petition for involuntary inpatient placement is withdrawn and we had asked for a guardian advocate, do we need to send a copy of the withdrawal to the prospective guardian advocate? We do notify them by phone.

> **65E-5.290 Involuntary Inpatient Placement.**
> (6) Recommended form CF-MH 3033, Feb. 05, "Notification to Court of Withdrawal of Petition on Involuntary Inpatient or Outpatient Placement," as referenced in paragraph 65E-5.285(2)(d), F.A.C., may be used if the facility administrator seeks to withdraw the petition for involuntary placement prior to the hearing. The facility shall retain a copy in the person's clinical record. When a facility withdraws a petition for involuntary inpatient placement, it shall notify the court, state attorney, attorney for the person, and guardian or representative by telephone within 1 business day of its decision to withdraw the petition, unless such decision is made within 24 hours prior to the hearing. In such cases, the notification must be made immediately. In all cases involving potential involuntary inpatient placement in a state treatment facility, a copy of the notification form shall also be provided to the designated community mental health center or clinic responsible for conducting a transfer evaluation.

As you can see, the prospective guardian advocate isn't one of the parties requiring notification. However, it is thoughtful of you to call the prospective guardian advocate to advise him/her of the change in plans so no unnecessary trip is made.

Hearings

Q. A new Public Defender was recently assigned to Baker Act court. Apparently, the strict wording of the Statutes is "HEARING ON INVOLUNTARY INPATIENT PLACEMENT.— (6) The court shall hold the hearing on involuntary inpatient placement (a)1. *within 5 days*, unless a continuance is granted. All instructions in the Handbook such as Appendix J which reads: "The court will hold the hearing on involuntary inpatient placement within *five court working days* after the petition is filed, unless a continuance is granted." The language specific to "Five Court Working Days" is how we have been proceeding in our county for as long as I can remember. And although I believe that "court working days" is the intended interpretation, the law is written without specification. This is extremely important when it comes to week-ends and holidays; as would any court contend with non-working court days? But without this language in the actual law and other areas of the law so specifically written out, the Public Defender has successfully had most petition overturned; especially in light of the recent extended holiday week end, such as Thanksgiving and Christmas.

The statute only refers to "5 days" and an old Attorney General opinion interpreted this as calendar days. Since that time, the courts have determined that this is 5 court working days – not calendar days -- as follows:

> **D.M.H. v. Pietilla, 33 So. 3d 800 (Fla. 5th DCA 2010).** The Appellate court held that Fla. R. Civ P. 1.010 governed the computation of time prescribed for an involuntary inpatient placement hearing under 394.467(6)(a)1. The Rule provides that Saturdays, Sundays, and legal holidays are excluded when the time period is seven days or less. Therefore, the appellate court affirmed the trial court's denial of the petitioner's petition for a writ of habeas corpus for the failure to hold a hearing within 5 calendar days.

The timing of the hearing had traditionally been 5 court working days, but in 1997 the Florida Attorney General opined in AGO 97-81 that this was actually five calendar days. The 17th Circuit immediately and formally rejected this AG opinion in the following order:

> **17th Judicial Circuit Court Order, December 19, 1997.** The Circuit Court disagrees with the AGO 97-81 above. The State maintains that the Rules of Civil Procedure apply to Baker Act hearings and thus Saturdays, Sundays, and legal holidays should not be calculated into the time within which a Baker Act hearing is computed. The Florida Rule of Civil Procedure states "when the time prescribed or allowed is less than seven days, intermediate Saturdays, Sundays, and legal holidays shall be excluded in the computation." Further, Crum v. State, 507 So 2d 759 (Fla 1st DCA 1987) found that the Rules of Civil Procedure 1.010 are to be applied in Baker Act procedures. Crum, which involved the issue of whether the state could file a motion for rehearing on a Baker Act petition held

that although the statute is silent regarding rehearing…there is no reason why the Rules of Civil Procedure regarding rehearing should not be applicable. (see 5th DCA opinion below).

When the Legislature enacted the involuntary outpatient placement provisions in 2004, it specified five court working days for the hearing, but never addressed the involuntary inpatient placement timing. However the 5th DCA case provides statewide clarity needed in the absence of legislative action. The appellate case is the basis of the material in the 2011 Baker Act Handbook citing five working days for the involuntary inpatient placement hearing.

Q. If you have completed the 1st & 2nd opinions for a consumer on or near a holiday and the court tells you there will not be a hearing due to the holiday schedule , how would you proceed? The consumer is incompetent and your immediate concern is for their safety. Does the court or monitoring agencies see that as a viable reason for keeping them beyond the allotted time?

As long as your facility completes the Petition (both opinions and the facility administrator's signatures) and you have filed the petition with the Clerk of Court within 72 hours of the individual's arrival (could be less time if the individual had been held at a hospital ED or other receiving facility prior to arrival) you have met your duty under the law. The law allows for the actual filing to be delayed until the next court working day only if the examination period ends on a weekend or legal holiday (not just a week night).

Once the petition has been timely filed with the court, you've met your duty to the individual and have the right to hold the individual until the hearing. The court must conduct the involuntary placement hearing within 5 court working days after filing of the petition. The only legal way of delaying the hearing is if the individual requests a "continuance" of his/her hearing with the concurrence of legal counsel. The statutory provisions governing this issue are as follows:

394.463)INVOLUNTARY EXAMINATION.—
(2)(i)Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:
1.The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;
2.The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;
3.The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or
4.A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary….

394.467 Involuntary inpatient placement.
(2)ADMISSION TO A TREATMENT FACILITY.—A patient may be retained by a receiving facility or involuntarily placed in a treatment facility upon the

recommendation of the administrator of the receiving facility where the patient has been examined and after adherence to the notice and hearing procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary inpatient placement are met. ..Such recommendation shall be entered on an involuntary inpatient placement certificate that ***authorizes the receiving facility to retain the patient pending transfer to a treatment facility or completion of a hearing.***

(5)CONTINUANCE OF HEARING.—The patient is entitled, with the concurrence of the patient's counsel, to at least one continuance of the hearing. The continuance shall be for a period of up to 4 weeks.

(6)HEARING ON INVOLUNTARY INPATIENT PLACEMENT.—

(a)1.The court shall hold the hearing on involuntary inpatient placement within 5 days, unless a continuance is granted.

If your facility doesn't file or the court doesn't conduct the hearing within the time periods shown above, a dismissal of the petition is likely to occur.

Q. What are the required elements of an involuntary placement hearing?

To determine if there is clear and convincing evidence that the person meets all criteria for involuntary placement and to consider testimony and evidence regarding the person's competence to consent to treatment. If the court finds the person is incompetent to consent to treatment, it is required to appoint a guardian advocate.

Q. I thought that hearings are to be held in each receiving facility. So if there are three receiving facilities in an area, three dockets are created, etc. But I can not find this in the law. It just says, "...shall be as convenient to the patient as may be consistent with orderly procedure and shall be conducted in physical settings not likely to be injurious to the patient's condition." We have it set up in our county that hearings for three facilities take place in one location.

The citation from the statutes you provided in your inquiry is correct. Historically, these hearings were generally conducted in court houses. They've gradually moved the hearings to the various Baker Act receiving facilities in most judicial circuits. This has been found to be much safer for the patients by avoiding transport and increased the privacy and confidentiality of the patients. This is what was recommended by the Florida Supreme Court Commission on Fairness, assuming that facilities were using space for the hearings not used by patients for any other program purpose. It is important that wherever the hearings are held, the person understands that they've had their day in court – not just a staffing or other event occurring in the cafeteria or activity room. Hopefully, you have a US and Florida flag, a conference room table for the magistrate and other court staff, and the same decorum expected in any courtroom is expected at your Baker Act hearings.

The only other place the practice of bringing patients from multiple receiving facilities to a single facility is used is in Miami-Dade where everyone is brought to Jackson Memorial Hospital for hearings. While having hearings in each receiving facility may be a

workload consideration for the court personnel, it may be a fairer process in that the each receiving facility is dealt with the same and doesn't' have to transport its patients, staff, physician expert, etc to another facility and have to wait its turn for hearings. It reduces the concern for safety while allowing for feeding, access to bathrooms, and familiar staff for the patients.

Q. Can Baker Act involuntary placement hearings be done via remote video?

The Baker Act requires involuntary placement hearings to be conducted in a location "as convenient to the patient as may be consistent with orderly procedure and shall be conducted in physical settings not likely to be injurious to the patient's condition". The Florida Supreme Court Commission on Fairness made many recommendations regarding the Baker Act, including a very strong recommendation against the use of any video or telephonic hearings or testimony in Baker Act related matters. The reason for this is that the person's appearance at a hearing done in this fashion may be altered by the use of such electronic means, particularly if the person's mental illness is characterized by paranoia or hallucinations. If all court personnel, including the Public Defender, are sitting in a court room many miles away. How does the person even know who is representing him/her? Is the court aware of what influences may be exerted by staff prior to or during the hearing? How does the court even know who else is in the room with the person? Certain rules governing juvenile procedures also limit video or telephonic means due to the minors' diminished capacity. If so, than persons with mental illnesses certainly also have such a diminished capacity.

Q. I provide most of the testimony at involuntary placement hearings for my receiving facility. My question is about criteria 1A of the Involuntary inpatient placement (he or she is manifestly incapable...). I could not find a definition in Florida statutes for the terms "neglect" (for adults) "well-being" or the concept of "self-care". It seems that the court/public defender's office have no difficulty accepting behaviors such as not eating, not sleeping, neglect of hygiene, and refusal to take medical medications, obvious physical behaviors, however struggle with the ideas of: refusing to take psychiatric medication; paranoia leading to isolation; having persecutory delusions; or other "psychological" or "emotional" concepts related someone's well being. In short, there is resistance to say that someone refusing psychiatric medication is experiencing neglect, even if they are paranoid, delusional, and suffering emotionally. Has this been brought up before?

Good question, since many assistant state attorneys don't always elicit the testimony on these issues to support the petitions. As a result, some persons are released from receiving facilities that need to be held longer. The statutory language for involuntary examination and involuntary placement requires the neglect to be real, present, and substantial. It also needs to be documented that there isn't any other help available to assist the person to avoid this neglect and that there are no less restrictive treatment alternatives.

There isn't any other Baker Act related statutory or regulatory provisions that would provide more help in this area. The only other statute governing the issue of neglect is in the Florida Adult Protective Services law. That law defines "neglect" as follows:

> **415.102(15)** "Neglect" means the failure or omission on the part of the caregiver or vulnerable adult to provide the care, supervision, and services necessary to maintain the physical and mental health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, which a prudent person would consider essential for the well-being of a vulnerable adult. The term "neglect" also means the failure of a caregiver or vulnerable adult to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness which produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death.

The burden of proof in the involuntary inpatient placement hearings is "clear and convincing evidence". Testimony given by witnesses that fails to meet this standard is not likely to be helpful in supporting the petition. The only definition I know of "clear and convincing" is the following:

> Evidence that is precise, explicit, lacking in confusion, and of such weight that it produces a firm belief or conviction, without hesitation, about the matter at issue (Standard Jury Instructions – Criminal Cases, published by the Supreme Court of Florida, No. SC95832, June 15, 2000).

The best source of information regarding your question is going to come directly from how the appellate courts have ruled on the subject. Some of them are listed here:

> **Brenda J. BOLLER v. STATE of Florida,** 775 So. 2d 408. 1st DCA found on December 29, 2000 that the need for treatment and medication and the refusal to take psychotropic medication despite a deteriorating mental condition, standing alone, do not justify involuntary commitment under the Baker Act; rather there must also be clear and convincing evidence that without treatment, the patient would pose a real and present threat of substantial harm to herself, or a substantial likelihood that in the near future she will inflict serious bodily harm on herself or another, as evidenced by recent behavior. Conclusory testimony, unsubstantiated by facts in evidence, that a patient has a potential for aggression and the possibility of substantial harm to herself, is insufficient to satisfy the statutory criteria by the clear and convincing evidence standard. Testimony that patient refused to take her psychotropic medication, that she had slapped hospital staff member and that she believed others were trying to kill her, and psychiatrist's conclusory testimony that it was more likely than not that a patient might inflict serious bodily harm on self or other was insufficient to establish by clear and convincing evidence that patient posed present threat of substantial harm to justify involuntary commitment. Testimony that a person may have threatened someone in the past doesn't amount to clear and convincing evidence that she is a current danger to others.
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> **Catherine SALTER v. STATE OF FLORIDA**, No.92-1612, Mary 17, 1993;618 So. 2d 352, 18 Fla. L. Weekly D1283; 1st DCA. Person involuntarily committed to state hospital pursuant to order of the Circuit Court. Psychiatrist testified that the person refused to cooperate with any treatment recommended, but he failed to state what treatment or medication was recommended or necessary, testified that person was in danger of self-neglect or some violent act and needed to be

involuntarily placed for further care and supervision, but he did not state nature of self-neglect that person would sustain if not committed. The 1st DCA held that testimony of psychiatrist failed to establish that person was manifestly incapable of surviving alone or with help of willing and responsible family or friends, and this, testimony of psychiatrist was not sufficient to support involuntary commitment of the person.

Elise Everett vs. STATE OF FLORIDA, 1st District Case No. 87-931, May 4, 1988. Appellant contend in this appeal that the state failed to prove she met all statutory criteria for involuntary placement. The 1st DCA reversed the Circuit Court order because the state failed to present evidence that, because of her mental illness, appellant refused voluntary placement for treatment or was unable to determine whether placement was necessary. The only evidence was that appellant was hospitalized "on multiple occasions" as a result of her failure to take medication prescribed for her condition. The record didn't indicate whether the hospitalizations were voluntary or involuntary, initiated by appellant or someone else. The appeal took so long, appellant had already been ordered to "continued" involuntary placement upon expiration of the original court order. The 1st DCA determined that the appeal of the original placement order was not superseded by the order of continued involuntary placement If a circuit judge's order of initial involuntary placement is erroneous, subsequent administrative orders of continued involuntary placement predicated as they are on the initial order do not render challenges to that order moot. The 1st DCA urged those who challenge involuntary placement orders to seek expedited appellate review or to promptly challenge the order in a habeas corpus petition to the circuit court.

Sharon ARCHER v. STATE of Florida, 681 So. 2d 296 (Fla. 1st DCA 1996). The First District Court of Appeals reversed an order for involuntary placement finding that clear and convincing evidence did not support the assertion in the petition for involuntary placement that the Baker Act patient was incapable for surviving alone and would suffer from neglect or refuse to care for herself if released. The only evidence supporting such an assertion was the psychologist's testimony, however, the psychologist acknowledged that the patient had not threatened to hurt herself or anyone else. The patient also testified that if she was released she would take her medication.

Ezra WADE v. Northeast Florida State Hospital, 655 So. 2d 125 (Fla. 1st DCA 1995). Appellate Judge Allen wrote the opinion with Appellate Judges Davis and Smith concurring. The First District Court of Appeals held that the conclusory statements reciting a patient's potential for aggression and the possibility of the patient causing substantial harm to his well-being did not meet the standard of clear and convincing evidence to support an order of continued involuntary placement for treatment pursuant to Baker Act section 394.467, Fla. Stat. The order of continued involuntary placement for treatment under the Baker Act was reversed.

Steven LISCHKA v. STATE of Florida, (Case No. ID05-0458 1st DCA May 25, 2005). Appellant asserted that the state failed to present clear and convincing evidence that patient met the required statutory criteria for involuntary commitment. The state filed a confession of error. While the appellate court was concerned about the significant problems that can occur when mental health

patients refuse to take their prescribed medication, the statute and case law require reversal. It is well-settled that the need for treatment and medication and the refusal to take medication despite a deteriorating mental condition, standing alone, do not justify involuntary commitment under the Baker Act. Rather, there must also be clear and convincing evidence that without treatment, the patient would pose a real and present threat of substantial harm to himself, or a substantial likelihood that in the near future he will inflict serious bodily harm on himself or another, as evidenced by recent behavior. The confession of error is proper and the involuntary commitment order is reversed.

Cheryl L. WELK v. STATE of Florida, 542 So.2d 1343 (Fla. 1st DCA April 21, 1989). A circuit judge from Duval County ordered a person's involuntary placement at the state hospital. The DCA held that evidence was insufficient to support finding that person posed real and present threat of substantial harm to herself or others such that involuntary placement was justified, despite expert testimony that person needed supervision and would continue to encounter problems if such supervision was not available.

Mabel LYON v. STATE of Florida, 724 So. 2d 1241 (Fla. 1st DCA 1999), decided on January 27, 1999. Held that the involuntary commitment of a schizophrenic woman on the grounds that she was likely to suffer from neglect or refusal to care for herself was not warranted since there was no specific showing that any self-neglect posed a real and present threat of substantial harm to her well-being. The First District Court of Appeals reversed the trial court order of involuntary commitment which was based on a doctor's opinion that if the schizophrenic woman did not take her medication, "She would be almost incoherent in her speech, not able to take care of herself, she'll require supervision, she'll require structure," and found that the trial court's finding was not based on clear and convincing evidence. Id. at 1241. The First District Court of Appeals reversed the trial court's order of involuntary commitment.

David W. HEDRICK v. Florida Hospital Medical Center, 633 So. 2d 1153 (Fla. 5th DCA 1994). The Fifth District Court of Appeals held that evidence of a Baker Act patient's potential for poor judgment was insufficient to satisfy the statutory test for involuntary examination absent evidence of the present threat of substantial harm to the patient's well-being. The Fifth District Court of Appeals reversed the order for involuntary examination and remanded the case for further proceedings.

Barbara Suzanne ROSICKA v. STATE of Florida. (No. ID04-5065, 1st DCF March 24, 2003). The appellant challenged an order of involuntary commitment because the record was devoid of competent substantial evidence, either that the appellant posed a real and present threat of substantial harm to her well0being or that her recent behavior evidenced a substantial likelihood that she would inflict serious bodily harm on herself or another in the near future. The trial court found that the appellant had a history of multiple suicidal gestures, but the review of the court record didn't reveal any evidence to support that determination or any competent substantial evidence that the appellant posed a threat to herself through neglect. The order for involuntary placement was reversed.

Carol SCHEXNAYDER v. STATE of Florida. 495 So. 2d 850 (Fla. 1st DCA October 7, 1986). DCA held that the State failed to provide, by clear and convincing evidence, that involuntary commitment was required where person had a place to live, financial resources, insight into her mental illness, knowledge of necessity for medication, and history of self-admissions to hospitals. The person periodically forgets to take her medication, without which she becomes disoriented, nervous, agitated, and ultimately in need of hospitalization. In the past, she had self-admitted to voluntary hospitalization. Psychiatrist testified that without the medication, she would become disoriented and at times would forget to eat and to take care of herself. He testified that alternative treatment programs, such as care in a halfway house and supervision through a daycare program, had been ineffective. A psychologist testified that there was no evidence of dehydration or gross malnutrition, she was not psychotic and had surprising insight into her illness and need for medication, and that she was non-dangerous even though she had trouble controlling her moods and behavior. There was no evidence of specific occasions when such lapses of personal care had resulted in substantial harm to her well-being.

In re Preer Beverly (342 So. 2nd 481 Supreme Court of Florida January 27, 1977). Supreme Court held that the Baker Act authorizing involuntary commitment of mentally ill persons is not unconstitutionally vague or overbroad; that the standard of proof to be applied in civil commitment proceedings is 'clear and convincing evidence'; that the patient's Fifth Amendment rights were not denied because he was not given Miranda warnings during a psychiatric examination; that the subject of an involuntary commitment proceeding has the right to effective assistance of counsel at all significant stages of the commitment process; that testimony by the examining psychiatrist concerning conversations he had with the patient at the preliminary psychiatric interview did not violate the patient-psychiatrist statutory privilege; but that evidence failed to establish that the patient, who was mentally ill and in need of care or treatment, was also dangerous or that he lacked sufficient capacity to make a responsible application on his own behalf. The appellant was mentally ill, had quit his job because of his religious beliefs, had been violent on two occasions, and a psychiatrist testified that appellant was likely to injure himself or others and was in need of care but could not seek it on his own behalf. The court found this evidence not to be clear and convincing proof that appellant was dangerous to himself or others or that he lacked the capacity to seek help on his own behalf. The court stated that "the seriousness of the deprivation of liberty and the consequences which follow in adjudication of mental illness make imperative strict adherence to the rules of evidence generally applicable to other proceedings win which an individual's liberty is in jeopardy. The court is required to strike a proper balance between the State interest in civilly committed persons who pose a danger to society or themselves and the individual's interest in remaining free from unwanted restraint.

NEFF v. STATE of Florida 356 So. 2d 901 (Fla. 1st DCA 1978). Even though appellant was mentally ill and unable to recognize his illness, the order of involuntary commitment was reversed because appellant was a non-dangerous individual capable of taking care of himself and surviving safely in freedom.

Barbara Singletary v. STATE of Florida, 765 So. 2d 180 (Fla. 1st DCA 2000). The First District Court of Appeals held that the State of Florida failed to prove by clear and convincing evidence that a Baker Act patient met the criteria for involuntary placement. The First District Court of Appeals found that testimony that the Baker Act patient may have threatened others at some point in the past, did not amount to clear and convincing evidence that she was a danger to others as required by section, 394.467(1)(a)2b, Fla. Stat. (1999). In addition, testimony that the Baker Act patient would likely have to be rehospitalized if she did not take her medication was insufficient to prove a real and present threat of substantial harm to her well-being pursuant to section 394.467(1)(a)2a, Fla. Stat. (1999). And lastly, the State did not present clear and convincing evidence that less restrictive treatment alternatives were unavailable pursuant to section 394.467(1)(b), Fla. Stat. (1999) when the patient's mother testified that she wanted to have her daughter live with her in a new neighborhood and that the mother testified that she would ensure that her daughter continued to take her medication and promised to initiate involuntary commitment proceedings if her daughter did not take her medication. The First District Court of Appeals found that the state failed to prove by clear and convincing evidence that the Baker Act patient required involuntary placement and thus reversed the order for involuntary placement.

Carolyn Blue v. STATE of Florida, 764 So. 2d 697 (Fla. 1st DCA 2000). The First District Court of Appeals held that evidence presented to the trial court that a Baker Act patient was unstable and threatening to others, that her emotional outbursts scared her family, and that she was argumentative and hostile, did not meet the statutory standard of clear and convincing evidence that there was a substantial likelihood in the near future the Baker Act patient will inflict serious bodily injury/harm on herself or another person. The First District Court of Appeals reversed the trial court's order of involuntary placement and treatment under the Baker Act, section 394.467, Fla. Stat. and remanded the case for further proceedings.

Delora Berry v. STATE of Florida, 751 So. 2d 764 (Fla. 1st DCA 2000), decided on March 1, 2000. The First District Court of Appeals held that the fact that a Baker Act patient may derive some benefit from further treatment in a structured living arrangement does not justify a Baker Act commitment; the trial court's order of involuntary placement for treatment pursuant to Baker Act section 394.467 (1)(a)2.b., Fla. Stat. must be based upon a finding by the trial court by clear and convincing evidence that the Baker Act patient will inflict serious bodily injury/harm on herself or another person. The First District Court of Appeals reversed the trial court's order of involuntary placement for treatment under the Baker Act, section 394.467, Fla. Stat.

Eric ADAMS v. STATE of Florida, 713 So. 2d 1063 (Fla. 1st DCA 1998), decided on July 9, 1998. The First District Court of Appeals held that a Baker Act commitment was not justified by clear and convincing evidence where the order of involuntary placement for treatment referred to a witness who did not testify at the involuntary commitment hearing and the order directly quoted the contents of the petition for involuntary placement. Furthermore, the trial court made oral findings at the conclusion of the hearing regarding the respondent's need for treatment and medication, however, the First District Court of Appeals held that

the trial court's oral findings were not supported by clear and convincing evidence and thus were insufficient to support a Baker Act commitment. The First District Court of Appeals reversed the trial court's order of involuntary placement for treatment under the Baker Act, section 394.467, Fla. Stat.

Q. Can a judge merge a Baker Act involuntary placement hearing and an emergency guardianship proceeding, allowing the family / temporary guardians and the receiving facility status as intervenors in the Baker Act hearing?

The Handley vs. Dennis case may be on point here. The First District Court of Appeals held that when there is a conflict with the area of guardianship law, Chapter 744, Fla. Stat., and the Baker Act, Chapter 394, Fla. Stat., both the duty of the guardian and the power of the guardianship court, must give way to the ward's rights under the Baker Act to be in the least restrictive environment. The court went on to say that a liberty interest asserted on behalf of an involuntary mental patient in a Baker Act hearing is superior to any conflicting right that could be asserted on behalf of the patient under the guardianship laws.

Having a combined hearing would be most unusual. There could potentially be two hearings, one right after another that might be allowable as long as the required notice was provided for each. Notice requirements for a Baker Act hearing are listed in 394.4599(2)(c), including an independent expert provided by the court. Since the Public Defender's Office must be appointed to represent the person in a Baker Act proceeding, unless the person is represented by private counsel, it is presumed that the person was appointed a different attorney to represent him/her under the guardianship matter. Both would be required to be an independent advocate for the least restrictive alternative for the client.

Family / temporary guardians and the hospital staff have no standing as "intervenors" in a Baker Act proceeding. Chapter 394 only permits the public defender representing the person and the state attorney as the "real party in interest" representing the state to call witnesses. These "intervenors" could have been called as witnesses by the state in support of the continued detention of the person, but counsel for the ward could have invoked the exclusionary rule to keep them out of the rest of the hearing. They would have had no standing.

Chapter 744 doesn't establish (nor could it) any superior rights of the guardian over the ward in the Baker Act case. While 744.3725 allows extraordinary authority to be given to a guardian by the court, the court must first provide for the required array of protections specified in this section of the statute to the incapacitated person. While Chapter 744 allows a court to give a guardian the power to have the ward committed voluntarily, but a later revision of the Baker Act (1996) prohibited a facility from admitting as a voluntary patient anyone adjudicated incapacitated \394.4625(1)(d), FS].

Involuntary Placement Orders

Q. We have just been approved for licensure for an SRT and I'm trying to find statutory support for a person being ordered here under the Baker Act. I am fully aware that judges/magistrates order folks with the 3008 to SRTs all the time in

other areas but our Baker Act judge wants to know what gives her the authority to do so. Is it classified as a receiving facility or Treatment facility and if so, who says so and where is it in the law?

The Baker Act gives the court the authority to order persons to a state mental health facility (treatment facility), to any receiving facility, or to receive services from a receiving facility. It is this last provision that has allowed courts in other circuits to order people for involuntary inpatient placement at SRT's for services provided by a receiving facility.

Your facility is designated as receiving facility. If the SRT is operated by or considered as part of the receiving facility, there is no problem with the judge ordering a person there for involuntary inpatient placement. If located on the same premises or at the same address as found on the CSU designation letter, there definitely wouldn't be a problem. However, if this is not the case, a petition for involuntary outpatient placement might be needed to accomplish a court order to services that aren't at or by a receiving or treatment facility.

Q. Should a copy of the court order for involuntary inpatient placement be forwarded to patients who have been discharged? The reason we are asking is that on the Release/Discharge Baker Act form the person is listed.

> The Baker Act is silent on this point. It is assumed that a signed court order would be promptly provided to the receiving facility by the court immediately after the hearing in which clear and convincing evidence was presented that the person met criteria for involuntary inpatient placement. If a substantial delay in receiving such signed orders from the court occur, you may want to urge the court to process these more quickly.

However, since the patient has a right to access his/her own record during or after hospitalization, keeping a copy of the signed order in the closed chart may be sufficient. Unless the patient requests that a copy of the signed order received by the facility after the patient's discharge occurs, forwarding a copy of the order after discharge doesn't appear to be necessary.

Q. I attended a Baker Act hearing this morning and the Assistant Public Defender argued an oral motion to dismiss the petition for involuntary placement due to the insufficiency of the petition. Basically, the physician's second opinion supporting the opinion failed to specify that the patient posed a danger to himself or others or that without the proper care / treatment, the patient was likely to suffer from neglect which posed a threat of substantial harm to the patient's well-being. Is the only way in which to remedy the physician's failure to specify conditions, to re-file the petition and have the patient re-examined?

If you had a Magistrate instead of a circuit court judge hear the case, you can immediately file an exception to the Magistrate's recommended order. This would get the case in front of a judge – in person or by review of the tape or transcript. Again, if a magistrate heard the case, there is an old appellate case that considers orders resulting from a magistrate's recommendation not to be official for 10 days.

TAMMY LYNN JOHNSON, Appellant, v. WALTER LEE JOHNSON, Appellee, 2nd District, 585 So. 2d 1188. Opinion filed September 20, 1991. A master, empowered by the trial court pursuant to rule 1.490 of the Florida Rules of Civil Procedure to hear and consider pleadings, entered findings and recommendations. On the succeeding day, the trial court executed an order adopting the master's findings and recommendations. The Florida Rules provide as follows: "The master shall file his report and serve copes on the parties. The parties may serve exceptions to the report within 10 days from the time it is served on them. If no exceptions are filed within the period, the court shall take appropriate action on the report. If exceptions are filed, they shall be heard on reasonable notice by either party. The trial court denied appellant the period prescribed for the filing of exceptions to the master's findings and recommendations. The DCA vacated the order and remanded for further proceedings complying with the rule.

If the hearing was conducted by a judge, it is possible to request the judge reconsider the decision. The only alternative is to file an appeal of the decision which, given you're in the 1st DCA, would probably not be supported given their past opinions on such issues. There are many cases, mostly from the 1st DCA, on the very issue raised in this case.

If a judge heard the case, you may want to read the judge's order carefully. If the order requires the hospital to release the person, the hospital pretty much has to do so or risk a complaint for contempt. However, most of these orders just dismiss the petition (rather than ordering release) and it is a common practice for hospitals to re-file a BA-32 better documenting how the person fully meets each of the criteria for involuntary inpatient placement.

Q. When a court order for Involuntary Placement at a state hospital has been entered, there is often so long a wait for a bed that the person stabilizes and less restrictive alternative is found to be appropriate. Is an Order Rescinding the NEFSH Order required, or does section 394.469, FS suffice?

Courts rarely, if ever, do new orders rescinding a preceding order for placement in such circumstances. The law requires the administrator of the facility to discharge the person at any time he/she is found to no longer meet the criteria for involuntary placement. The release of the person doesn't require an order of the court.

Q. While a resident was at our SRT, the doctor filed a petition for involuntary treatment under the Marchman Act and an order for up to 60 days was entered by the circuit court. However, no bed has been available in the substance program for him. Does the Baker Act expire when a Marchman Act is granted by the Court?

Generally, the Baker and Marchman laws are considered mutually exclusive since substance abuse is specifically excluded under the Baker Act definition of mental illness. Chapter 394.467(6)(c), FS states

> If at any time prior to the conclusion of the hearing on involuntary inpatient placement it appears to the court that the person does not meet the criteria for involuntary inpatient placement under this section, but instead meets the criteria for involuntary outpatient placement, the court may order the person evaluated for involuntary outpatient placement pursuant to s. 394.4655. The petition and hearing procedures set forth in s. 394.4655 shall apply. If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to s. 397.675, then the court may order the person to be admitted for involuntary assessment for a period of 5 days pursuant to s. 397.6811. Thereafter, all proceedings shall be governed by chapter 397.

Based on the appellate court case below, the Marchman Act order is still in force and will remain so until the man actually undergoes the 60 days of involuntary substance abuse treatment ordered by the court

> S.M.F. v. Needle, 757 So. 2d 1265 (Palm Beach County 2000). The circuit court granted a petition for involuntary substance abuse treatment for a minor in response to a petition filed by her parent. The order was for 60 days of involuntary treatment, the maximum period permitted under law, commencing upon her admission to the facility. However, the minor ran away prior to commencing treatment and was returned to the program after the initial court order had expired. She filed a petition for a writ of habeas corpus arguing that she was entitled to immediate release because the law provides that "at the conclusion of the 60-day period of court-ordered involuntary treatment, the client is automatically discharged unless a motion for renewal of the involuntary treatment order has been filed with the court…" The Fourth District Court of Appeals decided that the original court order for 60 days of court ordered involuntary treatment was not merely 60-days after the entry of the order for treatment and that the 60-day period contemplated by the Marchman Act did not expire, because the petitioner ran away before commencing treatment. The petition for writ of habeas corpus was denied.

Q. If a patient is admitted under a Baker Act to an inpatient unit of a receiving facility and the facility files the petition within 72 hours, the hearing is held, and the Court orders the patient to remain in the facility for a period not to exceed 30 days. What does the law require the facility to do if the patient is in the hospital for 28 out of those 30 days, still needs continued inpatient treatment, and the 30 days will expire before the patient can be discharged? The Magistrate presiding over the Baker Act Hearing is now required to provide patients' date of birth for the Court to include on the Court order for the patients. The Magistrate has concerns about patient's confidentiality and would like to know if this is a new requirement.

In the circumstances you describe, you should file a petition for continued involuntary placement with the Clerk of Court prior to the expiration of the original order. The court may require you to file it sufficiently in advance of the order's expiration so a hearing can be conducted within that period of time. A recent appellate case gave the judiciary concurrent jurisdiction with the State Division of Administrative Hearings for continuation of all involuntary inpatient orders up to a six month maximum.

It is unclear why the Magistrate has to place the patient's birth date on the order. The model form 3031 "Order for Continued Involuntary Inpatient Placement or for Release" doesn't have any such question included. The judiciary has the right to modify any form recommended by the executive branch of government to achieve the purpose set forth in the law. Adding the birth date has nothing to do with the Baker Act and is not a result of any requirement by the Legislature or DCF. It may be something required of courts for all orders, not limited to Baker Act orders.

Q. If we have a patient awaiting involuntary inpatient placement at a state hospital. She regularly has to go out for medical issues, stays at the medical hospital for a while, and gets scheduled to come back. Is our BA-08 order still good or do we need to re-do the Baker Act and start all over again? We did discharge the patient because she was admitted to the medical hospital. Was the order still in effect while she was in the med hospital? Do we need to re-Baker Act her once she returns to our receiving facility?

It is important to "transfer" persons for medical care instead of "discharging" them, the same as you do to the State hospital. This might just be documented in the last note. This keeps the BA-08 and the guardian advocacy intact. The Baker Act gives a receiving facility the power to "discharge" only when the person no longer meets the criteria for involuntary placement. However, everyone recognizes that a person leaving the facility to another facility for whatever reason is going to also undergo a discharge to prevent billings from two different facilities for the same day of care. Such forms documenting a financial or administrative discharge can also be included in the chart.

The term of the BA 8 ordered by the court will expire at the time specified on the involuntary placement order – the clock doesn't stop for a medical emergency like it does during the involuntary examination period. If you transfer a person who is subject to such an order to a medical hospital and the order expires, a new BA 32 would need to be filed with the court unless you were able to get the court to consider an extension of an existing order. This would involve asking the court for a change of venue so that the hearing could take place at the medical hospital. (394.46343599(2)(c)4, FS Page 66 of the 2008 Baker Act Handbook)

Q. Does an order for involuntary placement need to be for six-months?

NO. The maximum period for which a person can be ordered for involuntary placement is six-months. However, most courts order the period of placement to be the length of time it is expected to take to stabilize the person.

Q. Magistrates in our area have been placing time restrictions on the orders for periods of weeks instead of the six months permitted by law. It is difficult to estimate how long it will take to stabilize the person on medication or difficulty with discharge placement issues which may prohibit the person from being discharged prior to the end of the order. Would this become subject to involuntary inpatient placement criteria requiring an administrative law judge from Tallahassee (requires a minimum of 20 days notice prior to the expiration of the

order) to perform the hearing? Or do we re-file a 3032, in order to get the hearing scheduled and a new court order entered?

Judges and Magistrates throughout the state typically enter orders for less than 6 months, unless it is expected that the person will be sent to a state hospital. Chapter 394.467(6)(b), FS states that "if the court concludes that the patient meets the criteria for involuntary placement, it shall order that the patient be ….. For a period of up to 6 months"… "The facility shall discharge a patient any time the patient no longer meets the criteria for involuntary placement, unless the patient has transferred to voluntary status".

The Baker Act was originally written to place the burden on the receiving or treatment facility to make the clinical decision as to when, during the 6 month period, the person no longer met the criteria. Over the past 10 years or so, there has been an increasing use of shorter court orders, transferring the control over the maximum length of time a person could be held from the facility to the court.

The "Continued Involuntary Placement" provisions in subsection (7) are administrative hearings rather than judicial ones. However, courts around the state have handled this issue in several ways. Some have considered anything within the first 6 months as within the court's jurisdiction. They do this by having the facility request a reconsideration of the court's original order or an amending the original order to extend the period of time the person can be held. Others have the facilities file a new BA-32, prior to the expiration of the original order, initiating a new involuntary inpatient placement order. This allows the facility to retain the person pending the second hearing and allows the court to hear evidence as to what factors require a longer than anticipated length of stay (should the person still be retained when the second hearing is held).

This matter needs to be negotiated with the local courts. Each person has an attorney and if that attorney and the assistant state attorney concur with the procedures used locally, due process has been provided.

In 2008, the 5th DCA established that concurrent jurisdiction between the judiciary and the Division of Administrative Hearings exists within the 6 months of the original order, as follows:

> **W.M., Appellant, v. STATE OF FLORIDA**, et al., Appellees. No. 5D07-3762. October 10, 2008. Circuit Court involuntarily committed patient for 3 weeks. When patient didn't respond to treatment during this time, a petition for continued involuntary placement was filed and she was ordered by the Court for six additional months of treatment. The court ordered this additional treatment, but the patient appealed the order arguing the court had no jurisdiction to order the continued treatment. The 5th DCA agrees that continued involuntary placement hearings are to be administrative, the circuit court retains concurrent jurisdiction over the commitment proceedings. The Legislature's intent was that the administrative hearing requirement applies after a patient is committed to long-term treatment at a treatment facility instead of a community-based receiving facility. Because the initial treatment ordered by the court was short-term, the court properly exercised jurisdiction to order further treatment. However, once long-term treatment is ordered, a petition for continued treatment must be addressed in an administrative hearing.

Q. What authority does the court have to specify a particular program or facility in an involuntary inpatient placement order?

The court has the power to order a person be transferred to a treatment facility or, if the person is at a treatment facility, that he/she be retained there or be treated at or receive services from any designated receiving or treatment facility. The recommended BA-8 Order for Involuntary Inpatient Placement intentionally doesn't include a space for a name of a facility in order that a person's right to request transfer from one facility to another is expedited without having to go back to court for an amended order. With that said, if the court opts to modify the form; that is certainly a judicial prerogative. If it enters its order on a modified form that includes a specific facility or program, the only alternative that program would have is to request the court to reconsider or amend its order or to file an appeal of the order. An uncontested court order must be followed.

Q. A circuit judge entered an order for our receiving facility to accept a person who was in jail on felony charges. The order provided that the inmate be sent to a state hospital as soon as a bed became available. Is this proper?

No. This is not a proper use of the Baker Act. However, one can't ignore a court order. There are procedures to be followed in challenging a court order – requesting reconsideration or having a re-hearing, or appealing the order, as determined by the receiving facility's attorney to determine in the future what to do with such orders. The attorney will probably want to discuss this matter with the judge to avoid having to respond to such orders later. The only way to legally order someone into a State Hospital is under 394, Part I (Baker Act) or 916 (forensic). If the judge didn't follow either of these two statutes, it is essential that the facility properly challenge the order. The state hospital attorney should also be consulted on the matter.

Q. Does a facility have the discretion to release a person from an order for involuntary placement without the consent of the court?

YES. The administrator has the duty to discharge a person at any time the person no longer meets the criteria for involuntary placement, unless the person has transferred to voluntary status.

Q. As soon as a person is issued a signed order from the court to commit them under the Baker Act, the third party payor stops payment to the private receiving facilities. The problem with this is that it may take many days/weeks to transfer the person to a state hospital and the receiving facility has to bear the cost. The court is required to hold the hearing within 5 days and can grant one continuance of up to 4 weeks per 394.467. Does the court has to actually sign it and/or send it right after the hearing? Is it true that state hospitals don't accept a referral without the order?

There could actually be more than one continuance requested by the patient and granted by the court, further extending the period of time a person could be sitting in a community-based receiving facility awaiting transfer.

> **394.467(5)** CONTINUANCE OF HEARING.--The patient is entitled, with the concurrence of the patient's counsel, to **at least one** continuance of the hearing. The continuance shall be for a period of up to 4 weeks.

A person is not required to be on involuntary status in order to be admitted to a state mental health facility, although that is usually the case. If on an involuntary inpatient placement basis, the law does say:

> **394.367(6)(e)** The administrator of the receiving facility shall provide a copy of the court order and adequate documentation of a patient's mental illness to the administrator of a treatment facility whenever a patient is ordered for involuntary inpatient placement, whether by civil or criminal court. Such documentation shall include any advance directives made by the patient, a psychiatric evaluation of the patient, and any evaluations of the patient performed by a clinical psychologist or a clinical social worker. The administrator of a treatment facility may refuse admission to any patient directed to its facilities on an involuntary basis, whether by civil or criminal court order, who is not accompanied at the same time by adequate orders and documentation.

The admission paperwork could be processed by the state hospital in advance of receiving the court order as long as the order itself is provided no later than the time of admission. It sounds like the policy is more stringent than the law. You may want to have the district legal counsel speak with the judge or his/her judicial assistant about the urgency of getting the order signed quickly. Once the magistrate submits the findings of fact and a recommended order to the judge, it could be signed immediately, assuming neither the state attorney or public defender files an exception to the recommended order, which could extend the period.

Continued Involuntary Inpatient Placement

Q. I'm an Assistant Public Defender. I received a copy of a Request for Continued Involuntary Placement Hearing. Where did this form originate and was it ever approved for implementation?

This form, along with most of the Baker Act form series, is a recommended one but not required. It was developed in 1998 and revised in 2005 – promulgated under the Administrative Procedures Act. The recommended forms can be modified as long as they retain the legal requirements. It tracks the requirements of 394.467(7), FS, but any suggestions you can make as to how it can be improved would be appreciated.

A separate issue is whether the circuit court has jurisdiction. If the original order for involuntary inpatient placement was for the maximum of six months, only the Division of Administrative Hearings has jurisdiction to hear petitions for continued involuntary placement. If the original was less than six months, the court and DOAH have concurrent jurisdiction for up to a total of six months according to a recent appellate decision.

These community-based continuation hearings have become more common since more individuals have been ordered to placement at SRT type of facilities. In any case, the PD is always appointed to represent the respondent in the case, regardless of whether it is a judicial or administrative hearing. However, the state attorney has no statutory role in continuation hearings like they do in the initial placement hearing. The type and number of expert opinions is also different. The following is the summary of the appellate case:

> **W.M., Appellant, v. STATE OF FLORIDA**, et al., Appellees. No. 5D07-3762. October 10, 2008. Circuit Court involuntarily committed patient for 3 weeks. When patient didn't respond to treatment during this time, a petition for continued involuntary placement was filed and she was ordered by the Court for six additional months of treatment. The court ordered this additional treatment, but the patient appealed the order arguing the court had no jurisdiction to order the continued treatment. The 5th DCA agrees that continued involuntary placement hearings are to be administrative, the circuit court retains concurrent jurisdiction over the commitment proceedings. The Legislature's intent was that the administrative hearing requirement applies after a patient is committed to long-term treatment at a treatment facility instead of a community-based receiving facility. Because the initial treatment ordered by the court was short-term, the court properly exercised jurisdiction to order further treatment. However, once long-term treatment is ordered, a petition for continued treatment must be addressed in an administrative hearing.

Q. Does a circuit court have jurisdiction to hear a petition for continued involuntary inpatient placement?

The 5th DCA has recently ruled that circuit courts and the Division of Administrative hearings have concurrent jurisdiction for continued involuntary inpatient placement hearings in the case of W.M., v STATE of Florida (No. 5D07-3762. Oct. 10, 2008). A mental health facility filed a petition for involuntary inpatient placement, and the Circuit Court committed the patient for three weeks of treatment. At the end of the three-week period, the facility administrator petitioned for a hearing to order continued treatment. After the hearing, the Circuit Court entered an order subjecting patient to an additional six months of treatment. The patient appealed.

Where a person is committed to short-term treatment in mental health facility, the circuit court may properly exercise its concurrent jurisdiction over the involuntary commitment proceedings; however, where such treatment becomes long-term, administrative hearings are required. Administrative agencies can have jurisdiction over continued involuntary placement proceedings so long as a circuit court makes the initial determination of incompetency; however, such jurisdiction can be exercised concurrently with the original, nonexclusive jurisdiction given to circuit courts over the same matters.

In 2008, the 5th DCA established that concurrent jurisdiction between the judiciary and the Division of Administrative Hearings exists within the 6 months of the original order, as follows:

W.M., Appellant, v. STATE OF FLORIDA, et al., Appellees. No. 5D07-3762. October 10, 2008. Circuit Court involuntarily committed patient for 3 weeks. When patient didn't respond to treatment during this time, a petition for continued involuntary placement was filed and she was ordered by the Court for six additional months of treatment. The court ordered this additional treatment, but the patient appealed the order arguing the court had no jurisdiction to order the continued treatment. The 5th DCA agrees that continued involuntary placement hearings are to be administrative, the circuit court retains concurrent jurisdiction over the commitment proceedings. The Legislature's intent was that the administrative hearing requirement applies after a patient is committed to long-term treatment at a treatment facility instead of a community-based receiving facility. Because the initial treatment ordered by the court was short-term, the court properly exercised jurisdiction to order further treatment. However, once long-term treatment is ordered, a petition for continued treatment must be addressed in an administrative hearing.

Q. I am an Assistant Public Defender. Who has the authority to continue a person's involuntary placement at a receiving (not treatment) facility? Locally, a new petition is submitted at or before the end of the court order. The statute, 394.467(7)(a) says that the hearings are administrative without specifying receiving or treatment facility.

"Continued" Involuntary Inpatient Placement hearings are administrative, rather than judicial, and are handled by the State Division of Administrative Hearings out of Tallahassee. It is clear that when the original order is for the maximum period of 6 months, that the petition must be filed with DOA to extend the length of stay. However, when the original order is for a shorter period of time and the person doesn't stabilize during this period as had been anticipated by the psychiatrist, the matter is handled differently by different circuits around the state:

1. Some get the court to reconsider the original term of the order and modify the term, extending it for an additional period of time, assuming the length of stay is less than 6 months authorized in the statute.
2. Some have the facility submit a new BA-32 as long as the entire length of stay is less than the 6 months permitted by law.
3. Some file a petition for continued involuntary inpatient placement with the state division of administrative hearings

If your probate court requires the petition for a continued involuntary placement order to be filed with the state, it must be filed within 20 days prior to the expiration date of the person's order. An administrative law judge is sent from Tallahassee to hear the case. As you may know, the state attorney's office doesn't represent the state in continuation hearings and some facilities have found it necessary to have their corporate counsel represent the agency as petitioner. Others have retained an independent attorney to act in this role.

Q. Why are continued involuntary inpatient placement orders under the jurisdiction of Administrative Law Judges instead of circuit judges? Since the law

authorized "up to 6 months" for these initial orders, why do the circuit courts enter the orders for shorter periods of time?

When the Baker Act was first enacted in the early 70's, state-operated mental hospitals represented the majority of the care offered in Florida. Once persons were sent from their home communities to state hospitals on involuntary placement orders, it would have been a logistical nightmare for the patients to be brought back to their own circuits for continued involuntary hearings at the expiration of the original orders and it would have created an undue burden on the circuits where the state hospitals were located to take on this workload. The problem was resolved by having Administrative Law Judges from the State Division of Administrative Hearings circuit ride to the various state hospitals to conduct these hearings.

The law was written to allow "up to six months" for the orders and required receiving / treatment facility administrators to release the person or transfer to voluntary status at any time the criteria for involuntary placement was no longer met [s.394.468, F.S.]. For many years, all involuntary placement orders entered reflected a six month time frame. Over the past decade or more, a trend emerged that fundamentally changed the control over the time period a person could be held from facility administrators to the judiciary by limiting the period of time of the order to the length of time evidence documented it would take to stabilize the person's condition. These shortened periods, as well as court order of persons to SRT settings, resulted in court orders for involuntary inpatient placement expiring while persons are still in the community.

Q. If an initial order for involuntary inpatient placement is for 30 days and the patient doesn't stabilize as expected, what process should we follow to get the order extended?

Some circuits have the facility file a new BA-32 for this purpose if the original order was for less than 6 months. Other courts have a hearing to reconsider or to amend the original court order (if it was less than 6 months) to extend the term of the order. However, if the first court order was for 6 months, there is no question that the court loses jurisdiction and the matter must be handled as an administrative hearing. (*As of March 2008 this issue was being considered by a district court of appeals)*

Q. We are currently attempting to petition for continuation of involuntary inpatient placement for a severely demented, even more severely medically compromised patient at the VA. The Baker Act continuation petition was filed in a timely fashion with the circuit court. However, the court says we have to file in Tallahassee and an administrative judge must hear the case. We have no experience with these requirements. The patient was only given a thirty day placement order which expires today.

The court is correct. The procedure for continued involuntary inpatient placement in the Baker Act statute, are:

> **394.467(7 Procedure For Continued Involuntary Inpatient Placement.--**
> (a) Hearings on petitions for continued involuntary inpatient placement shall be administrative hearings and shall be conducted in accordance with the provisions

of s. 120.57(1), except that any order entered by the administrative law judge shall be final and subject to judicial review in accordance with s. 120.68.

While the initial order can be for a period of up to six months, it doesn't have to be for this long. When the initial order runs out, the judiciary loses jurisdiction and it switches over to the state Division of Administrative Hearings. The petition form (#3035) is to be used. However, since you waited until the day the initial order expired to file for continued involuntary placement, this is no longer an option

The 2011 Baker Act Handbook (Appendix J) provides the address and phone number of the Division of Administrative Hearings for your future reference. Some other circuits are known to extend the initial order (as long as it's within the 6- month period allowed by law) by reconsidering or amending the order. In some other circuits, the court allow the facility to file a new BA 32 petition form, but the court, state attorney, and public defender in your circuit may not accept this practice. I don't know what role you have with the VA hospital, but if you're not the hospital attorney, I would recommend that you contact the legal office to find out what options may exist.

Q. I had thought that the administrative law judge had to hear the case if the initial judgment had been for the whole six months, not realizing the local magistrate could not hear ANY continuations. I thought she could hear a continuation if both petitions, total, didn't exceed the six months.

Some circuits do retain jurisdiction when the order is less than 6 months, considering an amendment to that order as part of the initial order. However, your circuit is taking the most conservative approach, considering anything after the initial order to be a "continued" order. It does have this discretion. In any case, a petition to keep the person longer than the period indicated in the order would have to be filed before the expiration of the order holding the person.

Q. I am a general magistrate with a couple of questions about involuntary inpatient placements:

1. **Can involuntary placement at a receiving/short term placement facility be continued pursuant to 394.467(7) past the period of the initial court ordered placement?**
2. **Are continued placement hearings administrative or judicial in nature. i.e. must administrative law judges conduct all continued placement hearings?**

Yes, the initial involuntary inpatient placement can be continued at the receiving facility, but only pursuant to s.394.467(7)(a), FS,. This provision requires that continued involuntary inpatient placement hearings be administrative hearings and be conducted in accordance with the procedures of s.120.57(1), FS. That said, most circuits limit the period of an initial involuntary inpatient placement to less than the maximum of 6 months permitted by law; usually the period of time the psychiatrist testifies that it will take to stabilize the patient. Sometimes the course of the illness and recovery are not so predictable and it is subsequently determined that it will take longer than originally expected.

In these cases, some circuits permit the receiving facility administrator to request a reconsideration of the original order or a modified order to be entered to allow for the additional time expected to be needed. Other circuits have the facility file a new BA-32 petition for involuntary inpatient placement and conduct a hearing on the new petition. These methods retain the jurisdiction of the court rather than shifting it to a circuit riding state administrative law judge.

Initial and continued involuntary outpatient placement hearings are both judicial hearings and do not involve administrative law judges.

Baker Act Forms & Process Service

Q. I work for a CSU at a community mental health center and wonder if you can answer a question for me. Who is responsible for serving our clients their Baker Act court papers? My understanding is that it has to be a deputy? Do you know if this is true? Recently we were told that a designated staff can do this but I disagree. Any information about this would be helpful.

The Baker Act law provides limited guidance:

> **394.467 Involuntary inpatient placement.**
> **(3)PETITION FOR INVOLUNTARY INPATIENT PLACEMENT.—**The **administrator of the facility shall** file a petition for involuntary inpatient placement in the court in the county where the patient is located. Upon filing, **the clerk of the court shall provide copies** to the department, the patient, the patient's guardian or representative, and the state attorney and public defender of the judicial circuit in which the patient is located…
> **(4)APPOINTMENT OF COUNSEL**.—Within 1 court working day after the filing of a petition for involuntary inpatient placement, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The **clerk of the court shall immediately notify** the public defender of such appointment. Any attorney representing the patient shall have access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.
>
> **394.4599 Notice.**
> **(2)INVOLUNTARY PATIENTS.—**
> (a)Whenever notice is required to be given under this part, **such notice shall be given** to the patient and the patient's guardian, guardian advocate, attorney, and representative.
> 1.When notice is required to be given to a patient, it shall be given both orally and in writing, in the language and terminology that the patient can understand, and, if needed, the facility shall provide an interpreter for the patient.
> 2.Notice to a patient's guardian, guardian advocate, attorney, and representative shall be given by United States mail and by registered or certified mail with the receipts attached to the patient's clinical record. **Hand delivery by a facility employee may be used as an alternative, with delivery documented in the clinical record**. If notice is given by a state attorney or an attorney for the department, a certificate of service shall be sufficient to document service.

(c)The written notice of the filing of the petition for involuntary placement must contain the following:
1.Notice that the petition has been filed with the circuit court in the county in which the patient is hospitalized and the address of such court.
2.Notice that the office of the public defender has been appointed to represent the patient in the proceeding, if the patient is not otherwise represented by counsel.
3.The date, time, and place of the hearing and the name of each examining expert and every other person expected to testify in support of continued detention.
4.Notice that the patient, the patient's guardian or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the patient.
5.Notice that the patient is entitled to an independent expert examination and, if the patient cannot afford such an examination, that the court will provide for one.
(d)A treatment facility shall provide notice of a patient's involuntary admission on the next regular working day after the patient's arrival at the facility.
(e)When a patient is to be transferred from one facility to another, notice shall be given by the facility where the patient is located prior to the transfer.

As you can see above, the law doesn't always designate who is responsibility to provide "notice". The law places the responsibility of providing copies of the petition on the Clerk of Court, although in some locales, the Clerk has arranged for the facility to provide the copies of the petition to the various parties. It would take an attorney to determine if the "provide copies" is the same as "process service".

Below is a section from chapter 48, FS that governs the entire issue of service of process. If the provision of copies of the notice of hearings is consider a "process service", the Sheriff can appoint a special process server, but it cannot be one who has an interest in the process.

48.021 Process; by whom served.—
(1) All process shall be served by the sheriff of the county where the person to be served is found, except initial nonenforceable civil process, criminal witness subpoenas, and criminal summonses may be served by a special process server appointed by the sheriff as provided for in this section or by a certified process server as provided for in ss. 48.25-48.31. Civil witness subpoenas may be served by any person authorized by rules of civil procedure.
(2)(a) **The sheriff of each county may, in his or her discretion, establish an approved list of natural persons designated as special process servers**. The sheriff shall add to such list the names of those natural persons who have met the requirements provided for in this section. Each natural person whose name has been added to the approved list is subject to annual recertification and reappointment by the sheriff. The sheriff shall prescribe an appropriate form for application for appointment. A reasonable fee for the processing of the application shall be charged.
(b) A person applying to become a special process server shall:
1. Be at least 18 years of age.
2. Have no mental or legal disability.
3. Be a permanent resident of the state.

4. Submit to a background investigation that includes the right to obtain and review the criminal record of the applicant.
5. Obtain and file with the application a certificate of good conduct that specifies there is no pending criminal case against the applicant and that there is no record of any felony conviction, nor a record of a misdemeanor involving moral turpitude or dishonesty, with respect to the applicant within the past 5 years.
6. Submit to an examination testing the applicant's knowledge of the laws and rules regarding the service of process. The content of the examination and the passing grade thereon, and the frequency and the location at which the examination is offered must be prescribed by the sheriff. The examination must be offered at least once annually.
7. Take an oath that the applicant will honestly, diligently, and faithfully exercise the duties of a special process server.

(c) The sheriff may prescribe additional rules and requirements directly related to subparagraphs (b)1.-7. regarding the eligibility of a person to become a special process server or to have his or her name maintained on the list of special process servers.

(d) An applicant who completes the requirements of this section must be designated as a special process server provided that the sheriff of the county has determined that the appointment of special process servers is necessary or desirable. Each special process server must be issued an identification card bearing his or her identification number, printed name, signature and photograph, and an expiration date. Each identification card must be renewable annually upon proof of good standing.

(e) The sheriff shall have the discretion to revoke an appointment at any time that he or she determines a special process server is not fully and properly discharging the duties as a special process server. The sheriff shall institute a program to determine whether the special process servers appointed as provided for in this section are faithfully discharging their duties pursuant to such appointment, and a reasonable fee may be charged for the costs of administering such program.

(3) A special process server appointed in accordance with this section shall be authorized to serve process in only the county in which the sheriff who appointed him or her resides and may charge a reasonable fee for his or her services.

(4) Any special process server shall be disinterested in any process he or she serves; and if the special process server willfully and knowingly executes a false return of service or otherwise violates the oath of office, he or she shall be guilty of a felony of the third degree, punishable as provided for in s. 775.082, s. 775.083, or s. 775.084, and shall be permanently barred from serving process in Florida.

This issue should be addressed by the legal counsel for your agency and with your Clerk of Court. They are the ones who can help sort this out. If statutory change is necessary, DCF/HQ may want to include such a change in proposed legislation.

Q. Can documents that need to go to the County Clerk of Court be faxed if a hard copy is sent within a specific amount of time?

This issue isn't governed by the Baker Act. Many judicial circuits actually accept emailed or faxed filings and others do not. Some are currently actively working toward

such electronic systems, but aren't quite there yet. You need to contact the office of Clerk of Court serving your Circuit and determine what their requirements may be. With separation of powers, the executive branch of government (DCF) can't tell the judicial branch how to conduct its business. Whatever is acceptable to your courts on petition filing would suffice.

Q. Is the Circuit Court required to use the model Baker Act form developed by the Department of Children and Families?

NO. Separation of powers between each branch of government ensures that the executive branch can't compel the judicial branch to a specific action. However, the Florida Supreme Court Commission on Fairness recommended that each judicial circuit should review and consider adapting and adopting the model forms prepared by DCF.

Q. If a petition for involuntary inpatient placement is filed with the court, is the clerk of the court responsible for providing copies of the petition and the notice of hearing to all required parties?

Yes. Chapter 394.467(3) states that upon filing a petition for involuntary inpatient placement, the clerk of the court shall provide copies of the petition to the department, the patient, the patient's guardian or representative, and the state attorney and public defender of the judicial circuit in which the patient is located. Chapter 394.4655(3)(c) assigns the same responsibility (along with a copy of the proposed treatment plan) to the clerk of the court for involuntary outpatient placement.

Chapter 394.4599(2)(c) governing notice of the filing of petitions for involuntary (inpatient or outpatient) placement doesn't specify who is responsible for filing the notice of hearing. However, one can only conclude that this lies with the Clerk's office because it requires confirmation of petition filing, of Public Defender's appointment, the date/time/place of hearing, court appointment for independent expert, change of venue, etc – all issues that are the responsibility of the court.

Q. Who uses Form CF-MH 3114 titled "Order Requiring Involuntary Assessment and Stabilization for Substance Abuse and for Baker Act Discharge of Person"? Does this that takes the place of a Marchman Act?

The 3114 form is used by the court when, prior to the conclusion of a hearing for involuntary inpatient or involuntary outpatient placement under the Baker Act, finds that the person instead meets the criteria for involuntary admission under the Marchman Act. This form can then be used to order the person to undergo such admission for involuntary assessment under the Marchman Act.

Q. The Magistrate recently dismissed our Petition (CF-MH 3032) because we hadn't submitted a number of forms, including the Notice of Petition for Involuntary Placement, Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances, Certificate of Professional Initiating Involuntary Examination, Petition for Adjudication of Incompetence to Consent to Treatment

and Appointment of a Guardian Advocate, Certification of Person's Incompetence to Consent to Treatment, and Notification of Health Care Surrogate /Proxy. Was this correct?

There is no requirement that these forms, other than the 3032 Petition, be filed by the petitioner with the court. Specifically:

- Notice of Petition for Involuntary Placement --The notice of petition filing is prepared by the clerk of the court.
- Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances – The must be provided to every patient on voluntary and involuntary status and documentation is only required to be kept in the clinical record.
- 3052 b Certificate of Professional Initiating Involuntary Examination -- The involuntary examination initiation form, assuming the person arrived at the petitioning facility on an involuntary status, must be retained in the clinical record whether it is a Certificate of Professional, Report of Law Enforcement, or Ex Parte Order.
- 3106 Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate – only filed if the patient has been alleged to be incompetent to consent by the physician. Typically, this form isn't used when competency is considered at the same time as the petition for involuntary placement, since the placement petition has all required information. The 3106 is typically used when adjudication of incompetence is considered at a separate time from that of placement.
- 3122 Certification of Person's Incompetence to Consent to Treatment and Notification of Health Care Surrogate /Proxy –This form isn't required by any other court but, if used, would be retained in the clinical record.

The 3089 form does need to be submitted to the court prior to the hearing when placement at a state hospital is sought. However, it would be sent later than the petition. The Public Defender and State Attorney generally review these forms at the facility prior to or at the time of the hearing. Submitting copies simultaneous with petition filing seems to be unnecessary.

Elopements

Q. We have had a resident in our SRT program for 26 days, transferred from the CSU after a hearing and order for involuntary placement. This person eloped from the SRT and has not returned. I have requested that this resident be discharged from the SRT, stating that if he returns he should then be admitted to the CSU if he meets inpatient criteria. However, the doctor says he wants him directly admitted back to the SRT and does not want to admit him to the CSU. There isn't a clear statement in the law re readmission to an SRT after an elopement.

The Baker Act law and the CSU rules don't address this issue – it would be considered an admission rather than a readmission. However, the Florida Administrative Code governing SRT programs does, as follows:

> **65E-12.108** Minimum Standards for Short-Term Residential Treatment Programs (SRT).

In addition to sections 65E-12.104, 65E-12.105, and 65E-12.106, F.A.C., above, these standards apply to SRT programs.

(1) Admission Criteria.

(a) Referral Required. People may be admitted to an SRT only following a psychiatric or psychological evaluation and referral from a CSU, inpatient unit, or a designated public or private receiving facility.

This rule limits SRT admissions to those coming directly from a CSU or inpatient unit -- in either case directly from a designated receiving facility. His stay at the CSU may be very short – for assessment only before transfer to the SRT. However, he may need to have full laboratory testing, physical examination, and a psychiatric assessment to ensure his medical and mental stability can be safely managed in the SRT. The longer the elopement period, the greater the risk in putting him into the SRT without stabilization in the CSU.

Q. Are there any Baker or Marchman Act appellate cases having to do with elopements after an order for involuntary placement has been entered?

There isn't any appellate case addressing elopements from facilities under the Baker Act. However, there is a Marchman case on point that is similar:

> **S.M.F. v. Needle**, 757 So. 2d 1265 (Palm Beach County 2000). The circuit court granted a petition for involuntary substance abuse treatment for a minor in response to a petition filed by her parent. The order was for 60 days of involuntary treatment, the maximum period permitted under law, commencing upon her admission to the facility. However, the minor ran away prior to commencing treatment and was returned to the program after the initial court order had expired. She filed a petition for a writ of habeas corpus arguing that she was entitled to immediate release because the law provides that "at the conclusion of the 60-day period of court-ordered involuntary treatment, the client is automatically discharged unless a motion for renewal of the involuntary treatment order has been filed with the court…" The Fourth District Court of Appeals decided that the original court order for 60 days of court ordered involuntary treatment was not merely 60-days after the entry of the order for treatment and that the 60-day period contemplated by the Marchman Act did not expire, because the petitioner ran away before commencing treatment. The petition for writ of habeas corpus was denied.

Transfers of Persons under Involuntary Placement

Q. Can persons on involuntary inpatient placement orders be transferred from one facility to another?

Yes. The Baker Act law and rules don't require that the name of the facility be incorporated into the court order for placement. In fact, the recommended model Involuntary Placement Order form #3008 doesn't include space for such limitation. This was deliberately done to facilitate a patient's right to request transfer from one facility to another without the delay involved in scheduling a court hearing. It appears that the circuit court in your county has added the specific name of the facility to the form,

retaining the control over where the patient may be placed vs allowing the patient, guardian, or facility the right given in the Baker Act to transfer from one facility to another without the delay in waiting for another hearing.

Q. The Public Defender assigned to represent persons on involuntary status in our receiving facility said that when an involuntary patient is transferred from our facility to another facility, that it is his opinion that the Baker Act involuntary order is void - because to transfer the patient, our hospital effectively discharged them and that by discharging the patient, the Baker Act order is automatically rescinded. When I asked him if that means that the patient has to be re-Baker Acted (involuntary placement) he said yes. Do you agree? I've checked through the statutes and can't find anything to support his opinion - but neither can I find anything that I thought directly contradicted his position.

The Baker Act makes a very distinct difference between transfers and discharges. While a receiving facility would have to do some sort of a back office discharge of a patient when a transfer to another receiving or treatment facility takes place, the Baker Act record should reflect that a transfer is taking place. A facility only has the power to discharge a person who longer meets the criteria for involuntary placement. Otherwise the facility must retain the person or transfer to another facility, as follows:

> **394.469 Discharge of involuntary patients.--**
> (1) POWER TO DISCHARGE.--At any time a patient is found to no longer meet the criteria for involuntary placement, the administrator shall:
> (a) Discharge the patient, unless the patient is under a criminal charge, in which case the patient shall be transferred to the custody of the appropriate law enforcement officer;
> (b) Transfer the patient to voluntary status on his or her own authority or at the patient's request, unless the patient is under criminal charge or adjudicated incapacitated; or
> (c) Place an improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.
> (2) NOTICE.--Notice of discharge or transfer of a patient shall be given as provided in s. 394.4599.

Even the Involuntary Inpatient Placement provisions make this distinction, as follow:

> **394.467 Involuntary inpatient placement.--**
> (6) HEARING ON INVOLUNTARY INPATIENT PLACEMENT.--
> (b) If the court concludes that the patient meets the criteria for involuntary inpatient placement, it shall order that the patient be **transferred** to a treatment facility or, if the patient is at a treatment facility, that the patient be retained there or be treated at any other appropriate receiving or treatment facility, or that the patient receive services from a receiving or treatment facility, on an involuntary basis, for a period of up to 6 months. The order shall specify the nature and extent of the patient's mental illness. The **facility shall discharge a patient any time the patient no longer meets the criteria for involuntary inpatient placement**, unless the patient has transferred to voluntary status.

Transfers of person among receiving and treatment facilities are specifically provided for as follows:

> 394.4685 **Transfer** of patients among facilities.--
> (1) TRANSFER BETWEEN PUBLIC FACILITIES.--
> (a) A patient who has been admitted to a public receiving facility, or the family member, guardian, or guardian advocate of such patient, may request the transfer of the patient to another public receiving facility. A patient who has been admitted to a public treatment facility, or the family member, guardian, or guardian advocate of such patient, may request the transfer of the patient to another public treatment facility. Depending on the medical treatment or mental health treatment needs of the patient and the availability of appropriate facility resources, the patient may be transferred at the discretion of the department. If the department approves the transfer of an involuntary patient, notice according to the provisions of s. 394.4599 shall be given prior to the transfer by the transferring facility. The department shall respond to the request for transfer within 2 working days after receipt of the request by the facility administrator.
> (b) When required by the medical treatment or mental health treatment needs of the patient or the efficient utilization of a public receiving or public treatment facility, a patient may be transferred from one receiving facility to another, or one treatment facility to another, at the department's discretion, or, with the express and informed consent of the patient or the patient's guardian or guardian advocate, to a facility in another state. Notice according to the provisions of s. 394.4599 shall be given prior to the transfer by the transferring facility. If prior notice is not possible, notice of the transfer shall be provided as soon as practicable after the transfer.
> (2) TRANSFER FROM PUBLIC TO PRIVATE FACILITIES.--A patient who has been admitted to a public receiving or public treatment facility and has requested, either personally or through his or her guardian or guardian advocate, and is able to pay for treatment in a private facility shall be transferred at the patient's expense to a private facility upon acceptance of the patient by the private facility.
> (3) TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.--
> (a) A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.
> (b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.
> (c) A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.
> (4) TRANSFER BETWEEN PRIVATE FACILITIES.--A patient in a private facility or the patient's guardian or guardian advocate may request the transfer of the patient to another private facility at any time, and the patient shall be transferred upon acceptance of the patient by the facility to which transfer is sought.

Even the Guardian Advocate section of the Baker Act makes this distinction, as follows:

> **394.4598 Guardian advocate.--**
> (7) The guardian advocate shall be discharged when the patient is **discharged** from an order for involuntary outpatient placement or involuntary inpatient

placement **or** when the patient is **transferred from involuntary to voluntary status**. The court or a hearing officer shall consider the competence of the patient pursuant to subsection (1) and may consider an involuntarily placed patient's competence to consent to treatment at any hearing. Upon sufficient evidence, the court may restore, or the hearing officer may recommend that the court restore, the patient's competence. A copy of the order restoring competence or the certificate of discharge containing the restoration of competence shall be provided to the patient and the guardian advocate.

It is clear that the involuntary status and any guardian advocate appointed by the court are retained in any transfer among receiving or treatment facilities unless the person is determined by a physician to be competent to consent to admission/treatment.

There are occasions when a person might go from a receiving facility to a medical facility for such a long period of time or when a receiving facility in error discharges a person who continues to meet criteria that initiating a new involuntary examination/placement might be necessary. However, that should be the exception and only used to cure a problem that shouldn't have happened in the first place.

Q. When patients who are under involuntary exam status (or a petition has been filed for involuntary placement) and are transferred to the medical floor (for an emergency or medical intervention) does their Baker Act need to be re-initiated (or petitions need to be re-filed)? Several cases were dismissed in court because, according to the public defender and Magistrate, the patient is discharged from psychiatry when they go to medical. However, our hospital's Policy & Procedure states that the patient's "discharge from an inpatient unit from psychiatry is only a discharge for billing purposes and that the discharge does not represent any medical determination that the patient is appropriate for discharge from the hospital, or that a patient subject to the Baker Act no longer meets criteria for involuntary placement or involuntary examination". How does this work in other hospitals?

You are correct. A designated receiving facility only has the right to "discharge" a person when he/she no longer meets criteria for involuntary exam or placement unless an existing court order expires. It can "transfer" for medical purposes and if the medical condition is of an emergency nature, the involuntary examination clock stops.

Your policy is correct and, while you'll do an administrative type of discharge from one unit to another, the entire hospital is designated as the receiving facility -- not just the psychiatric unit. A Baker Act discharge would invalidate any legal hold you may have on the person and would also discharge the guardian advocate at a time when consent issues for medical conditions may be most important. Your hospital attorney should speak with DCF staff and also with court personnel.office is not present at the hearing, the Commission urges the court to halt the proceeding while the state attorney is summoned.

Q. A petition for involuntary inpatient placement was dismissed by the court recently because the patient had been transferred from a CCSU to a private receiving facility without signing the transfer form.

Transfers between different types of facilities have different requirements. EMTALA requires:

- Transfers from non-receiving facility hospital ER's generally can be accomplished by a physician certifying that the benefits of a transfer outweigh the risks. This is because such a hospital doesn't have the capability or capacity to meet the person's needs.

- Transfers from receiving facility ER's generally require the person or his/her legal representative to sign a consent to transfer since the sending facility has the capability and capacity to meet the person's needs and the transfer is usually done for financial reasons.

After admission to a hospital, EMTALA no longer applies, but federal Conditions of Participation for transfer/discharge do.

Transfers between receiving facilities, once EMTALA and federal CoP requirements are met, are governed by s.**394.4685 Transfer of patients among facilities**. Section (2) governs transfers from public to private facilities. Transfers from private to public receiving facilities can be done at the request of the patient or of the private receiving facility. However, transfers from private to public receiving facilities don't establish a separate right of the facility to request the transfer absent the patient/legal representative's request. Persons don't need to be transferred to the "nearest" receiving facility – this is consistent with federal EMTALA law, Florida's hospital statute, and Baker Act.

Q. If we have a patient on involuntary placement status (BA-08) who goes to an ER and is subsequently admitted to that hospital for a period of time, what do we do about the legal status? Would we be required to discharge the patient from our services, thus discontinuing the BA-08? This, of course, is not in the best interest for the client from a treatment and time in treatment perspective. I would rather have the client stabilized, keep on the BA-08 status and return for treatment but I'm not sure the legality of this. It looks like we wouldn't have to provide staff to stay with the person throughout their hospital stay.

A facility only has the power to discharge a person who no longer meets the criteria for involuntary placement.

> **394.469 Discharge of involuntary patients.--**
> (1) POWER TO DISCHARGE.--At any time a patient is found to no longer meet the criteria for involuntary placement, the administrator shall:
> (a) Discharge the patient, unless the patient is under a criminal charge, in which case the patient shall be transferred to the custody of the appropriate law enforcement officer;
> (b) Transfer the patient to voluntary status on his or her own authority or at the patient's request, unless the patient is under criminal charge or adjudicated incapacitated; or
> (c) Place an improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.

If the person continues to meet the criteria for involuntary placement, the facility would "transfer" the person rather than "release" or "discharge". This keeps the legal status intact as well as retains any guardian advocate appointed by the court that may be needed to provide consent to medical tests and treatment. This is the same as a transfer to the state hospital. While your facility would have to do some type of administrative or financial "discharge" to avoid duplicate payment in two different facilities for the same days, your clinical record should reflect that the person was "transferred" for medical treatment.

The obvious problem with this is that the term of the court order is time limited – the "clock" doesn't stop under an involuntary placement order for an emergency medical condition as it does during the involuntary examination period. If the BA-8 expires while the person is at the medical facility (non-receiving facility), he/she cannot be detained under the Baker Act. Should it be necessary, a new BA-52 could be initiated. You could also request that the court reconsider the length of the existing court order (if under the six month maximum) and to extend it if the person appears to continue to meet the involuntary placement criteria. However, if the BA-8 is still in effect, it is perfectly legal and appropriate for you to accept the person back. The CSU rule governing this is as follows:

> **Minimum Standards for Crisis Stabilization Units (CSUs)** (65E-12.107(1), F.A.C.)
> **Referral**. Individuals referred, or to be referred, to a receiving facility, who also require treatment for an acute physical condition shall be delivered and, if appropriate, admitted to an emergency medical or inpatient service for health care until medically cleared and stabilized to meet the CSU's medical criteria as prescribed in its policies and procedures. Medical clearance shall be documented in the clinical record.

Q. When an individual under a BA 32 is transferred from a private receiving facility to a public receiving/treatment facility and a BA 32 has been submitted by the transferring facility for state hospital placement, does the facility receiving the transfer have to start the state hospital process over again? What forms and documentation need to be completed by sending facility and receiving facility in such a case? Also, once a guardian advocate process is started at one facility and the person is transferred to somewhere else, does the GA process have to be started over again since the person was "transferred", not "discharged" from the sending facility?

There is no reason the second facility would have to start the transfer process again as the same information should apply. A guardian advocate appointed by the court remains unless the person is "discharged" from an involuntary placement order or transferred to voluntary status. From your question, it is clear you understand the importance of a "transfer" instead of a "discharge" to preserve the involuntary status of the person as well as the appointment of the guardian advocate. Some type of back office administrative or financial discharge of the person from the first facility will take place to prevent dual billing, but the Baker Act documents and notes should reflect a transfer.

If the hearing on the BA-32 petition filed by the first facility was conducted or whether the involuntary placement hearing would be conducted at the second facility could require different processes. This is possible if one of the two examining experts that completed opinions on the petition form is going to testify at the hearing -- even though it may be conducted at the second facility. If the patient is intended to go to the state hospital, a Transfer Evaluation must be conducted prior to the hearing -- this completed Transfer Evaluation must be provided to the court prior to the hearing and the evaluator must be present at the hearing to provide testimony as desired by the court.

Q. Our CSU is petitioning for a man's involuntary inpatient placement at a state hospital. We had to transfer him to a medical facility for chest pains. He was medically cleared and returned to us, but now we wonder what would have happened if he was admitted and remained for medical treatment at their facility? We had already gone through one hearing in which a four week continuance was ordered. Would we have to start the process over? If so, would our physicians have to attend the next hearing at the medical facility? What if we had filed the petition, but had not yet had the hearing?

It was good that you "transferred" the man to the medical hospital instead of "discharging" him there. While some type of a administrative or financial discharge may be needed to prevent double billing for a person on the same day of care, it is essential that the Baker Act record reflect a transfer in order to retain the involuntary status and any Guardian Advocate that may have been appointed.

If this medical emergency arose prior to the filing of a petition and it was within the initial 72 hour examination period, it may have been possible to "stop the clock" under s.394.463(2)(g), FS until the emergency medical condition was resolved. However, once the petition for involuntary placement is filed, there isn't any provision for stopping the "5-day" period in which the hearing must be conducted.
The only exception is if the patient, with concurrence of counsel, requests a continuance. The language of the Baker Act doesn't limit the person to just one 30-day continuance.

> **394.457(5) Continuance of Hearing.--**The patient is entitled, with the concurrence of the patient's counsel, to at least one continuance of the hearing. The continuance shall be for a period of up to 4 weeks.

Therefore, if necessary, an additional continuance could be requested while he was being treated in the medical hospital. An alternative is that a change of venue be requested to conduct the hearing at the medical hospital, as follow:

> **394.4599(2)(c)4. Notice** that the patient, the patient's guardian or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the patient.

A change of venue for the hearing isn't a usual event, but it is used for cases of advanced pregnancy and other conditions in which a person couldn't be transferred to a psychiatric receiving facility. If the involuntary inpatient placement hearing was conducted at the medical hospital, it would require that the court personnel go to the hospital for the hearing. The law requires that "One of the professionals who executed

the involuntary inpatient placement certificate shall be a witness". Such testimony could be done telephonically, but this would require that both the assistant state attorney and public defender stipulate to this.

Q. How is a transfer of a person pending an involuntary placement hearing handled and who must be noticed? Should a new BA-32 be filed?

The transfer is initiated by the receiving facility where the individual is held and sent directly to the receiving facility where the individual's placement is sought. A copy of the transfer request form is then sent to persons specified in the law, including the individual, his/her guardian or guardian advocate, representative, and attorney. DCF isn't involved in a transfer unless it is a public to public transfer. A private to public transfer requires the response by the public facility within 2 working days -- not by DCF.

A new BA-32 shouldn't be filed by the facility accepting the transfer because that would cause a delay in the hearing and probably exceed the 5 days permitted by law for the hearing to take place once the first 72-hour exam period expired. If the hearing hasn't occurred by the time the individual is transferred, one of the two psychiatrists signing the original BA-32 would have to testify at the hearing -- perhaps at the second facility. Otherwise, the transfer should be delayed until after the hearing takes place and an order for involuntary inpatient placement entered.

Q. A patient in a receiving facility two counties away has had a petition for involuntary inpatient placement filed. The patient has now requested a transfer to our receiving facility. How can this be accomplished?

Unless one of the two psychiatrists who provided evaluations in support of the petition is willing to be present at the involuntary inpatient placement hearing, there isn't any way the transfer can take place until after the hearing is conducted in the county where he is held.

> 394.467 Involuntary Inpatient Placement
> (6) Hearing on Involuntary Inpatient Placement.--
> (a)2. The court may appoint a general or special magistrate to preside at the hearing. One of the professionals who executed the involuntary inpatient placement certificate shall be a witness.

Transfers can be easily accomplished prior to the filing of the petition. It may even expedite matters if the petition is begun at the first receiving facility with one psychiatrist's opinion – the second opinion can be conducted at the destination facility, with the psychiatrist performing the second opinion providing the statutorily required testimony. It may be possible for the receiving facility that filed the petition to request expedited judicial intervention to conduct a quicker hearing so the person can be transferred before the usual date of hearings. If none of these options are possible, the transfer must wait until after the hearing is held.

State Treatment Facilities & Transfer Evaluations

Q. Our hospital-based receiving facility has an individual who appears appropriate for the state hospital. I believe I read somewhere before an individual can be admitted there has to be a transfer evaluation done by the public receiving facility. Is this correct? If so would you please provide me with the law or FAC which states this requirement?

In summary, no one may be transferred to a state mental health treatment facility (voluntary or involuntary) without a transfer evaluation. The following summary and detail should help:

Criteria:

- Whether the person meets the statutory criteria for admission to a state treatment facility; and
- Whether there are appropriate, more integrated, and less restrictive treatment resources available to meet the person's needs.

Process:

- Following evaluation of the person, CMHC director recommends admission to a state treatment facility or, if criteria for involuntary placement not met, to alternative treatment programs, by completing and signing the "Transfer Evaluation" (3089)
- Evaluation forwarded to court prior to hearing -- Court shall receive and consider information
- Testimony at hearing by evaluator or other knowledgeable staff as desired by court

Requirements in Florida Statute

> **394.455 Definitions.—**
> (29) **"Transfer evaluation"** means the process, as approved by the appropriate district office of the department, whereby a person who is being considered for placement in a state treatment facility is first evaluated for appropriateness of admission to the facility by a community-based public receiving facility or by a community mental health center or clinic if the public receiving facility is not a community mental health center or clinic.
> (6) "Community mental health center or clinic" means a publicly funded, not-for-profit center which contracts with the department for the provision of inpatient, outpatient, day treatment, or emergency services.
>
> **394.461 Designation of receiving and treatment facilities.--**The department is authorized to designate and monitor receiving facilities and treatment facilities and may suspend or withdraw such designation for failure to comply with this part and rules adopted under this part. Unless designated by the department, facilities are not permitted to hold or treat involuntary patients under this part.
> (1) RECEIVING FACILITY.--The department may designate any community facility as a receiving facility. Any other facility within the state, including a private facility or a federal facility, may be so designated by the department, provided that such designation is agreed to by the governing body or authority of the facility.
> (2) TREATMENT FACILITY.--The department may designate any state-owned, state-operated, or state-supported facility as a state treatment facility. A civil patient shall not be admitted to a state treatment facility without previously

undergoing a transfer evaluation. Before a court hearing for involuntary placement in a state treatment facility, the court shall receive and consider the information documented in the transfer evaluation. Any other facility, including a private facility or a federal facility, may be designated as a treatment facility by the department, provided that such designation is agreed to by the appropriate governing body or authority of the facility.

394.467 Involuntary inpatient placement.--
(1) CRITERIA.--A person may be placed in involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:
(a) He or she is mentally ill and because of his or her mental illness:
1.a. He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or
b. He or she is unable to determine for himself or herself whether placement is necessary; and
2.a. He or she is manifestly 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 himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and
(b) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

Requirements in Florida Administrative Code

65E-5.1301 Transfer Evaluations for Admission to State Mental Health Treatment Facilities from Receiving Facilities.
(1) A person in a receiving facility shall not be transferred to a state treatment facility without the completion of a transfer evaluation, in accordance with Section 394.461(2), F.S., using mandatory form CF-MH 3089, Feb. 05, “Transfer Evaluation,” which is hereby incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter. The process for conducting such transfer evaluations shall be developed by the community mental health center or clinic and be approved by the district or regional office of the department where the center or clinic is located and shall include:
(a) Designation of the contracted mental health centers or clinics that are responsible for conducting the transfer evaluations, including the receiving facilities or persons for which each center or clinic is responsible;
(b) Establishment of the time within which a mandatory form CF-MH 3089, “Transfer Evaluation,” as referenced in subsection 65E-5.1301(1), F.A.C., shall be completed. This form shall be completed by the designated community mental health center and submitted to the court for all persons for whom involuntary placement in a state treatment facility is sought, and directly to the state treatment facility for all persons for whom voluntary admission is sought; and
(c) Specification of the minimum training and education of the persons qualified to conduct the transfer evaluations and the training and educational qualifications

of the evaluators' immediate supervisor. Unless otherwise established in writing by the district or region, the evaluator shall have at least a bachelor's degree and the immediate supervisor a master's degree in a clinical or human services area of study.
(2) A community mental health center or clinic shall evaluate each person seeking voluntary admission to a state treatment facility and each person for whom involuntary placement in a state treatment facility is sought, to determine and document:
(a) Whether the person meets the statutory criteria for admission to a state treatment facility; and
(b) Whether there are appropriate more integrated and less restrictive mental health treatment resources available to meet the person's needs.
(3) Following an evaluation of the person, the executive director of the community mental health center or clinic shall recommend the admission to a state treatment facility or, if criteria for involuntary placement are not met, to alternative treatment programs and shall document that recommendation by completing and signing the form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E-5.1301(1), F.A.C.
(a) The executive director's responsibility for completing and signing mandatory form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E-5.1301(1), F.A.C., may be delegated in writing to the chief clinical officer of the center or clinic.
(b) An original signature on the mandatory form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E- 5.1301(1), F.A.C., is required.
(c) A copy of the mandatory form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E-5.1301(1), F.A.C., shall be retained in the files of the community mental health center or clinic.
(d) The completed and signed mandatory form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E- 5.1301(1), F.A.C., shall be forwarded to the court before the hearing at which a person's involuntary placement in a state treatment facility will be considered. The evaluator, or in the absence of the evaluator, another knowledgeable staff person employed by the community mental health center or clinic, shall be present at any hearing on involuntary placement in a state treatment facility to provide testimony as desired by the court.

65E-5.1302 Admissions to State Treatment Facilities.
(1) Receiving facilities must obtain approval from the state treatment facility prior to the transfer of a person. A state treatment facility shall be permitted to accept persons for transfer from a receiving facility if the administrator of the receiving facility has provided the following documentation, which documentation shall be retained in the person's clinical record:
(a) Recommended form CF-MH 7000, Jan. 98, "State Mental Health Facility Admission Form," with all required attachments, which is hereby incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter;
(b) Recommended forms CF-MH 3040, Feb. 05, "Application for Voluntary Admission," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or CF-MH 3008, Feb. 05, "Order for Involuntary Inpatient Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter; and

(c) Mandatory form CF-MH 3089, “Transfer Evaluation” as referenced in subsection 65E-5.1301(1), F.A.C.

65E-5.290 Involuntary Inpatient Placement.
(1) If a person is retained involuntarily after an involuntary examination is conducted, a petition for involuntary inpatient placement or involuntary outpatient placement shall be filed with the court by the facility administrator within the 72-hour examination period, or if the 72 hours ends on a weekend or legal holiday, the petition shall be filed no later than the next court working day thereafter. Recommended form CF-MH 3032, “Petition for Involuntary Inpatient Placement,” as referenced in subparagraph 65E-5.170(1)(d)1., F.A.C., or recommended form CF-MH 3130, “Petition for Involuntary Outpatient Placement,” as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., or other forms adopted by the court may be used for this purpose. A copy of the completed petition shall be retained in the person’s clinical record.
(2) Each criterion alleged must be substantiated by evidence.
(3) Use of recommended form CF-MH 3021, Feb. 05, “Notice of Petition for Involuntary Placement,” as referenced in subparagraph 65E-5.285(1)(b)7., F.A.C., or other form used by the court, when properly completed, will satisfy the requirements of Section 394.4599, F.S. A copy of that completed form, or its equivalent, shall be retained in the person’s clinical record. Whenever potential involuntary inpatient placement in a state treatment facility is proposed, a copy of the completed notice form shall also be provided to the designated community mental health center or clinic for purposes of conducting a transfer evaluation.

(6) Recommended form CF-MH 3033, Feb. 05, “Notification to Court of Withdrawal of Petition on Involuntary Inpatient or Outpatient Placement,” as referenced in paragraph 65E-5.285(2)(d), F.A.C., may be used if the facility administrator seeks to withdraw the petition for involuntary placement prior to the hearing. The facility shall retain a copy in the person’s clinical record. When a facility withdraws a petition for involuntary inpatient placement, it shall notify the court, state attorney, attorney for the person, and guardian or representative by telephone within 1 business day of its decision to withdraw the petition, unless such decision is made within 24 hours prior to the hearing. In such cases, the notification must be made immediately. In all cases involving potential involuntary inpatient placement in a state treatment facility, a copy of the notification form shall also be provided to the designated community mental health center or clinic responsible for conducting a transfer evaluation.

Q. Can you explain the Transfer Evaluation process and the use of the 3089 form?

Please refer to the previous FAQ for the requirements in law and rule governing the Transfer Evaluations. It is the community mental health center ED that is responsible for signing the 3089 -- not the receiving facility administrator. The legislative intention for the transfer evaluation was initially (when I drafted the language for it back around 1980) to ensure that the experts in the community system of care and knowledge of all less restrictive alternatives to the state hospital had input to the court's decision as to whether the criteria dealing with this issue was met. It is why this form must be submitted to the court in advance of the person's involuntary placement hearing and the assessor must be present to offer testimony as desired by the court.

As to which community mental health center(s) is responsible for conducting this evaluation in your area, you need to contact the DCF circuit office because it is determined on a circuit by circuit basis.

As you can see above, since a public receiving facility is generally a community mental health center, its Executive director is authorized by law to sign the transfer evaluation directly, even those done for persons in its own receiving facility. However, after the person goes to court and an order for involuntary inpatient placement to a state hospital is entered, it is the receiving facility administrator (or designee) that is responsible for putting together the packet of information for state hospitalization -- one piece of this packet is the completed 3089 form that had previously been submitted to the court by the community mental health center.

You are correct that only the Executive Director of the designated community mental health center is authorized to sign the 3089 Transfer Evaluation form. The rules specify that the Executive Director can
delegate in writing this responsibility to the chief clinical officer of the center.

The 7000 form is not required to be signed by the Executive Director or Chief Clinical Officer. It is signed by a staff member of the receiving facility from which the individual is being sent.

Chapter 65E-5.1302 specifies that a receiving facility must obtain approval from the state treatment facility prior to the transfer. In order to request this approval, the receiving facility must submit:

- The 7000 form with attachments,
- The 3089 form,
- Either a court order for involuntary inpatient placement or an application for voluntary admission.
- The 7002 Physician to Physician Transfer form

There is a patient at a private receiving facility scheduled to go to the state hospital. Which public entity should review \ concur?

The statutorily required Transfer Evaluation must be done prior to the person's involuntary inpatient placement hearing pursuant to the following provisions in the Florida Administrative Code. See FAQ's above for the entity to conduct the Transfer Evaluation. DCF could designate a single CMHC to do this county or circuit wide or assign to each CMHC those private receiving facilities in closest proximity. A CMHC that has a public receiving facility would conduct Transfer Evaluations on persons in its own CSU. A community mental health center or clinic is defined in the Baker Act as follows:

> (6) "Community mental health center or clinic" means a publicly funded, not-for-profit center which contracts with the department for the provision of inpatient, outpatient, day treatment, or emergency services.

A CMHC isn't required to have to have its own CSU to do this.

Q. I am the misdemeanor division chief for the State Attorney's Office in our county. One of our mental health facilities has asked if a person who was involuntarily committed to the SRT program and remains too violent can be transferred to the state hospital. What vehicle they would use?

A person transferred to a state hospital must undergo a Transfer Evaluation in advance of the transfer, as described in the previous FAQ's.

Discharge of Persons under Involuntary Placement

Q. A physically assaultive patient was committed 2 weeks ago and is currently awaiting a state hospital bed. Within the two weeks, this patient has physically struck (on two different occasions) two staff members requiring medical attention and we are unable to care for this type of unprovoked behavior. The patient was subsequently discharged to the county jail. The attending psychiatrist still feels that the patient needs an emergency forensic bed at Florida State Hospital but our District admission's committee states that because the he was discharged to jail that he no longer meets criteria for a state bed. This facility never filed an order for dismissal of inpatient placement and feels the patient needs long term care for mental health treatment. What recourse do we have?

The DCF circuit staff was correct in saying that when your doctor "discharged" the man from the hospital to jail, this voided the BA-8 involuntary inpatient placement order. People should be "transferred" for medical or other purposes instead of "discharged". The man cannot go to a forensic bed under the Baker Act. This takes a finding by the court under Chapter 916 that he is incompetent to proceed with his felony charges or is ultimately found not guilty by reason of insanity.

The public defender may concur with hospitalization instead of jail and consider having the receiving facility administrator file a new BA-32 petition after two opinions (2 psychiatrists or a psychiatrist and a psychologist examine) find he meets criteria. The court may also consider an expedited hearing and a change of venue with the hearing actually conducted at the jail. Possibly DCF can arrange an expedited admit date to the state civil hospital to get him out of jail quicker once a new BA-8 is entered by the court.

Q. A patient that has been 32'd to our facility and suddenly became medically ill and was transferred to a medical bed. I have recently been told that the 32 becomes null and void and if / when the patient returns to the psych unit and the entire 32 process needs to be restarted. Is this true?

This is not necessarily true. A person who is on a BA-32 awaiting a court hearing who continues to meet the involuntary placement criteria should be "transferred" to the medical bed, rather than "discharged" from the psychiatric unit. While a financial or administrative type of "discharge" may be needed, a "transfer" would maintain the involuntary status. The person's involuntary placement hearing would have to be conducted within 5 days of filing unless a continuance was requested and granted.

However, if the person is actually discharged when sent to the medical unit, he/she couldn't be held against his/her will for medical treatment.

Q. How long can a person be held at a civil SMHTF after his/her Baker Act involuntary placement order expires? is there a certain amount of time that the facility has to discharge the resident if the resident does not want to sign voluntary?

The negotiation with the person and his/her public defender for a brief extension is usually acceptable. Even if a person on voluntary status requests discharge from a state treatment facility, the facility has up to three working days to actually release the person (receiving facilities are a maximum of 24 hours). This is the absolute outside limit. However, up to that point, given a documented good faith effort made to secure reasonable discharge placement and aftercare services, a brief delay should be acceptable. If this isn't OK with the PD, an earlier discharge (even if less acceptable arrangements) must be executed. Otherwise, a petition for a writ of habeas corpus is likely.

Convalescent Status

Q. I have a question about convalescent leave from the state hospital. The only reference I can find about it is 394.469. Is this correct? Our problem is that when a patient decompensates while on convalescent leave, and is not willing to return to the facility, law enforcement in some counties will not get involved. I know that the original commit order is our authority, but not sure how to convince law enforcement to help return the person. From time to time, we will ask them to get the person to their nearest receiving facility and then we will arrange transport through a private company, but there are times they don't want to even do that much. Any thoughts?

All references to convalescent status were removed from the Baker Act in the 1996 statutory reform except for the single instance you reference in 394.469:

> **394.469 Discharge of involuntary patients.**
> (1)POWER TO DISCHARGE.—At any time a patient is found to no longer meet the criteria for involuntary placement, the administrator shall:
> (a)Discharge the patient, unless the patient is under a criminal charge, in which case the patient shall be transferred to the custody of the appropriate law enforcement officer;
> (b)Transfer the patient to voluntary status on his or her own authority or at the patient's request, unless the patient is under criminal charge or adjudicated incapacitated; or
> (c)Place an improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.

Whether this was an oversight by the Legislature or not, the provision is still in the statute. A different provision addresses the return of a person to a treatment facility who has left the facility without authorization, as follows:

394.467(8) RETURN OF PATIENTS. When a patient at a treatment facility leaves the facility without authorization, the administrator may authorize a search for the patient and the return of the patient to the facility. The administrator may request the assistance of a law enforcement agency in the search for and return of the patient.

The above reference doesn't really address your situation because it relates to elopement status of a person from a designated treatment facility, not a refusal to return to the facility after release on convalescent status. The only alternatives I can think of are:

1. Have the circuit staff assist you in working with law enforcement to understand their right to take a person into custody who is still under an circuit court order for involuntary placement, assuming that there is evidence the person continues to meet the involuntary placement criteria. The DCF circuit staff work with law enforcement all the time and may have contacts that can expedite the solution.
2. Have a new involuntary examination initiated by the court, law enforcement, or mental health professional, assuming the person meets the involuntary examination criteria and arrange for the person's transfer back to the hospital if the court enters a new BA-8 placement order.

Q. I work for a Clerk of Courts. A section of the Baker Act [Chapter 394.469(1)(c)] references the placement of an improved patient on convalescent status in the care of a community facility. What is "convalescent status"? There is confusion amongst the discharge planners at the facility as to the Judges' authority to order a patient who no longer meets inpatient criteria into a secure facility (ie; ALF or nursing home-type facility) upon discharge from the receiving facility. Would it be more appropriate to include that (ALF) placement as part of the treatment plan in an Outpatient Placement petition? Or does the Judge actually have authority to include in the Inpatient Placement Order discharge to a secure facility?

All references to "convalescent status" were removed from the statute back in 1996 except for one:

394.469 Discharge of involuntary patients.--
(1) POWER TO DISCHARGE.--At any time a patient is found to no longer meet the criteria for involuntary placement, the administrator shall:
(a) Discharge the patient, unless the patient is under a criminal charge, in which case the patient shall be transferred to the custody of the appropriate law enforcement officer;
(b) Transfer the patient to voluntary status on his or her own authority or at the patient's request, unless the patient is under criminal charge or adjudicated incapacitated; or
(c) Place an improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.

While this was probably an oversight by the Legislature, it remains in the statute. It doesn't make a lot of sense since if there is an available less restrictive treatment alternative which would offer an opportunity for improvement of the patient's condition

than a locked hospital inpatient unit, the person wouldn't meet the last criteria for involuntary inpatient placement:

> **394.467 Involuntary inpatient placement.--**
> (1) CRITERIA.--A person may be placed in involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:
> (a) He or she is mentally ill and because of his or her mental illness:
> 1.a. He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or
> b. He or she is unable to determine for himself or herself whether placement is necessary; and
> 2.a. He or she is manifestly 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 himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and
> (b) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

However, assuming that a locked “community based facility” exists that isn’t any less restrictive than a hospital, the Baker Act offers the following options:

> **394.467(6)** HEARING ON INVOLUNTARY INPATIENT PLACEMENT.--
> (b) If the court concludes that the patient meets the criteria for involuntary inpatient placement, it shall order that the patient be transferred to a treatment facility or, if the patient is at a treatment facility, that the patient be retained there or be treated at any other appropriate receiving or treatment facility, or that the patient receive services from a receiving or treatment facility, on an involuntary basis, for a period of up to 6 months. The order shall specify the nature and extent of the patient's mental illness. The facility shall discharge a patient any time the patient no longer meets the criteria for involuntary inpatient placement, unless the patient has transferred to voluntary status.
> (c) If at any time prior to the conclusion of the hearing on involuntary inpatient placement it appears to the court that the person does not meet the criteria for involuntary inpatient placement under this section, but instead meets the criteria for involuntary outpatient placement, the court may order the person evaluated for involuntary outpatient placement pursuant to s. 394.4655. The petition and hearing procedures set forth in s. 394.4655 shall apply. If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to s. 397.675, then the court may order the person to be admitted for involuntary assessment for a period of 5 days pursuant to s. 397.6811. Thereafter, all proceedings shall be governed by chapter 397.

Subsection (b) above would limit the order to service or facility operated by a designated receiving facility, even if it wasn’t part of the hospital or CSU. An Involuntary Outpatient

Placement Order would open up the alternatives to be included in a court order to any provider that meets the criteria of a “service provider”:

> **394.455(33) "Service provider"** means any public or private receiving facility, an entity under contract with the Department of Children and Family Services to provide mental health services, a clinical psychologist, a clinical social worker, a marriage and family therapist, a mental health counselor, a physician, a psychiatric nurse as defined in subsection (23), or a community mental health center or clinic as defined in this part.

The Baker Act permits service providers to select and provide supervision to other individuals to implement specific aspects of the treatment plan that must be submitted to the court by the receiving/treatment facility administrator as part of the petition for involuntary outpatient placement.