



# The Florida Senate

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Committee on Children, Families, and Elder Affairs

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## REVIEW OF THE BAKER ACT

### Issue Description

In 1971, the Florida Legislature passed into law the “Florida Mental Health Act,” also known as the “Baker Act” (chapter 394 [part I], F.S.). This Act brought about a dramatic and comprehensive revision of Florida’s mental health laws and substantially strengthened the due process and civil rights of persons in mental health facilities. At the time of its enactment, the Baker Act was considered landmark legislation.

Since becoming effective in 1972, the Baker Act has been amended a number of times to strengthen the protection of public safety, the assurance of appropriate care, and the protection of civil liberty and due process rights. However, concerns continue to be raised about its implementation and efficacy.

This project evaluates the criteria for involuntary examination and involuntary admission under the Baker Act to review whether the Act adequately balances the due process and civil rights of persons with mental illness against the protection of public safety and the need for appropriate care and treatment for such persons.

### Background

It is estimated that one in four Americans ages eighteen and older suffers from a diagnosable mental illness, including substance abuse, in any given year,<sup>1</sup> while one out of every seventeen lives with a serious mental illness (e.g. schizophrenia, major depression, or bipolar disorder).<sup>2</sup> When applied to the most recent U.S. Census residential population estimates for people ages eighteen and older, the following data are obtained:

- 57 million Americans (3.5 million Floridians) suffer from a diagnosable mental illness; and
- 12.6 million Americans (827,720 Floridians) suffer from a serious mental illness.

Part I of Chapter 394, F.S., the “Florida Mental Health Act,” also known as the “Baker Act,” is a civil commitment law which provides a process for the involuntary examination and subsequent involuntary placement (admission) of a person for either inpatient or outpatient treatment of a mental, emotional, or behavioral disorder. It is designed to use the least restrictive means of intervention, while preserving a person’s dignity and human rights.<sup>3</sup>

The Baker Act encourages the voluntary evaluation and, in some cases, admission to a psychiatric facility,<sup>4</sup> of persons who have a mental illness,<sup>5</sup> when they are able to give express and informed consent to admission and treatment and are able to independently exercise their rights. When voluntary treatment is not possible due to the

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<sup>1</sup>National Institute of Mental Health website (available at <http://www.nimh.nih.gov/health/topics/statistics/index.shtml>) (last visited September 23, 2008).

<sup>2</sup>National Institute of Mental Health, *The Numbers Count : Mental Disorders in America* (available at <http://www.nimh.nih.gov/publicat/numbers.cfm>) (last visited September 23, 2008).

<sup>3</sup>Section 394.453, F.S.

<sup>4</sup>Section 394.455(10), F.S., defines the term “facility” as a hospital, community facility, public or private facility, or receiving or treatment facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who appear to have a mental illness or have been diagnosed as having a mental illness.

<sup>5</sup>Section 394.455(18), F.S., defines “mental illness” as 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.

severity of a person's illness, the law ensures that the person's due process rights are protected.<sup>6</sup>

### Express and Informed Consent

The issue of competence to provide express and informed consent to mental health treatment is separate from the issue of placement for mental health treatment, and is applicable in both voluntary and involuntary contexts.

The Baker Act provides the following definitions:

“Express and informed consent” means consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.<sup>7</sup>

“Incompetent to consent to treatment” means that a person's judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.<sup>8</sup>

The admitting physician of each receiving or treatment facility must determine and document whether a person being admitted pursuant to the Baker Act is competent to provide express and informed consent to treatment.<sup>9</sup> If the physician determines that an individual is incompetent to consent to treatment, treatment may not be administered<sup>10</sup> until a guardian advocate<sup>11</sup> is appointed, unless the criteria for an emergency treatment order are met. An emergency treatment order supersedes a person's right to refuse treatment if a physician determines that the person is not capable of exercising voluntary control over his or her behaviors and these behaviors, if left uncontrolled, are an imminent danger to that person or to others within the facility.<sup>12</sup>

### Involuntary Examination

#### Criteria

Section 394.463(1), F.S., provides that a person may be taken to a receiving facility for involuntary examination if the person is believed to be mentally ill and because of that mental illness the person has refused voluntary examination or cannot determine whether examination is necessary.

In addition, it must be determined that, without care or treatment, the person is either likely to suffer from neglect<sup>13</sup> resulting in a real and present threat of substantial harm that can't be avoided with the help of others, or is likely to cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent

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<sup>6</sup>Department of Children and Families (Mental Health Program Office), in collaboration with Department of Mental Health Law and Policy, Louis de la Parte Mental Health Institute, Univ. S. Fla., *2008 Baker Act User Reference Guide*, Appendix F-1 (2008) (hereinafter “*Baker Act Guide*”).

<sup>7</sup>Section 394.455(9), F.S.

<sup>8</sup>Section 394.455(15), F.S.

<sup>9</sup>See Sections 394.459(3) and 394.4625(1)(f), F.S.; Chapters 65E-5.170; 65E-5.270, F.A.C.; Baker Act Form CF-MH 3104. See also, s. 765.204, F.S. A person who has been adjudicated incapacitated will have a court-appointed guardian who, in most cases, will have the power to give express and informed consent to mental health treatment. The guardian of a minor must provide express and informed consent to mental health treatment of the minor.

<sup>10</sup>The constitutionality of the forcible medication of civilly committed individuals has not been explicitly addressed by the United States Supreme Court. The Court has held, however, that both prisoners and pretrial detainees retain a fundamental right to refuse psychotropic medication, and that forcing antipsychotic drugs on a convicted prisoner or a pretrial detainee is “impermissible absent a finding of overriding justification and a determination of medical appropriateness.” *Riggins v. Nevada*, 504 U.S. 127, 135 (1992).

<sup>11</sup> A guardian advocate is a person appointed by the court to make decisions regarding the mental health treatment of an individual who has been found to be incompetent to consent to treatment under the Baker Act. Section 394.455(12), F.S.

<sup>12</sup>Chapter 65E-5.1703, F.A.C.

<sup>13</sup>Neglect may take the form of refusing necessary prescription medications, refusing to eat or drink, inability to sleep, placing oneself in imminently dangerous situations, or other high risk behaviors. *Baker Act Guide*, Appendix F-4 (2008).

behavior.<sup>14</sup>

### **Initiation**

Section 394.463(2), F.S., provides that an involuntary examination may be initiated in one of the following three ways:

1. A **court** may enter an *ex parte* order, based on sworn testimony by the petitioner, directing a law enforcement officer or other designated agent of the court to take the person to the nearest receiving facility. The order is only valid until executed, or if it is not executed, the order is valid only for the period specified in the order itself.<sup>15</sup> If no time limit is specified, the order is valid for seven days after the date it is signed. This method is most frequently used by relatives.
2. A **medical professional**<sup>16</sup> may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. A law enforcement officer shall take the person into custody and deliver him or her to the nearest receiving facility. The officer must execute a written report detailing the circumstances under which the person was taken into custody.
3. A **law enforcement officer**<sup>17</sup> may take a person who appears to meet the criteria for involuntary examination into custody and deliver that person to the nearest receiving facility. The law enforcement officer must complete certain forms documenting the behavior and transportation of the individual.<sup>18</sup>

In 2007, there were 122,443 Baker Act involuntary examinations. Approximately 48 percent of these examinations were initiated by law enforcement officers; 49 percent by mental health professionals; and less than three percent by *ex parte* order.<sup>19</sup>

Once an involuntary examination has been initiated, the subject of the examination must receive an initial examination by a physician or clinical psychologist at a receiving facility within 24-hours<sup>20</sup> to rule out mock psychiatric symptoms caused by non-psychiatric medical illness, injury, metabolic disorders, and drug toxicity. This initial mandatory involuntary examination must include:<sup>21</sup>

- A thorough review of any observations of the person's recent behavior;
- A review of the document initiating the involuntary examination and transportation form;
- A brief psychiatric history; and
- A face-to-face examination of the person in a timely manner to determine if the person meets criteria for release.

A person may not be held for involuntary examination longer than 72 hours and must be given the opportunity to notify others of his or her whereabouts. Within the 72-hour involuntary examination period, one of the following must take place:

- The person must be released unless charged with a crime;

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<sup>14</sup>Section 394.463(1)(b), F.S.

<sup>15</sup>An order may expire simply because the subject of that order cannot be located. Anecdotal evidence indicates that approximately 90 to 95 percent of *ex parte* orders are executed within two to three days.

<sup>16</sup>Section 394.463(2)(a)3, F.S., lists a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker as being able to execute a certificate.

<sup>17</sup>The Baker Act defines "law enforcement officer" with reference to s. 943.10(1), F.S.

<sup>18</sup>Report of Law Enforcement Officer Initiating Involuntary Examination Form (Baker Act Form CF-MH 3052a) and Transportation to a Receiving Facility – Part 1 Form (Baker Act Form CF-MH 3100).

<sup>19</sup>Annette Christy, *Summary: Involuntary Examination Data and Key Research Finding*, page 7 (2008) (on file with the committee).

<sup>20</sup>Section 394.459(2)(c), F.S.

<sup>21</sup>Chapter 65E-5.2801, F.A.C.

- The person must be released for voluntary outpatient treatment;
- The person must be asked to give express and informed consent to voluntary placement; or
- A petition for involuntary placement must be filed with the circuit court by the facility administrator.<sup>22</sup>

The person cannot be released by the receiving facility without the documented approval of a psychiatrist, clinical psychologist, or physician in a hospital's emergency department.<sup>23</sup>

If an individual is determined to require continued psychiatric care and does not give consent to voluntary placement, he or she may be the subject of a petition for involuntary placement filed by the facility administrator as indicated above. The Baker Act permits either involuntary inpatient<sup>24</sup> or involuntary outpatient<sup>25</sup> orders.

## Involuntary Inpatient Placement

### Criteria

The Baker Act provides that a person may be involuntarily placed for inpatient treatment if a court finds by clear and convincing evidence that the person has a mental illness, and because of the mental illness:<sup>26</sup>

- The person has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or is unable to determine for himself or herself whether placement is necessary; **and**
- He/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**

There is substantial likelihood that in the near future he or she will inflict serious bodily harm<sup>27</sup> on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; **and**

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

### Initiation

While the administrator of a facility may file a petition for involuntary placement, the facility's recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or other psychiatrist,<sup>28</sup> both of whom have personally examined the subject of the recommendation within the preceding 72 hours.

Once a petition for involuntary placement is filed, the court must appoint the public defender to represent the subject of the petition within one court working day, unless he or she is otherwise represented.<sup>29</sup> The court is required to hold the hearing on involuntary commitment within five days of the filing of a petition, unless a continuance is granted.<sup>30</sup> The state attorney for the circuit where the patient is located is designated to represent

<sup>22</sup>Section 394.463(2)(i), F.S.

<sup>23</sup>Section 394.463(2)(f), F.S.

<sup>24</sup>Section 394.467, F.S.

<sup>25</sup>Section 394.4655, F.S.

<sup>26</sup>Section 394.467(1), F.S.

<sup>27</sup>“Serious bodily harm” is interpreted to mean harm that requires medical treatment. *Craig v. State*, 804 So.2d 532, 534 (Fla. 3<sup>rd</sup> DCA 2002).

<sup>28</sup>Section 394.467(2), F.S., provides that in counties of less than 50,000 population, the second opinion may be provided by a licensed physician trained and experienced in mental and nervous disorder diagnosis and treatment or a psychiatric nurse.

<sup>29</sup>Section 394.467(4), F.S.

<sup>30</sup>Section 394.467(6)(a), F.S.

the state.

If the court concludes that the subject of the petition meets the criteria for involuntary inpatient placement, it will order that the person be transferred to the proper facility and retained for treatment for up to six months. However, the facility is required to discharge a person any time he or she no longer meets the criteria for involuntary inpatient placement, unless the person has transferred to voluntary status.

If a person continues to meet the criteria for involuntary inpatient placement, the facility administrator must, prior to the expiration of the period during which the facility is authorized to retain the person, file a petition to request continued involuntary inpatient placement. Hearings on petitions for continued involuntary inpatient placement are administrative hearings conducted by an administrative law judge. The subject of the petition, unless otherwise represented, is represented by the public defender of the circuit in which the facility is located. If at these hearings it is shown that the patient continues to meet the criteria for involuntary inpatient placement, the judge must sign the order for continued involuntary placement for a period not to exceed six months.<sup>31</sup>

## Findings and Conclusions

### “Need-for-Treatment” Standard for Involuntary Treatment

Of the total number of Americans with a diagnosable mental or substance abuse disorder, only about one-third is receiving treatment on any given day.<sup>32</sup> The consequences of non-treatment are significant, and include the following:

- Homelessness (people with untreated psychiatric illnesses comprise one-third of the estimated homeless population of 600,000);
- Incarceration (people with untreated brain disorders comprise approximately 16 percent of the total jail and prison population of 300,000);
- Violence (approximately 1,000 of the 20,000 total homicides each year are committed by people with untreated schizophrenia and bipolar disorder);
- Victimization; and
- Suicide (between 10 and 15 percent of individuals with schizophrenia or bipolar disorder take their own lives).<sup>33</sup>

There are many reasons for non-treatment, including lack of resources, anosognosia (unawareness of illness), and medication side effects.

In 1975, the United States Supreme Court set the constitutional standard for the involuntary treatment of the mentally ill. In *O'Connor v. Donaldson*, the Court held that “a state cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”<sup>34</sup> The Court recognized that states have a legitimate interest in providing “care and assistance to the unfortunate,” but noted that “the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution.”<sup>35</sup>

Since *O'Connor*, the Supreme Court has repeatedly recognized that involuntary, civil commitment is a “significant deprivation of liberty that requires due process protection.”<sup>36</sup> In addition, the Court has confirmed that, while states have legitimate interests both in providing care to persons unable to care for themselves (*parens patriae* power), as well as in protecting citizens from danger (police power), they have no interest in confining

<sup>31</sup>Section 394.467, F.S.

<sup>32</sup>Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, ch. 2, page 75 (1999)(available at <http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec7.html#overall>) (last visited October 1, 2008).

<sup>33</sup>Treatment Advocacy Center, *Fact Sheet: Consequences of Non-Treatment* (available at <http://www.psychlaws.org/GeneralResources/Fact1.htm>) (last visited September 23, 2008).

<sup>34</sup>*O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975).

<sup>35</sup>*Id.* at 575.

<sup>36</sup>*Addington v. Texas*, 441 U.S. 418, 425 (1979).

individuals who “do not pose some danger to themselves or others.”<sup>37</sup>

Although the *O'Connor* decision has been widely interpreted to mean that dangerousness is a constitutional requirement for civil commitment, the *O'Connor* Court explicitly declined to decide “whether the State may compulsorily confine a non-dangerous, mentally ill individual for the purpose of treatment.”<sup>38</sup>

In 1977, the Florida Supreme Court considered the constitutionality of Florida’s involuntary commitment statute with reference to the *O'Connor* decision.<sup>39</sup> In *In re Beverly*, the court held that the statute was constitutional on its face, but noted that even if the criteria for involuntary commitment defined by the statute were met,<sup>40</sup> “a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends should never be hospitalized involuntarily.”<sup>41</sup>

Relying on *Beverly*, Florida courts have repeatedly overturned involuntary commitment orders, on the ground that “[t]he mere need for treatment alone is insufficient” to justify civil commitment.<sup>42</sup> In Florida today,

It is well settled 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.<sup>43</sup>

As a result of *Beverly* and its progeny, the standard for involuntary, civil commitment in Florida is very high, perhaps even higher than the United States Supreme Court intended it to be.<sup>44</sup> In many cases, individuals who need treatment remain untreated because they are not imminently dangerous to themselves or others, or because their self-neglect does not rise to the level of a “real and present threat of substantial harm” (i.e. it is not imminently dangerous).<sup>45</sup> In the opinion of some commentators, the view that dangerousness is the exclusive justification for civil commitment ignores the state’s legitimate *parens patriae* power.<sup>46</sup>

<sup>37</sup>*Addington*, 441 U.S at 426 (1979).

<sup>38</sup>*O'Connor*, 422 U.S. at 573 (1975).

<sup>39</sup>*In re Beverly*, 342 So.2d 481 (Fla. 1977). At the time, s. 394.467, F.S. (1973), provided as follows: “(1) Criteria.-A person may be involuntarily hospitalized if he is mentally ill and because of his illness is: (a) Likely to injure himself or others if allowed to remain at liberty, or (b) In need of care or treatment and lacks sufficient capacity to make a responsible application on his own behalf.”

<sup>40</sup>The court read the statute to require the court to first decide that a person is mentally ill and to then decide that the person is likely to injure himself or others or that the person, if non-dangerous, needs treatment, lacks capacity to act for himself and faces a “a real and present threat of substantial harm to his well-being . . .” *Id.* at 487. The statute was subsequently amended, adopting some of the language used by the *Beverly* court.

<sup>41</sup>*Id.*

<sup>42</sup>*Williams v. State*, 522 So.2d 983, 984 (Fla. 1<sup>st</sup> DCA 1988); *Braden v. State*, 575 So.2d 756, 757 (Fla. 1<sup>st</sup> DCA 1991); *Adams v. State*, 713 So.2d 1063 (Fla. 1<sup>st</sup> DCA 1998); *Lyon v. State*, 724 So.2d 1241, 1243 (Fla. 1<sup>st</sup> DCA 1999); *Blue v. State*, 764 So.2d 697, 698 (Fla. 1<sup>st</sup> DCA 2000) (refusal to take medication, and resulting deterioration of condition, does not justify Baker Act commitment); *Singletary v. State*, 765 So.2d 180, 181 (Fla. 1<sup>st</sup> DCA 2000) (testimony that mentally ill woman would likely have to be hospitalized if she failed to take her medication was insufficient to demonstrate a real and substantial threat to her well-being).

<sup>43</sup>*Boller v. State*, 775 So. 2d 408, 409 (Fla. 1<sup>st</sup> DCA 2000). *See also, Lischka v. State*, 901 So.2d 1025, 1026 (Fla. 1<sup>st</sup> DCA 2005).

<sup>44</sup>Geoffrey E. Linburn, *Donaldson Revisited: Is Dangerousness a Constitutional Requirement for Civil Commitment?*, 26:3 J. Am. Acad. Psychiatry Law 343, 350 (1998) (arguing that *O'Connor* “does not support a restrictive, civil libertarian view of dangerousness as a limiting justification . . .”); Paul F. Stavis, *Involuntary Hospitalization in the Modern Era: Is Dangerousness Ambiguous or Obsolete?*, Quality of Care Newsletter, Issue 41 (August-September 1989) (arguing that requiring danger ignores the state’s *parens patriae* power which *O'Connor* acknowledged); Jeffrey Geller and Jonathan Stanley, *Settling the Doubts about the Constitutionality of Outpatient Commitment*, 31 New England J. on Criminal and Civil Confinement 127, 130 (Winter 2005) (arguing that dangerousness is not “an indispensable predicate to involuntary commitment . . .”).

<sup>45</sup>Imminent dangerousness is not explicitly defined in the Baker Act or in Baker Act case law. In the criminal context, however, “imminent danger” means danger that is “near at hand, mediate rather than immediate, close rather than touching.” *Scholl v. State*, 115 So. 43, 44 (1927).

<sup>46</sup>Linburn; Stavis; Geller and Stanley, *supra* note 44.

Responding to this problem, some states have amended their civil commitment laws to include a “need-for-treatment” standard, which permits involuntary treatment of a mentally ill person whose condition is likely to deteriorate to the point of dangerousness in the absence of treatment.<sup>47</sup>

Most recently, for example, Idaho reformed its civil commitment laws, amending the definitions of the terms “likely to injure himself or others” and “gravely disabled.”<sup>48</sup> The amended language allows a court to order the involuntary commitment of a mentally ill individual who is either dangerous to himself or others or lacks insight into his need for treatment,<sup>49</sup> is unable or unwilling to comply with treatment and is at substantial risk of deterioration to the point of dangerousness.<sup>50</sup>

Illinois also recently amended its definition of a “person subject to involuntary admission” to include:

A person with mental illness who because of the nature of his or her illness, is unable to understand his or her need for treatment and who, if not treated, is at risk of suffering or continuing to suffer mental deterioration or emotional deterioration, or both, to the point that the person is at risk of engaging in dangerous conduct.<sup>51</sup>

The Illinois statute also explicitly allows a court to consider “evidence of the person’s repeated past pattern of specific behavior and actions related to the person’s mental illness.”<sup>52</sup> In Florida, however, the court’s inquiry, at least in an involuntary inpatient placement proceeding, is limited to considering “recent behavior” to determine whether there is a risk of substantial harm.<sup>53</sup> This limitation precludes a court from considering a person’s past psychiatric history, even though it may be significant.

Wisconsin passed need-for-treatment legislation in 1995, and its constitutionality was upheld by the Wisconsin Supreme Court in *In re Commitment of Dennis H.*<sup>54</sup> Called the “fifth standard” because it added a fifth definition of dangerousness to Wisconsin’s civil commitment laws, Wisconsin’s need-for-treatment standard provides that a person may be involuntarily committed (for inpatient or outpatient treatment) if the court finds that, *inter alia*, the individual needs treatment to prevent further disability or deterioration and there is a substantial probability that, left untreated, the individual will “suffer severe mental, emotional or physical harm that will result in the loss of the individual’s ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions.”<sup>55</sup>

The statute explicitly limits its reach by providing that if care and treatment (beyond the simple provision of food or shelter) is available in the community, and the individual is likely to avail himself of the services, the probability of suffering severe harm is not substantial.<sup>56</sup>

Relying on *O’Connor*, the appellant in *Dennis H.* argued that the fifth standard is unconstitutional because, *inter alia*, it “violates substantive due process by allowing involuntary commitment without evidence of a risk of

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<sup>47</sup>See Treatment Advocacy Center, *State Standards for Assisted Treatment: State by State Chart* (May 8, 2007) (available at <http://www.psychlaws.org/LegalResources/statechart.htm>) (last visited August 21, 2008).

<sup>48</sup>The “gravely disabled” language used by some states is comparable to the neglect language in the Baker Act.

<sup>49</sup>Research suggests that 50 percent of individuals with schizophrenia and 40 percent of individuals with bipolar disorder suffer from anosognosia, a lack of awareness of illness, which causes them to refuse treatment. D.J. Jaffe, *Sane Policy Needed to Help Mentally Ill*, timesunion.com (March 11, 2008).

<sup>50</sup>Idaho Code Ann. s. 66-317 (2008).

<sup>51</sup>405 Ill. Comp. Stat. 5/1-119(3) (2008). “Dangerous conduct” is defined as “threatening behavior or conduct that places another individual in reasonable expectation of being harmed, or a person’s inability to provide, without the assistance of family or outside help, for his or her basic physical needs so as to guard himself or herself from serious harm.”

405 Ill. Comp. Stat. 5/1-104.5 (2008).

<sup>52</sup>405 Ill. Comp. Stat. 5/1-119 (2008).

<sup>53</sup>Section 394.467(1)(a)2.b., F.S.

<sup>54</sup>647 N.W. 2d 851 (Wisc. 2002).

<sup>55</sup>Wis. Stat. Ann. s. 51.20 (1)(a) 2.e. (2008).

<sup>56</sup>*Id.*

imminent physical dangerousness to self or others.”<sup>57</sup>

The Wisconsin Supreme Court acknowledged that a state does not have a legitimate interest in confining an individual who is not mentally ill or who does not pose some danger to himself or others, but held that substantive due process “has not been held to require proof of imminent physical dangerousness to self or others as a necessary prerequisite to involuntary commitment.”<sup>58</sup> The court relied on *O’Connor’s* statement that a person may be dangerous to himself, even in the absence of a foreseeable risk of self-injury or suicide, if “for physical or other reasons he is helpless to avoid the hazards of freedom . . .”<sup>59</sup> and held that the fifth standard was constitutional because it “fits easily within the *O’Connor* formulation . . .”<sup>60</sup>

In a more recent decision, the Alaska Supreme Court, in *Wetherhorn v. Alaska Psychiatric Institute*,<sup>61</sup> implicitly disagreed with its counterpart in Wisconsin. In 1984, Alaska amended the definition of “gravely disabled” in its civil commitment statute to include a need-for-treatment standard.<sup>62</sup> The appellant in *Wetherhorn* argued that involuntary commitment was warranted only if it was highly probable that an individual’s need for treatment would result in a serious accident, illness or death. The court concluded that the definition of “gravely disabled” was constitutional, but only if it was construed to refer to “a level of incapacity that prevents the person from being able to live safely outside of a controlled environment.”<sup>63</sup>

Noting that the statute was amended after *O’Connor*, the Alaska court concluded that it was intended to comply with *O’Connor’s* admonition that the State may not constitutionally confine a nondangerous person unless the person is incapable of *surviving safely in freedom* and rejected the State’s argument that *O’Connor* required only a showing of “some danger.” The court explicitly declined to decide whether the constitutionality of the definition of “grave disability” required that the harm be imminent or evidenced by recent acts.<sup>64</sup>

The Treatment Advocacy Center (TAC)<sup>65</sup> has drafted a model civil commitment law, which reflects the kind of need-for-treatment standard adopted in Idaho, Illinois and Wisconsin.<sup>66</sup> The TAC’s model law defines four individuals affected by mental illness for whom involuntary (i.e., assisted)<sup>67</sup> treatment is justified:

- **Chronically disabled:** An individual is incapable of making an informed medical decision, unlikely to comply with treatment as demonstrated by psychiatric history, and likely to deteriorate;
- **Gravely disabled:**<sup>68</sup> An individual is incapable of making an informed medical decision, and is unlikely, without assistance, to provide for basic needs, including medical care and self-protection, and it is probable that deterioration or serious illness will result;
- **Danger to others:** Includes presenting a threat to someone in the care of an individual and allows consideration of intentional destruction of property by an individual; and
- **Danger to self:** Allows the consideration of an individual’s past behavior.

The Model Law applies the same criteria to both inpatient and outpatient placement decisions, obviating the need

<sup>57</sup>*In re Commitment of Dennis H.*, 647 N.W.2d 851, 862 (Wisc. 2002).

<sup>58</sup>*Id.*

<sup>59</sup>*O’Connor*, 423 U.S. at 574, n 9.

<sup>60</sup>*In re Commitment of Dennis H.*, 647 N.W.2d 851, 863 (Wisc. 2002). *See also*, *Riley v. Rudloff*, 575 So.2d 377, 390 (concurring opinion) (W.Va. 2002); *In re Detention of LaBelle*, 728 P.2d 138 (Wash. 1986).

<sup>61</sup>156 P.2d 371 (Alaska 2007).

<sup>62</sup>Alaska Stat. s. 47.30.915(7)(B) (2008). *See also*, *id.* at 376.

<sup>63</sup>*Wetherhorn v. Alaska Psychiatric Institute*, 156 P.2d 371, 378 (Alaska 2007).

<sup>64</sup>*Id.* at 379.

<sup>65</sup>The Treatment Advocacy Center is a national nonprofit organization dedicated to eliminating barriers to the timely and effective treatment of severe mental illnesses.

<sup>66</sup>Treatment Advocacy Center, *Model Law for Assisted Treatment*, page 11 (2000) (hereinafter “*Model Law*”)(available at <http://www.treatmentadvocacycenter.org/LegalResources/ModelLaw.htm>) (last visited October 1, 2008).

<sup>67</sup>The TAC, as well as other treatment advocates, refers to all involuntary treatment as “assisted treatment.”

<sup>68</sup>Many states include gravely disabled as grounds for involuntary treatment, but most define it in terms of dangerousness: the person becomes so incapacitated that he cannot provide for the most basic needs of food, clothing and shelter. The model law defines “gravely disabled” more broadly.



for judicial approval to transfer individuals between placement types. Recognizing that inpatient placement represents a greater restriction on liberty than outpatient placement, however, the Model Law does require judicial confirmation of a transfer from outpatient to inpatient status. However, because the individual has already been deemed to meet the criteria for involuntary treatment, the transfer hearing focuses only on the clinical appropriateness of a more restrictive placement.<sup>69</sup>

While favored by some, TAC's Model Law is not without opponents. Speaking from a civil libertarian perspective, and emphasizing autonomy and self-determination, many advocates oppose involuntary inpatient commitment "except in response to an emergency and then only when based on a standard of imminent danger of significant physical harm to self or others and when there is no less restrictive alternative."<sup>70</sup>

The most serious mental illnesses (schizophrenia, major depression, and bipolar disorder) typically develop during early adulthood,<sup>71</sup> often when a young person has reached the age of majority, but has not yet reached financial independence.<sup>72</sup> Sometimes, the inability of families to intervene in cases where a young adult may need treatment but cannot or will not seek treatment results in tragic consequences, perhaps making a need-for-treatment standard especially appropriate for this limited population.

At least one scholar argues that the standards for civil commitment (and involuntary medication) should be less stringent when applied in the case of a first, serious psychotic break. The author then recommends that all patients execute an advance directive after this first episode.<sup>73</sup> This approach is compelling because many researchers agree that each psychotic episode progressively damages the brain and psychotic episodes tend to become worse over time if left untreated.<sup>74</sup>

## Recommendations

The Legislature may wish to consider adding a "need-for-treatment standard" to the criteria for involuntary treatment of mentally ill individuals. The need-for-treatment standard might be similar to that recently enacted in Illinois or in Idaho, allowing involuntary inpatient treatment when an individual is at risk of suffering mental deterioration and engaging in dangerous conduct. The Legislature may also wish to allow the court to consider evidence of past behavior in making a determination about an individual's need for treatment. The need-for-treatment standard may be extended to involuntary examinations, allowing medical professionals to initiate an involuntary examination if the need for treatment criteria are met. Alternatively, the need-for-treatment standard may be limited in its application to young adults or to individuals suffering a first, serious psychotic break.

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<sup>69</sup>Model Law, page 22.

<sup>70</sup>Bazelon Center for Mental Health Law, *Position Statement on Involuntary Commitment* (available at <http://www.bazelon.org/issues/commitment/positionstatement.html>) (last visited August 22, 2008). See also, Mental Health America, *Position Statement 22: Involuntary Mental Health Treatment* (last updated September 20, 2007) (available at <http://www.nmha.org/go/position-statements/p-36>) (last visited August 22, 2008).

<sup>71</sup>National Institute of Mental Health, *Bipolar Disorder* (April 3, 2008); National Institute of Mental Health, *Schizophrenia* (January 2007).

<sup>72</sup>See e.g., Section 627.6562, F.S., which requires insurance companies to insure dependent children up to age 25 if the children are living with a policy holder or attending school.

<sup>73</sup>See Elyn Saks, *Refusing Care: Forced Treatment and the Use of Psychiatric Advance Directives*, 4(4) J. of Forensic Psychology Practice 35 (2004).

<sup>74</sup>See Treatment Advocacy Center, *supra* note 33.