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# BRING ULYSSES TO FLORIDA: PROPOSED LEGISLATIVE RELIEF FOR MENTAL HEALTH PATIENTS

**Judy Ann Clausen\***

*This Article urges the Florida legislature to give patients the right to form Ulysses arrangements, which are a special type of mental health advance directive authorizing a doctor to administer treatment during a future episode even if the episode causes the patient to refuse treatment. Acute mental illness episodes may disrupt a patient's capacity to provide informed consent and cause the patient to refuse necessary intervention. In Florida, a physician cannot involuntarily examine, hospitalize, or treat a person unless she meets strict criteria, essentially requiring the person's behavior to reveal that she is dangerous to herself or others. Even a person exhibiting signs of psychosis and clearly in need of treatment may not meet such strict criteria. In such cases, intervention is postponed until the person becomes dangerous. In the meantime, the untreated episode may damage the person's relationships, savings, employment, safety, and mental and physical health. This Article explores how Florida law deprives patients of the ability to form Ulysses arrangements. It proposes legislative relief for Florida's mental health patients, which authorizes Ulysses arrangements. One novel component of this legislative relief provides patients the option to arrange for involuntary transportation to a hospital. Episodes which cause treatment refusals also cause patients to refuse transportation to a hospital. If a patient is unable to obtain transportation in contravention of refusals, she cannot secure intervention through her Ulysses arrangement.*

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## INTRODUCTION

Acute mental illness episodes may temporarily destroy the capacity required to provide informed consent, prevent individuals from recognizing they are sick, and cause them to refuse necessary intervention.<sup>1</sup> Even in the midst of an episode, which has disrupted behavior and cognitive functions, many people do not meet the Florida Mental Health Act's (otherwise

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1. KAY REDFIELD JAMISON, AN UNQUIET MIND: A MEMOIR OF MOODS AND MADNESS 36-38 (1995); Joanmarie I. Davoli, *Still Stuck in the Cuckoo's Nest: Why Do Courts Continue to Rely on Antiquated Mental Illness Research?*, 69 TENN. L. REV. 987, 1009 (2002); Nat'l. Ethics Comm'n., Veterans Health Admin., *Advance Directives for Mental Health: An Ethical Analysis of State Laws & Implications for VHA Policy*, Nat'l. Center for Ethics in Healthcare, US Dep't. Veterans Aff. 8 (Feb. 2008), [http://www.ethics.va.gov/docs/NEC\\_Report\\_20080220\\_Adv\\_Directives\\_MH-Analysis\\_of\\_State\\_Laws-Implications\\_for\\_VHA\\_Policy.pdf](http://www.ethics.va.gov/docs/NEC_Report_20080220_Adv_Directives_MH-Analysis_of_State_Laws-Implications_for_VHA_Policy.pdf) [hereinafter VHA Report]; Judy Clausen, *Making the Case for a Model Mental Health Advance Directive Statute*, 14 Yale J. Health Pol'y., L., & Ethics 1, 3-4 (2014) (describing the illness induced treatment refusal phenomena and arguing the Uniform Health-Care Decisions Act fails people with mental illness for many reasons, including by depriving them of the right to form Ulysses arrangements).

known as the Baker Act) strict criteria for involuntary evaluation, hospitalization, and treatment.<sup>2</sup> Once an episode has destroyed decision-making capacity and caused treatment refusals, the only hope for intervention is through involuntary commitment, which the Baker Act calls involuntary inpatient placement.<sup>3</sup> This is initiated through involuntary examination, a psychiatric examination conducted without the person's consent.<sup>4</sup> Under the Baker Act, a physician cannot involuntarily examine a person unless the person meets strict criteria, essentially requiring the person's behavior to reveal that she is dangerous to herself or others.<sup>5</sup> Even a person exhibiting signs of psychosis, and clearly in need of treatment, may not meet involuntary examination criteria.<sup>6</sup> In such cases, intervention is postponed until the person becomes dangerous.<sup>7</sup> In the meantime, the untreated episode may damage the person's relationships, savings, employment, safety, and mental and physical health.<sup>8</sup>

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2. FLA. STAT. § 394.467(1) (2013) (Involuntary inpatient placement criteria); FLA. STAT. § 394.4655(1) (2013) (Involuntary outpatient placement criteria); FLA. STAT. § 394.463(1) (2013) (Involuntary examination criteria).

3. FLA. STAT. §§ 394.467(1) (2013); 394.4655(1) (2013); Breanna M. Sheetz, Comment, *The Choice to Limit Choice: Using Psychiatric Advance Directives to Manage the Effects of Mental Illness and Support Responsibility*, 40 U. MICH. J. L. REFORM 401, 415 (2007).

4. FLA. STAT. § 394.463 (2013); FLA'S BAKER ACT: 2013 FACT SHEET DEP'T OF CHILDREN AND FAMILIES, <http://www.dcf.state.fl.us/programs/samh/mentalhealth/docs/Baker%20Act%20Overview%202013.pdf>. [hereinafter DCF Fact Sheet].

5. FLA. STAT. § 394.463 (2013).

6. *Id.* (This is because even if the person exhibits signs of psychosis there may not be a substantial likelihood that "without care . . . the person will cause serious bodily harm to . . . herself or others in the near future, as evidenced by recent behavior." Or, alternatively, "[w]ithout care . . . the person would be likely to suffer from neglect or refuse to care for . . . herself . . . [and that] such neglect . . . poses a real and present threat of substantial harm to [the person's] well-being).

7. *Id.*

8. See *Tuten v. Fariborzian*, 84 So.3d 1063, 1065 (Fla. Dist. Ct. App. 2012) (wrongful death action concerning a patient released after attempted suicide because he no longer met involuntary placement criteria, and the day after release shot his wife and then fatally shot himself); Nick Anderson, *Dr. Jekyll's Waiver of Mr. Hyde's Right to Refuse Medical Treatment: Washington's New Law Authorizing Mental Healthcare Advance Directives Needs Additional Protections*, 78 WASH. L. REV.

This Article urges Florida to give mental health patients the right to form and effectuate Ulysses arrangements. This arrangement derives its name from the Odyssey.<sup>9</sup> Concerned the Sirens' song would lead him into danger, Ulysses directed his shipmates to tie him to the mast of his ship to protect him even if the song compelled him to demand to be set free.<sup>10</sup> A patient forms a Ulysses arrangement when she has capacity.<sup>11</sup> Through the arrangement, the patient authorizes doctors to administer treatment during a future episode even in contravention of the patient's illness-induced refusals and even if the patient lacks capacity to provide informed consent.<sup>12</sup> Patients who form Ulysses arrangements have experienced previous episodes and have learned that such episodes cause them to refuse treatment.<sup>13</sup> Florida's statute governing all advance health care planning (Florida's generic directive statute) primarily addresses planning for end-of-life care instead of treatment for acute mental illness episodes.<sup>14</sup> Florida's generic directive statute does not enable patients to form Ulysses arrangements.<sup>15</sup>

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795, 801 (2003); Davoli, *supra* note 1, at 1045 (citing Ashok K. Malla et al., *Improving Outcomes in Schizophrenia: The Case for Early Intervention*, 160 CAN. MED. ASS'N J. 843, 844 (1999) (for the statement that prompt intervention at the beginning of psychosis greatly improves the chances of long-term recovery)); Clausen, *supra* note 1, at n. 13.

9. Clausen, *supra* note 1, at n. 8; Chrisoula Andreou, *Making a Clean Break: Addiction and Ulysses Contracts*, 22 BIOETHICS 25 (2008); Theo Van Willigenburg & Patrick J.J. Delaere, *Protecting Autonomy as Authenticity Using Ulysses Contracts*, 30 J. MED. & PHIL. 395, 396 (2005).

10. Andreou, *supra* note 9, at 25.

11. I. Gremmen et al., *Ulysses Arrangements in Psychiatry: A Matter of Good Care?*, 34 J. MED. ETHICS 77 (2008).

12. Sheetz, *supra* note 3, at 403-404.

13. Elizabeth M. Gallagher, *Advance Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals*, 4 PSYCHOL. PUB. POL'Y & L. 746, 780 (1998).

14. FLA. STAT. § 765.102 (3)-(5) (2013) (legislative findings addressing life-prolonging medical procedures, end-of-life and palliative care, pain management, and the creation of a campaign on end-of-life care for educating the public, but failing to address mental health treatments).

15. FLA. STAT. § 765.104(1) (2013) (allowing revocation of advance directives or designations of surrogates by competent principals only. If not given a choice

Part I explains the legal and clinical context for Ulysses arrangements. It explores the Baker Act, which governs involuntary examination, detention, transportation, hospitalization, and treatment of mental health patients.<sup>16</sup> Part I argues that a Ulysses arrangement intervention is preferable to involuntary placement for patients, and for Florida, for several reasons. Ulysses arrangement intervention is more timely, effective, and therapeutic than involuntary placement. Intervention through a Ulysses arrangement is less time-consuming, traumatic, and intrusive than involuntary placement. Moreover, Ulysses arrangements empower patients to avoid dehumanizing commitment and guardianship proceedings. These arrangements also potentially preserve scarce judicial and public defender resources and facilitate more cost-effective intervention than involuntary placement. Finally, Ulysses arrangements are a needed alternative to involuntary placement because in Florida, which ranks as one of the lowest states in mental health spending, there is a shortage of psychiatric hospital beds.

Part II illustrates several reasons why Florida's generic directive statute is not a Ulysses enabling statute. First, the generic directive statute does not enable patients to determine whether their directives are revocable when they lack capacity.<sup>17</sup> Second, the statute fails to provide safeguards to ensure Ulysses arrangements are formed knowingly and voluntarily.<sup>18</sup> Third, the statute provides no authority and no process for administering treatment in the face of contemporaneous refusals.<sup>19</sup> Finally, patients have no mechanism to arrange for involuntary transportation to a facility to obtain intervention pursuant to a Ulysses arrangement.<sup>20</sup>

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about revocability, a patient cannot form a Ulysses arrangement).

16. FLA. STAT., ch. 394 (2013).

17. FLA. STAT. § 765.104(1) (2013).

18. *See generally*, FLA. STAT., ch. 765 (2013).

19. *Id.*

20. *Id.*



Part III describes a Ulysses enabling statute Florida should adopt by amending both the Baker Act and the generic directive statute. The described statute ensures patients form Ulysses arrangements knowingly and voluntarily because it (1) empowers patients to decide whether they can revoke their arrangements, (2) requires a signed and witnessed writing, (3) mandates a capacity assessment and attestation, and (4) provides for automatic expiration of arrangements. Moreover, the described statute defines a process for Ulysses arrangement implementation through authorizing patient designated activation and involuntary transportation to a facility. The involuntary transportation option is novel and necessary. Patients whose illnesses cause them to refuse treatment will also refuse transportation to a hospital. If the patient is unable to obtain transportation in contravention of refusals, the patient is unable to secure intervention through her Ulysses arrangement. Finally, the described statute articulates procedures for admission, retention, and treatment pursuant to a Ulysses arrangement.

## **I. ULYSSES ARRANGEMENTS IN CONTEXT**

This Section explores the legal and clinical context for Ulysses arrangements in Florida. Then, it explores key provisions of the Baker Act and explains why Ulysses arrangement intervention is superior to involuntary commitment for most patients.

### **A. THE CLINICAL AND LEGAL CONTEXT**

In its legislative findings, Florida's generic directive statute states, "[E]very competent adult has the fundamental right of self-determination regarding [her health care decisions] including the right to choose or refuse . . . treatment."<sup>21</sup> To ensure patients do not lose this right because of later incapacity,

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21. FLA. STAT. § 765.102(1) (2013).

the statute sets forth a process allowing patients to create health care advance directives.<sup>22</sup> The legislative findings assert that establishing an advance directive should be less expensive and restrictive than guardianship, and should permit previously incapacitated people to exercise full control over their health care decisions as soon as capacity is restored.<sup>23</sup>

In many jurisdictions, competence is distinguished from capacity because a court determines incompetence, but a physician determines incapacity.<sup>24</sup> However, Florida's generic directive statute does not make this distinction, rather the statute uses competence and capacity interchangeably, as will this Article.<sup>25</sup> The generic directive statute states: "'Incapacity' or 'incompetent,' means the patient is physically or mentally unable to communicate a willful and knowing health care decision."<sup>26</sup> The statute defines informed consent as follows:

'Informed consent' means consent voluntarily given by a person after a sufficient explanation and disclosure of the subject matter involved to enable that person to have a general understanding of the treatment or procedure and the medically acceptable alternatives, including the substantial risks and hazards inherent in the proposed treatment or procedures, and to make a knowing health care decision without coercion or undue influence.<sup>27</sup>

Advance directives come in different forms.<sup>28</sup> Patients (also referred to as principals) use instructional directives to consent

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22. FLA. STAT. § 765.102(2) (2013).

23. *Id.*

24. Jessica Wilen Berg et al., *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345, 348-49 (1996); Sheetz, *supra* note 3, at 415.

25. FLA. STAT. § 765.101(8) (2013).

26. *Id.*

27. FLA. STAT. § 765.101(9) (2013).

28. Justine A. Dunlap, *Mental Health Advance Directives: Having One's Say*, 89 KY. L.J. 327, 347-51 (2001).

to or refuse care to be provided when the patient lacks capacity to consent.<sup>29</sup> The Florida generic directive statute regulates instructional directives through its provisions concerning living wills.<sup>30</sup> It is difficult for a patient to anticipate all circumstances that may arise when illness or injury has destroyed capacity. Therefore, proxy directives allow patients to appoint surrogates to make decisions for the patient when the patient lacks capacity to provide informed consent.<sup>31</sup> The patient can then engage in ongoing dialogue with her surrogate to ensure her surrogate understands her thoughts concerning treatment.<sup>32</sup> Florida's generic directive statute regulates proxy directives through provisions in Part II, which is entitled "Health Care Surrogate."<sup>33</sup> Hybrid directives enable patients to give instructions and designate surrogates to make decisions in line with patient values when situations arise that instructions fail to address.<sup>34</sup> Both general advance directives (generic directives) and mental health advance directives (mental health directives) come in all of these forms.<sup>35</sup> Typically, doctors follow generic directives at the end of the patient's life.<sup>36</sup> Generic directives address such issues as whether to cease life-sustaining treatment when illness or injury has caused the patient to enter a permanent vegetative state.<sup>37</sup> Doctors often implement generic directives when the

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29. John Q. La Fond & Debra Srebnik, *The Impact of Mental Health Advance Directives on Patient Perceptions of Coercion in Civil Commitment and Treatment Decisions*, 25 INT'L J.L. & PSYCHIATRY 537, 537-38 (2002).

30. FLA. STAT. §§ 765.301-765.305 (2013).

31. Karl A. Menninger, *Advance Directives for Medical and Psychiatric Care*, 102 AM. JUR. PROOF OF FACTS 3d 95, §25 (2008).

32. *Id.*

33. FLA. STAT. §§ 765.201-765.205 (2013).

34. Menninger, *supra* note 31, at §7, §25.

35. *Id.*

36. *Contra* Patricia Backlar, *Anticipatory Planning for Psychiatric Treatment is Not Quite the Same as Planning for End-of-life Care*, 33 CMTY. MENTAL HEALTH J. 261, 262 (1997).

37. FLA. STAT. §§ 765.301-765.309 (2013) (Florida's generic directive statute provisions on life prolonging procedures concerning such things as mercy killing or euthanasia not being authorized, suicide being distinguished).

patient lacks capacity because she is in a coma.<sup>38</sup>

The mental health context is different. Mental health directives enable patients to author intervention plans to be followed each time the patient suffers an acute episode.<sup>39</sup> Patients may use mental health directives to refuse or consent to mental health treatments such as electroconvulsive therapy, psychotropic medication, or inpatient treatment.<sup>40</sup> The mental health directive documents the patient's informed consent, enabling her doctor to intervene during an episode that has destroyed capacity.<sup>41</sup>

Episodes of many mental illnesses not only temporarily disrupt patient capacity, these episodes prevent patients from realizing they are sick and cause patients to refuse treatment to which they would otherwise consent.<sup>42</sup> For example, in *Paddock v. Chacko*, the plaintiff's husband drove her to the hospital, where she stayed for two days, following an attempt to take her own life.<sup>43</sup> Her treating psychiatrist determined an episode of paranoid psychosis caused her suicide attempt.<sup>44</sup> He recommended she be hospitalized because she was at risk for another suicide attempt.<sup>45</sup> Under the influence of the episode, she was unable to appreciate her need for treatment, did not follow her psychiatrist's advice, and was discharged.<sup>46</sup> Within a month, she again attempted suicide and sustained permanent injuries.<sup>47</sup>

Once a patient refuses treatment, her physician cannot

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38. David Y. Nakashima, Comment, *Your Body, Your Choice: How Mandatory Advance Health-Care Directives are Necessary to Protect Your Fundamental Right to Accept or Refuse Medical Treatment*, 27 U. HAW. L. REV. 201, 203 (2004).

39. Sheetz, *supra* note 3, at 403.

40. Menninger, *supra* note 31, at §25.

41. Backlar, *supra* note 36, at 265.

42. Jamison, *supra* note 1, at 37; Davoli, *supra* note 1, at 1009; VHA Report, *supra* note 1, 8; Clausen, *supra* note 1, at 3-5.

43. *Paddock v. Chacko*, 522 So.2d 410, 412 (Fla. Dist. Ct. App. 1988).

44. *Id.*

45. *Id.*

46. *Id.*

47. *Id.* at 413.

hospitalize or treat her unless she meets the strict criteria for involuntary placement.<sup>48</sup> By the time the patient meets the strict criteria, the episode may have wreaked havoc on the patient's life.<sup>49</sup> Untreated episodes may destroy the patient's career, relationships, and financial stability; lead to incarceration and a criminal record; and risk the patient's and others' health and safety.<sup>50</sup>

Ulysses arrangements provide patients a tool to secure intervention when an episode causes them to refuse treatment.<sup>51</sup> The patient forms the arrangement, which is a special type of irrevocable mental health directive, when she has full capacity.<sup>52</sup> Through the arrangement, the patient authorizes doctors to administer treatment during a future episode even in contravention of the patient's contemporaneous illness-induced refusals.<sup>53</sup> Patients who form Ulysses arrangements have experienced previous episodes and know from experience that episodes cause them to refuse treatment.<sup>54</sup>

## **B. ULYSSES ARRANGEMENT INTERVENTION SUPERIOR TO INVOLUNTARY PLACEMENT**

Without Ulysses arrangements, Florida mental health patients face tremendous obstacles to obtaining intervention when an episode temporarily destroys capacity and causes treatment refusals.<sup>55</sup> This Section explores involuntary

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48. FLA. STAT. § 394.463(1) (2013).

49. *See, e.g., Garcia v. Lifemark Hosp. of Fla.*, 754 So.2d 48, 48-49 (Fla. Dist. Ct. App. 2000) (wrongful death action against hospital which released mental health patient against medical advice and patient later committed suicide).

50. *See, e.g., Santa Cruz v. Nw. Dade Cmty. Health Ctr., Inc.*, 590 So.2d 444, 444-45 (Fla. Dist. Ct. App. 1992) (persons who were shot by mental health patient brought action against mental health center which did not detain patient).

51. Andreou, *supra* note 9, at 25.

52. Gremmen, *supra* note 11, at 77.

53. Andreou, *supra* note 9, at 25.

54. Gallagher, *supra* note 13, at 780.

55. *See* FLA. STAT. § 394.463(1) (2013) (revealing that a non-consenting patient cannot even be evaluated for her need for treatment unless she meets involuntary examination criteria).

outpatient and inpatient placement in Florida because the primary way a person obtains treatment, when an episode causes treatment refusals, is through involuntary placement.<sup>56</sup> The text below explains why intervention through a Ulysses arrangement respects patient autonomy and dignity, secures timely and effective treatment, and protects patient safety far more than involuntary placement. Moreover, intervention through Ulysses arrangements is far less expensive for Florida and for patients, and less traumatic for patients than involuntary placement.

### 1. *The Baker Act*

The Florida Mental Health Act, also known as the Baker Act, protects the rights of all people examined or treated for mental illness in Florida and governs civil commitment.<sup>57</sup> The text below explores the Baker Act criteria and procedures for involuntary detention, transportation, examination, and involuntary inpatient and outpatient placement.<sup>58</sup> “Involuntary inpatient placement . . . is the Baker Act’s term for civil commitment.”<sup>59</sup> Therefore, this Article will use “civil commitment” and “involuntary placement” interchangeably. “[O]utpatient placement . . . is a form of commitment that allows individuals to be mandated by the court to receive mental health treatment on an outpatient basis.”<sup>60</sup> This Section posits that Ulysses arrangements are superior to commitment, which often comes too late and is traumatic.<sup>61</sup> Moreover, commitment proceedings are dehumanizing. Additionally, state mental health hospitals are closing.<sup>62</sup> There

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56. FLA. STAT. §§ 394.4655, 394.467 (2013); Sheetz, *supra* note 3, at 415.

57. See DCF Fact Sheet, *supra* note 4.

58. FLA. STAT. ch. 394 (2013).

59. DCF Fact Sheet, *supra* note 4.

60. *Id.*

61. See *infra* Part I.B.

62. Paul S. Appelbaum, *The ‘Quiet’ Crisis in Mental Health Services*, 22 HEALTH AFFAIRS 110, 115 (2003).

are an insufficient number of beds to support patients.<sup>63</sup> Ulysses arrangements potentially preserve scarce resources by empowering patients to author their own stabilization plans, thereby avoiding longer-term hospitalization.

a. Involuntary Examination Criteria

Once an episode has destroyed capacity and caused treatment refusals, the best hope for intervention is through involuntary inpatient or outpatient placement, initiated through an involuntary examination.<sup>64</sup> "An involuntary exam[ination] is a psychiatric exam[ination] conducted without [the patient's] consent, often [referred to as] 'getting Baker Acted.'"<sup>65</sup> The Baker Act authorizes law enforcement officers to detain and transport a person who meets involuntary examination criteria as evidenced by one of three forms of documentation: (1) the officer's personal recorded observations, (2) an ex parte order of the court, or (3) a physician's certificate.<sup>66</sup> In 2013, law enforcement officers initiated approximately 49%, physicians initiated approximately 49%, and circuit court ex parte orders initiated approximately 2% of involuntary detentions for the purposes of involuntary examination.<sup>67</sup>

Involuntary examination criteria reflect the two forms of civil commitment: police power and *parens patriae* commitment.<sup>68</sup> The state's police power refers to its authority to maintain peace and order, and therefore confine a person who is likely to be dangerous to others.<sup>69</sup> Under the state's police power, police may detain and transport a person for involuntary examination if there is reason to believe she has a mental illness, defined as

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63. Sheetz, *supra* note 3, at 415.

64. *Id.*

65. DCF Fact Sheet, *supra* note 4.

66. FLA. STAT. § 394.463(2) (2013).

67. DCF Fact Sheet, *supra* note 4.

68. *Addington v. Texas*, 441 U.S. 418, 426 (1979).

69. *Id.*

“impairment of the mental or emotional processes that exercise conscious control [over the person’s] actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person’s ability to meet the ordinary demands of living.”<sup>70</sup> Moreover, there must be a “substantial likelihood that without . . . treatment the person will cause serious bodily harm to . . . herself or others in the near future, as evidenced by recent behavior” (police power examination criteria).<sup>71</sup>

*Parens patriae* authority allows Florida to protect a person whose mental illness prevents her from being able to care for her basic needs.<sup>72</sup> For involuntary examination based on *parens patriae* authority, there must be reason to believe the person has a mental illness which has either caused her to refuse involuntary examination after an explanation of the purpose of examination, or the person is unable to determine for herself whether examination is necessary.<sup>73</sup> Next, “without care . . . the person [must be] likely to suffer from neglect or refuse to care for . . . herself; such neglect or refusal [must pose] a real and present threat of substantial harm to . . . her well-being.”<sup>74</sup> Moreover, it must not be apparent that willing family or friends or the provision of other services can avoid the harm (*parens patriae* examination criteria).<sup>75</sup> Together, *parens patriae* and police power examination criteria will be referred to as: involuntary examination criteria.

These strict examination criteria prevent many patients in the midst of a mental health crisis from receiving necessary intervention. A common scenario involves a concerned family member who contacts law enforcement to report a loved one is in the midst of an episode. Even if the person exhibits signs of

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70. FLA. STAT. § 394.455(18) (2013).

71. FLA. STAT. § 394.463(2) (2013).

72. *Addington*, 441 U.S. 418, 426 (1979).

73. FLA. STAT. § 394.463(1) (2013).

74. *Id.*

75. *Id.*



psychosis, if the person refuses to go to the hospital, officers cannot detain and transport the person unless the person meets the strict criteria.<sup>76</sup> Evidence of psychosis alone does not necessarily meet police power examination criteria.<sup>77</sup> There may be insufficient evidence that there is “a substantial likelihood that without . . . treatment the person will cause serious bodily harm to himself . . . or others . . . evidenced by recent behavior.”<sup>78</sup> The person in the midst of an episode that has caused psychosis may also not meet *parens patriae* examination criteria.<sup>79</sup> There may be insufficient evidence that without care the person is likely to suffer from neglect to such an extent it poses a present threat of substantial harm to her well-being.<sup>80</sup> Left untreated, the person’s cognitive functions will likely continue to deteriorate, and loved ones will be unable to help.<sup>81</sup>

#### b. Detention & Transportation

Each county must designate a single law enforcement agency responsible for taking a person into custody for the purposes of transporting the person for involuntary examination.<sup>82</sup> The law enforcement agency may delegate the responsibility to transport the person to a receiving facility only in the following circumstances.<sup>83</sup> First, “[t]he jurisdiction . . . [must have] contracted on an annual basis with an emergency medical transport service or private transport company (transportation contractor) for [the] transportation of [patients] to receiving facilities.”<sup>84</sup> Second, the law enforcement agency and the transportation contractor must agree that continued

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76. FLA. STAT. § 394.463(1)-(2) (2013).

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.*

81. Anderson, *supra* note 8, at 801; Davoli, *supra* note 1, at 1045.

82. FLA. STAT. § 394.462 (1)(a) (2013).

83. *Id.*

84. *Id.*

presence of law enforcement personnel is unnecessary to protect the safety of the patient or others.<sup>85</sup> The jurisdiction may seek reimbursement for transportation expenses from the patient's insurance company or the patient.<sup>86</sup> The transportation contractor is an independent contractor and must comply with all applicable rules of the law enforcement agency.<sup>87</sup> This contractor "is solely liable for the safe and dignified transportation of the patient . . . [and] must be insured . . . with respect to the transportation of patients."<sup>88</sup>

When an episode has taken hold for sufficient time to cause the patient to finally meet involuntary examination criteria, police or the transportation contractor must transport her to a hospital.<sup>89</sup> This responsibility is not discretionary.<sup>90</sup> In *Pruessman v. Dr. John T. McDonald Foundation*, a patient sued the hospital and the City of Coral Gables based on the patient's alleged improper removal from the hospital and transportation to a mental health facility pursuant to the Baker Act.<sup>91</sup> Police transported the patient to the mental health facility despite the patient's refusal to leave the hospital and be transferred.<sup>92</sup> The Third District Court of Appeal (DCA) of Florida held, as a matter of law, Coral Gables was not liable for police detaining and transporting a patient to a mental health facility based on a facially valid certificate under the Baker Act executed by a physician.<sup>93</sup> In fact, police had no discretion to refuse to detain and transport the patient upon the presentation of the facially valid certificate.<sup>94</sup>

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85. *Id.*

86. *Id.*

87. *Id.* § 394.462(1)(b)-(c).

88. *Id.* § 394.462(1)(b).

89. *Pruessman v. Dr. John T. MacDonald Found.*, 589 So.2d 948, 949 (Fla. Dist. Ct. App. 1991).

90. *Id.*

91. *Id.* at 948-49.

92. *Id.* at 949.

93. *Id.*

94. *Id.*

However, it is important to remember police, physicians, and the court cannot execute a valid Baker Act certificate authorizing involuntary examination unless the patient meets involuntary examination criteria.<sup>95</sup> As explored in Part II, Florida patients are unable to form Ulysses arrangements to override their illness-induced treatment refusals.<sup>96</sup> Once an episode causes the patient to refuse to go to the hospital, no one can transport her unless she meets strict involuntary examination criteria.<sup>97</sup>

### c. Arrival at Facility and Examination

The nearest receiving facility must accept for involuntary examination a person brought by law enforcement or transportation contractors.<sup>98</sup> Only the Florida Department of Children and Families designated Baker Act receiving facilities, which include hospitals and crisis stabilization units, can conduct involuntary examinations.<sup>99</sup> Once the person arrives at the facility, a doctor shall examine the patient without delay.<sup>100</sup> A physician may administer emergency treatment if the physician determines such treatment is necessary for the safety of the patient or others.<sup>101</sup> These services focus on stabilizing the immediate mental health crisis.<sup>102</sup> The facility may not hold the patient for involuntary examination longer than seventy-two hours, which begins when the patient arrives at the hospital.<sup>103</sup> At the end of seventy-two hours, the facility must either offer the person voluntary placement, release the person, return the person to police custody if the person has been charged with a

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95. FLA. STAT. § 394.463(1)-(2) (2013).

96. See FLA. STAT. § 765.104(1) (2013).

97. FLA. STAT. § 394.463(1)-(2) (2013).

98. FLA. STAT. § 394.462(1)(j) (2013).

99. DCF Fact Sheet, *supra* note 4.

100. FLA. STAT. § 394.463(2)(f) (2013).

101. *Id.*

102. DCF Fact Sheet, *supra* note 4.

103. FLA. STAT. § 394.463(2)(g) (2013).

crime, or petition the court for involuntary placement.<sup>104</sup>

The average length of stay in a facility following involuntary examination is 4.5 days.<sup>105</sup> Approximately 76% of all involuntary examinations do not result in the filing of a petition for involuntary placement.<sup>106</sup> In 2011, there were 150,000 involuntary examinations in Florida.<sup>107</sup> Over the ten years between 2002 and 2011, there was an increase of 50% in involuntary examinations in Florida.<sup>108</sup> Therefore, in Florida, mental health crisis situations are on the rise.<sup>109</sup> The vast majority of people “Baker Acted” are released from the facility after a few days.<sup>110</sup> For many patients, a few days intervention may be sufficient to make the patient no longer meet involuntary examination criteria.<sup>111</sup> However, such short intervention is often insufficient to restore the patient to full functioning.<sup>112</sup> After only a few days, many patients are still in the midst of the episode, which will continue to cause them to refuse treatment.<sup>113</sup> Doctors are legally required to heed their illness-induced discharge demands despite the fact the patients need further treatment.<sup>114</sup> After release, patients still in the midst of an episode will continue to refuse treatment; their cognitive functions will continue to deteriorate.<sup>115</sup>

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104. FLA. STAT. § 394.463(2)(g)-(i) (2013).

105. DCF Fact Sheet, *supra* note 4.

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.*

111. *See, e.g.,* Tuten v. Fariborzian, 84 So.3d 1063, 1065 (Fla. Dist. Ct. App. 2012) (released because no longer met involuntary examination criteria then committed suicide).

112. *Id.*

113. *Id.*

114. FLA. STAT. § 394.463(2)(h)-(i) (2013); Liles v. P.I.A. Medfield, Inc., 681 So.2d 711, 712 (Fla. Dist. Ct. 1995) (holding a claim for the tort of false imprisonment can be asserted based on allegations a person was involuntarily held without compliance with the Baker Act).

115. *See e.g.,* Tuten v. Fariborzian, 84 So.3d 1063, 1065 (Fla. Dist. Ct. App. 2012) review denied, 107 So. 3d 407 (Fla. 2012).

#### d. Voluntary Placement Not Option

In Florida, voluntary placement is not an option for a person who does not have capacity or whose illness induces treatment refusals.<sup>116</sup> The Baker Act requires a facility<sup>117</sup> to transfer to involuntary status, or discharge, a patient who is unwilling or unable to provide express and informed consent to mental health treatment.<sup>118</sup> The Baker Act defines express and informed consent as “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 any form of constraint or coercion.”<sup>119</sup> Moreover, the Baker Act prohibits the “voluntary” patient’s surrogate from consenting to the patient’s mental health treatment.<sup>120</sup>

#### e. Involuntary Inpatient and Outpatient Placement

##### *i. Criteria*

Involuntary commitment imposes a serious deprivation of individual liberty, and is only justified when strict criteria are met.<sup>121</sup> In Florida, a person may be placed in involuntary inpatient placement only upon a court’s finding by clear and convincing evidence the following circumstances exist.<sup>122</sup> First,

116. FLA. STAT. § 394.4625(1)(a) (2013).

117. The Baker Act defines facility as “any 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.” FLA. STAT. § 394.455(10) (2013).

118. FLA. STAT. §§ 394.4625(2)(a), 394.4625(5) (2013).

119. FLA. STAT. § 394.455(9) (2013).

120. FLA. STAT. § 394.4625(1)(e) (2013).

121. *Humphrey v. Cady*, 405 U.S. 504, 509 (1972); *Vitek v. Jones*, 445 U.S. 480, 490-92 (1980); *Zinermon v. Burch*, 494 U.S. 113, 131 (1990).

122. FLA. STAT. § 394.467(1)(a) (2013).

the person is mentally ill.<sup>123</sup> Second, because of mental illness, the person refused voluntary admission or is unable to determine for herself whether admission is necessary.<sup>124</sup> Third, the person meets either police power or *parens patriae* commitment criteria.<sup>125</sup> Fourth, “All available less restrictive treatment alternatives which would offer an opportunity for improvement . . . have been judged . . . inappropriate.”<sup>126</sup>

For *parens patriae*, the person must be “manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services.”<sup>127</sup> Moreover, without treatment, it must be likely the person will suffer from neglect or refuse to care for herself.<sup>128</sup> Finally, such neglect must pose a real and present threat of substantial harm to the person’s well-being.<sup>129</sup> For police power commitment, there must be a “substantial likelihood that in the near future [the person] will inflict serious bodily harm on . . . herself or [others], as evidenced by recent behavior.”<sup>130</sup>

“Involuntary outpatient placement . . . is a form of commitment [allowing a person] to be mandated by the court to receive mental health treatment on an outpatient basis.”<sup>131</sup> Involuntary outpatient placement is “used infrequently and provider participation varies.”<sup>132</sup> It is currently available in several Florida counties.<sup>133</sup> Criteria for involuntary outpatient placement “are more difficult to meet than criteria for involuntary inpatient placement.”<sup>134</sup> A court may only order

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123. *Id.*

124. *Id.*

125. *Id.*

126. FLA. STAT. § 394.467(1)(b) (2013).

127. FLA. STAT. § 394.467(1)(a) (2013).

128. *Id.*

129. *Id.*

130. *Id.*

131. DCF Fact Sheet, *supra* note 4.

132. *Id.*

133. *Id.*

134. *Id.*

involuntary outpatient placement upon a finding by clear and convincing evidence that the person: (1) has a mental illness; (2) is unlikely to survive safely in the community without supervision based on a clinical determination; (3) has a history of lack of compliance with treatment; (4) has, within the preceding thirty-six months, (i) at least twice been involuntarily admitted, or (ii) engaged in serious violent behavior or has attempted serious bodily harm to his or her self or others; (5) as a result of mental illness, is unlikely to participate in treatment or has refused treatment after explanation; (6) is in need of involuntary outpatient placement to prevent relapse, or deterioration, likely to result in serious bodily harm to self or others, or substantial harm to the person's well-being; (7) will benefit from involuntary outpatient placement; and (8) all less restrictive alternatives have been adjudged inappropriate or unavailable (involuntary outpatient placement criteria.)<sup>135</sup>

Florida's strict involuntary placement criteria combined with its failure to authorize Ulysses arrangements preclude patients from obtaining timely intervention when an episode has caused treatment refusals. *Tuten v. Fariborzian* illustrates this failure can be fatal.<sup>136</sup> Rebecca Tuten's husband, James, voluntarily admitted himself to a facility after attempting suicide.<sup>137</sup> After three days, James requested release, and doctors discharged him.<sup>138</sup> Two months later, James attempted suicide again and was admitted to a mental health facility.<sup>139</sup> On the third day at the facility, James requested discharge.<sup>140</sup> His physician denied his request because he believed James met involuntary placement criteria.<sup>141</sup> A facility "administrator filed a petition for involuntary placement and a petition for

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135. FLA. STAT. § 394.4655(1) (2013).

136. *Tuten v. Fariborzian*, 84 So.3d 1063, 1065 (Fla. Dist. Ct. App. 2012).

137. *Id.*

138. *Id.*

139. *Id.*

140. *Id.*

141. *Id.*

adjudication of incompetence to consent to treatment pursuant to the Baker Act.”<sup>142</sup> Before the hearing on the petitions, James again requested release.<sup>143</sup> At that time, his physician believed James had improved and was able to function in an available less restrictive environment, no longer meeting involuntary placement criteria.<sup>144</sup> The physician released James.<sup>145</sup> The day after his release, James shot his wife and then fatally shot himself.<sup>146</sup>

Rebecca filed suit against the physician and the facility.<sup>147</sup> She alleged the Baker Act imposed a duty to keep James within the facility until the trial court ruled on the petition.<sup>148</sup> She also argued the physician and the facility owed James a duty of care, apart from the Baker Act, which they breached when they released him.<sup>149</sup> Given the physician’s opinion that James was competent, the First DCA of Florida held involuntary placement would have violated the Baker Act and James’s constitutional rights.<sup>150</sup> The court stated the Baker Act does not impose an affirmative obligation on psychiatrists or facilities to hospitalize a patient or commence proceedings for involuntary placement.<sup>151</sup> They cannot be held liable to those subsequently injured by the patient for failing to do so.<sup>152</sup> As to the alleged common law duty, the court declined to require doctors to be clairvoyant and “to navigate between Scylla and Charybdis, in deciding whether . . . to involuntarily detain and examine a patient.”<sup>153</sup> This is a reference to a Latin proverb, which means

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142. *Id.*

143. *Id.*

144. *Id.* at 1065-1067.

145. *Id.* at 1065.

146. *Id.*

147. *Id.*

148. *Id.*

149. *Id.*

150. *Id.* at 1066.

151. *Id.* at 1068.

152. *Id.*

153. *Id.* at 1067 (quoting *Paddock v. Chacko*, 522 So.2d 410,415 (Fla. Dist. Ct. App. 1988)).



in society's eagerness to avoid one evil, society often falls into a greater evil.<sup>154</sup> There was no common law duty to hospitalize James against his will when his physician believed he had become competent to make his own decision regarding commitment.<sup>155</sup>

However, improperly detaining and hospitalizing a patient exposes the facility, and the physician, to liability for various claims.<sup>156</sup> Florida courts have held health care professionals involuntarily holding a patient—without compliance with the Baker Act—constitutes false imprisonment.<sup>157</sup> Moreover, in Florida, a complaint that alleges that named individuals collaborated in wrongfully initiating and maintaining civil proceedings resulting in involuntary examination, states a cause of action for malicious prosecution.<sup>158</sup> Even when there is no flagrant disregard of Baker Act procedures, the physician may be liable for medical negligence for a wrongful diagnosis that results in improper detention, under the Baker Act.<sup>159</sup> The Baker Act itself allows the patient to file a claim against any person who violates the patient's rights under the Baker Act by, for example, admitting a patient without capacity under voluntary admission procedures.<sup>160</sup> Patients may also have federal civil rights claims under 42 USC §1983 for due process violations if the Florida facility admits the patient without obtaining informed consent or following involuntary placement procedures.<sup>161</sup>

Therefore, Florida incentivizes doctors to release patients in the midst of episodes that induce treatment refusals and

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154. *Id.*

155. *Id.* at 1067-68.

156. *See infra* notes 157-159 and accompanying text.

157. *Everett v. Fla. Inst. of Tech.*, 503 So.2d 1382 (Fla. Dist. Ct. App. 1987); *Liles v. Medfield, Inc.*, 681 So.2d 711, 712 (Fla. Dist. Ct. App. 1995).

158. *Pellegrini v. Winter*, 476 So.2d 1363, 1366 (Fla. Dist. Ct. App. 1985).

159. *Blom v. Adventist Health Sys./Sunbelt, Inc.*, 911 So.2d 211, 215 (Fla. Dist. Ct. App. 2005).

160. FLA. STAT. § 394.459(8)(b) (2013).

161. *Zinerman v. Burch*, 494 U.S. 113, 138-39 (1990).

therefore deters early intervention. As explored in Part II, Florida does not authorize patients to form Ulysses arrangements.<sup>162</sup> In this way, Florida law makes patients victims of their illnesses. Patients cannot obtain intervention once an episode destroys insight but must wait for the episode to produce violence or grave disability, making the patient finally meet involuntary placement criteria.<sup>163</sup> As was the case for James Tuten, prolonging intervention until the time the person meets involuntary placement criteria can be dangerous.<sup>164</sup>

*ii. Procedures*

Florida sets forth procedures that provide due process protections to people subject to involuntary placement.<sup>165</sup> The procedures for outpatient and inpatient placement are substantially similar.<sup>166</sup> First, the administrator of the facility may file with the court a petition for involuntary inpatient or outpatient treatment.<sup>167</sup> The petition must allege each of the required criteria for involuntary placement.<sup>168</sup> The opinion of a psychiatrist and the second opinion of another mental health professional based on the examination of the patient within the preceding seventy-two hours must support the recommendation for involuntary placement.<sup>169</sup>

“Within [one] court working day after the filing of [the] petition . . . the court shall appoint [a] public defender to represent the person . . . unless [that] person is otherwise represented by counsel.”<sup>170</sup> The attorney shall have access to the

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162. FLA. STAT. § 394.467 (2013).

163. *Id.*

164. Tuten v. Fariborzian, 84 So.3d 1063, 1065 (Fla. Dist. Ct. App. 2012).

165. FLA. STAT. §§ 394.4655, 394.467 (2013).

166. FLA. STAT. §§ 394.4655(3), 394.467(3) (2013).

167. FLA. STAT. §§ 394.4655(3)(a)-(b), 394.467(3) (2013).

168. FLA. STAT. §§ 394.4655(3), 394.467(2) (2013).

169. FLA. STAT. §§ 394.4655(2)(a), 394.467(2) (2013).

170. FLA. STAT. §§ 394.4655(4), 394.467(4) (2013).

patient, witnesses, and relevant records.<sup>171</sup> The court shall hold the hearing on involuntary placement within five days of the petition filing.<sup>172</sup> “If the court finds that the patient’s attendance at the hearing is [in]consistent with the best interests of the patient . . . the court may waive the presence of the patient from all or [a portion] of the hearing.”<sup>173</sup> At the hearing, the court shall allow testimony from family and others regarding the patient’s history and condition.<sup>174</sup> “The patient may refuse to testify at the hearing.”<sup>175</sup> If the court concludes the patient meets involuntary placement criteria, the court shall issue an order that shall be for a period up to six months.<sup>176</sup> The facility shall discharge a patient anytime the patient no longer meets involuntary placement criteria.<sup>177</sup> An individual ordered to involuntary inpatient placement may receive services in a state mental health treatment facility or a short-term residential treatment facility.<sup>178</sup> The average length of stay in a state mental health treatment facility is 1.7 years.<sup>179</sup> Spending over a year institutionalized is a massive deprivation of liberty.<sup>180</sup> One wonders if many of these people could avoid such long-term hospitalization if they were able to obtain effective intervention at the outset of an acute episode, before they met involuntary examination criteria.

### *iii. Appointment of Guardian*

At the hearing concerning involuntary outpatient or inpatient placement, “the court shall consider testimony and

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171. *Id.*

172. FLA. STAT. §§ 394.4655(6)(a), 394.467(6)(a) (2013).

173. *Id.*

174. FLA. STAT. § 394.4655(6)(a) (2013).

175. FLA. STAT. §§ 394.467(6)(a), 394.4655(6)(a) (2013).

176. FLA. STAT. §§ 394.467(6)(b), 394.4655(6)(b) (2013).

177. *Id.*

178. DCF Fact Sheet, *supra* note 4.

179. *Id.*

180. *Humphrey v. Cady*, 405 U.S. 504, 506-09 (1972) (civil commitment imposes a massive curtailment of liberty).

evidence regarding the patient's competence to consent to treatment."<sup>181</sup> If the court finds the patient is incompetent to consent to treatment, the court shall appoint a guardian advocate (guardian).<sup>182</sup> The patient has the right to have an attorney represent her at the hearing to appoint a guardian.<sup>183</sup> If the patient is indigent, the court shall appoint a public defender to represent the patient at that hearing.<sup>184</sup> The patient has a right to testify, cross-examine witnesses, and present witnesses at the hearing to appoint a guardian.<sup>185</sup> A mental health professional must testify in support of the involuntary placement.<sup>186</sup> The guardian must agree to the appointment.<sup>187</sup> In selecting a guardian, the court shall give preference to the surrogate if the patient has already designated one.<sup>188</sup> If not, the court shall select a guardian from a priority list, which begins with the spouse.<sup>189</sup> The guardian shall have the same authorities and restrictions as a surrogate designated by the patient in a directive.<sup>190</sup> Unless the guardian has sought and received express court approval in separate proceedings, the guardian may not consent to electroconvulsive therapy or psychosurgery.<sup>191</sup> The court may only grant authority to a guardian to consent to these procedures based on evidence the procedure is essential to the care of the patient and "does not present an unreasonable risk of serious, hazardous, or irreversible side effects."<sup>192</sup> "The guardian . . . shall be discharged when the patient is discharged from an order for

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181. FLA. STAT. § 394.467(d) (2013).

182. FLA. STAT. § 394.4598(1) (2013).

183. *Id.*

184. *Id.*

185. *Id.*

186. *Id.*

187. *Id.*

188. *Id.* § 395.4598(5).

189. *Id.*

190. *Id.* § 395.4598(6).

191. *Id.*

192. *Id.*

involuntary outpatient . . . or . . . inpatient placement, or when the patient is transferred . . . to voluntary status."<sup>193</sup>

2. *Reasons Ulysses Arrangements are Preferable to Involuntary Placement*

In Florida, intervention through a Ulysses arrangement is preferable to involuntary placement for patients, and the State, for several reasons. First, intervention through involuntary placement often comes too late.<sup>194</sup> Research indicates that early intervention at the onset of psychosis greatly improves the odds of the patient's long-term recovery.<sup>195</sup> For patients in the midst of a mental health crisis, time is of the essence. Acute episodes often cause destructive behavior.<sup>196</sup> Patients should not be forced to wait for intervention until the time at which they finally meet involuntary placement criteria.<sup>197</sup> By that time, the episode may have damaged relationships and caused job loss and a criminal record.<sup>198</sup> Moreover, as illustrated in *Tuten v. Fariborzian*, where a discharged patient in the midst of an

193. *Id.* § 395.4598(7).

194. Clausen, *supra* note 1, at 5; Anderson, *supra* note 8, at 801 (quoting patient testimony "when someone is allowed to decompose so severely before they can get help under the Involuntary Treatment Act, they never come back quite the same...").

195. Davoli, *supra* note 1, at 1045 (early intervention at the onset of psychosis improves the odds of long-term recovery).

196. Clausen, *supra* note 1, at n. 29; PETE EARLEY, CRAZY: A FATHER'S SEARCH THROUGH AMERICA'S MENTAL HEALTH MADNESS 2-3 (2006) (asserting the largest public mental health facility in the United States is the Los Angeles County jail); *Mental Health care, Inc. v. Stuart*, 909 So.2d 371, 374 (Fla. Dist. Ct. App. 2005) (there is no duty to warn that a patient may be dangerous, even when the patient is involuntarily committed under the Baker Act because of the "inherent unpredictability associated with mental illness and the near-impossibility of accurately or reliably predicting dangerousness").

197. FLA. STAT. §394.467; 394.4655; Gallagher, *supra* note 13, at 780 (setting forth a sample Ulysses arrangement).

198. See Davoli, *supra* note 1, at 1045 (asserting early intervention at the onset of an episode may prevent erosion of the patient's support system); Bruce Rheinstein, 'No Vacancy' Faces Mentally Ill, DAILY OKLAHOMAN, Oct. 6, 2000, <http://mentallillnesspolicy.org/imd/hospital-bed-shortage-4-states.html> (asserting mental illness prevents many patients from obtaining private insurance through employment and patients must rely on Medicaid to pay for treatment).

episode shot himself and his wife, untreated episodes endanger the patient's safety and the safety of others.<sup>199</sup> The Ulysses arrangement empowers the patient to secure intervention at the onset of an episode, before she meets involuntary placement criteria.<sup>200</sup>

Second, this Article's proposal authorizes patients to form Ulysses arrangements to secure up to three weeks of inpatient treatment.<sup>201</sup> For many patients, three weeks is sufficient to return to full functioning.<sup>202</sup> Relying on the average 4.5 days of treatment in response to an involuntary examination is too risky for patients.<sup>203</sup> In Florida, once seventy-two hours have elapsed from arrival at the facility, doctors must release a patient who refuses treatment unless she meets involuntary examination criteria.<sup>204</sup> After seventy-two hours, many patients will no longer meet the strict criteria but will nonetheless be in the midst of an episode that continues to cause them to refuse treatment.<sup>205</sup> Once released, these vulnerable patients will likely fail to recognize their need for treatment, continue to refuse intervention, and continue to deteriorate.<sup>206</sup>

Third, Ulysses arrangements empower patients to secure less time-consuming and less intrusive intervention than involuntary inpatient placement. This is because the Ulysses arrangement enables the patient to obtain intervention before the patient meets involuntary placement criteria. Through the arrangement, the patient can prevent further deterioration of her

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199. Tuten v. Fariborzian, 84 So.3d 1063, 1065 (Fla. Dist. Ct. App. 2012).

200. Clausen, *supra* note 1, at n. 3-4.

201. *See infra* Part III.

202. Rebecca S. Dresser, *Ulysses and the Psychiatrists: A Legal and Policy Analysis of the Voluntary Commitment Contract*, 16 HARV. C.R.-C.L. L. REV. 777, n. 3 (1982) (stating that for example in Sweden a medical director may lay down a condition for admission that the patient shall not be permitted to leave within three weeks of admission, even if he desired to do).

203. DCF Fact Sheet, *supra* note 4.

204. FLA. STAT. § 394.463(f) (2013).

205. *See e.g.*, Tuten v. Fariborzian, 84 So.3d 1063, 1065 (Fla. Dist. Ct. App. 2012).

206. *Id.*

cognitive functions resulting from leaving an episode untreated.<sup>207</sup> Early intervention returns the patient to full capacity sooner.<sup>208</sup> Involuntary inpatient placement criteria force the patient, whose illness has caused her to refuse treatment, to delay intervention until she is essentially dangerous.<sup>209</sup> Self-binding treatment will likely return the patient's capacity within three weeks.<sup>210</sup> Conversely, the average length of stay in a state mental health treatment facility is 1.7 years.<sup>211</sup> Many patients could avoid this significant intrusion into their lives if overriding their illness-induced refusals and obtaining early intervention were possible.

Fourth, intervention through a Ulysses arrangement is likely to be more therapeutic than involuntary inpatient placement. The Ulysses arrangement empowers the patient to secure treatment from the patient's regular psychiatrist, who understands the patient's illness and history in a facility the patient chooses.<sup>212</sup> A person is most likely to receive the best care from providers who have treated the person in the past.<sup>213</sup> Baker Act receiving facilities are both public and private hospitals.<sup>214</sup> There are approximately 2,600 beds in private hospitals for adults and 659 beds in public hospitals for adults.<sup>215</sup> There have been many complaints about the treatment in public hospitals.<sup>216</sup> As one patient advocate said about the South Florida State Hospital, "People there are not getting any

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207. Davoli, *supra* note 1, at 1045.

208. *Id.*

209. FLA. STAT. § 394.467(1)(a) (2013).

210. Dresser, *supra* note 202, at n. 3.

211. DCF Fact Sheet, *supra* note 4.

212. Bruce J. Winick, *Advance Directive Instruments for Those with Mental Illness*, 51 U. MIAMI L. REV. 57, 83 (1996). [hereinafter *Advance Directive Instruments*].

213. *Id.* at 72.

214. DCF Fact Sheet, *supra* note 4.

215. *Id.*

216. See Jenni Bergal, *Mental Hospital's Cost Per Patient Leads State*, SUN SENTINEL, Feb. 27, 1990, [http://articles.sun-sentinel.com/1990-02-27/news/9001260683\\_1\\_mental-hospitals-patient-florida-state-hospital](http://articles.sun-sentinel.com/1990-02-27/news/9001260683_1_mental-hospitals-patient-florida-state-hospital).

treatment. They smoke and they eat. It's ridiculous."<sup>217</sup> In 2012 the First DCA of Florida said, "It has been recognized that mental illness may be caused or intensified by institutionalizing mental patients."<sup>218</sup> Therefore, the practice of psychiatry is no longer limited to institutionalizing people with mental illness.<sup>219</sup> Institutionalized patients may be less likely to heal as quickly because of sleep deprivation and stress brought on by the noise and behaviors of fellow patients.<sup>220</sup>

Fifth, Ulysses arrangements enable patients to avoid the trauma of involuntary inpatient placement.<sup>221</sup> There is some evidence involuntarily committed patients are at risk for abuse from other patients and from staff.<sup>222</sup> Decades ago, it was the deplorable conditions of the Florida State Hospital in Chattahoochee (Chattahoochee), which was the subject of the landmark case *O'Connor v. Donaldson*,<sup>223</sup> that gave momentum to

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217. *Id.*

218. *Tuten v. Fariborzian*, 84 So.3d 1063, 1067 (Fla. Dist. Ct. App. 2012).

219. *Id.*

220. *Tuten*, 84 So.3d at 1067 (citing *Paddock v. Chacko*, 552 So.2d 410, 413-14 (Fla. Dist. Ct. App. 1988) for the following, "mental illness may be caused or intensified by institutionalizing mental patients"); *See also*, *Civil Commitment of the Mentally Ill*, 87 HARV. L. REV 1190, 1195-97 (1974) (stating, "Hospitalization itself interferes with privacy, since the patient cannot shield himself from constant observation by both his fellow patients and staff").

221. *Tuten*, 84 So.3d at 1067; Clausen, *supra* note 1, at 13.

222. Carol M. Miller, *Florida Hospital Ignores Pregnant Mental Patient's Pleas, and Tragedy Ensues*, MIAMI HAROLD, June 2, 2012, <http://www.miamiherald.com/incoming/article1940320.html> (outlining story of neglect of pregnant mental health patient in Chattahoochee, resulting in death of newborn child); Britney Jones, *Exclusive: Witness Speaks Out About Abuse at Florida State Hospital*, Sept. 4, 2013, [http://www.wtxl.com/news/exclusive-witness-speaks-out-about-abuse-at-fla-state-hospital/article\\_e8a80a84-15bd-11e3-8e6d-0019bb30f31a.html](http://www.wtxl.com/news/exclusive-witness-speaks-out-about-abuse-at-fla-state-hospital/article_e8a80a84-15bd-11e3-8e6d-0019bb30f31a.html) (an anonymous witness told reporters staff at Chattahoochee were abusing residents and some of the residents were beaten and sexually abused); Beverly Stracher, *Report Assails Mental Hospital*, SOUTH FLORIDA-SENTINEL, Oct. 6, 1988, [http://articles.sun-sentinel.com/1988-10-06/news/8802280198\\_1\\_two-dozen-patients-psychiatric-rehabilitation-advocacy-center](http://articles.sun-sentinel.com/1988-10-06/news/8802280198_1_two-dozen-patients-psychiatric-rehabilitation-advocacy-center) (asserting advocacy group denounced conditions at South Florida State Hospital and accused staff of allowing patients to go without clothing, ridiculing and abusing patients and providing no rehabilitation).

223. *O'Connor v. Donaldson*, 422 U.S. 563, 574-575 (1975); *see also* *Freundak v. United States*, 408 A.2d 364, 376 (D.C. Cir. 1979) ("Furthermore, patients in [State] hospitals risk brutality at the hands of their fellow residents and even their



the deinstitutionalization movement, causing the closure of many state mental health institutions in the United States. Although conditions in Florida's mental health hospitals have improved, allegations of abuse and neglect remain. For example, in 2013, an anonymous witness told reporters that some staff in Chattahoochee physically abused patients.<sup>224</sup> Similarly, in 2011, a Chattahoochee patient alleged a nurse neglected to care for her when she was pregnant, resulting in the death of her child.<sup>225</sup> At thirty-eight weeks pregnant, the patient went into labor.<sup>226</sup> The attending nurse ignored her calls for help.<sup>227</sup> The patient called authorities, but the hospital staff told authorities no intervention was necessary.<sup>228</sup> Ultimately, she was airlifted to another facility.<sup>229</sup> "The baby came out on the helicopter, attached to the mother, with the head on the floor with everyone looking at the baby on the floor of the helicopter not breathing."<sup>230</sup> The child had no brain activity and died when he was eight months old.<sup>231</sup>

Sixth, Ulysses arrangements enable people to avoid the dehumanizing experience of commitment hearings.<sup>232</sup> The Baker Act permits a judge to excuse the patient from the hearing if his presence could damage the patient's health.<sup>233</sup> This is an implicit recognition that involuntary placement hearings can be demeaning for patients.<sup>234</sup> The Baker Act expressly permits

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attendants").

224. Jones, *supra* note 222.

225. Lynn Hatter, *Family Speaks Out After Florida State Mental Hospital Nurse Charged with Neglect*, Oct. 26, 2012, <http://news.wfsu.org/post/family-speaks-out-after-fla-state-mental-hospital-nurse-charged-neglect>; Miller, *supra* note 222.

226. *Id.*

227. *Id.*

228. *Id.*

229. *Id.*

230. Hatter, *supra* note 225.

231. *Id.*

232. Clausen, *supra* note 1, at 14; *Advance Directive Instruments*, *supra* note 212, at 68-69.

233. FLA. STAT. §§ 394.4655(6)(a), 394.467(6)(a) (2013).

234. *Id.*

family and other individuals to testify at involuntary placement hearings.<sup>235</sup> Therefore, patients at involuntary placement hearings often endure the humiliating experience of witnessing loved ones testify about erratic behaviors caused by an episode.<sup>236</sup>

Seventh, Ulysses arrangements empower patients to avoid guardianship proceedings. As explained above, the Baker Act provides for the initiation of guardianship proceedings if the involuntarily committed patient is unable to consent to treatment.<sup>237</sup> Incompetency adjudications, a form of deviance labeling, have seriously detrimental societal consequences and cause significant psychological damage to the ward.<sup>238</sup> Some psychiatrists posit “guardianship poses a danger of harming the patient’s civil rights, autonomy, and independence,” and should be recommended “only as a last resort for patients who are severely incompetent.”<sup>239</sup> The Ulysses arrangement empowers the patient to designate a surrogate who can administer the patient’s self-authored intervention plan.<sup>240</sup> The patient can then avoid the humiliating experience of guardianship proceedings.

Eighth, Ulysses arrangements potentially preserve scarce judicial and public defender resources in Florida. Involuntary placement is time-consuming and expensive for courts and public defenders.<sup>241</sup> Adjudicatory hearings strain already overcrowded dockets of Florida courts.<sup>242</sup> Representing clients subject to involuntary placement burdens already overworked

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235. FLA. STAT. § 394.4655(6)(a) (2013).

236. *Id.*

237. FLA. STAT. § 394.4598(1) (2013).

238. Robert D. Miller, *Advance Directives for Psychiatric Treatment: A View from the Trenches*, 4 PSYCHOL. PUB. POL’Y & LAW 728, 736 (1998).

239. Clausen, *supra* note 1, at 20; Yuval Melamed et al., *Guardianship for the Severely Mentally Ill*, 19 MED. & L. 321, 325 (2000).

240. Clausen, *supra* note 1, at 55-56.

241. DCF Fact Sheet, *supra* note 4 (asserting involuntary examinations are on the rise and have increased 50% in the last 10 years resulting in 150,000 in 2011; approximately 10% of these involuntary examinations result in a hearing).

242. FLA. STAT. §§ 394.4655(6), 394.467(6) (2013).

public defenders.<sup>243</sup> Some of these clients would not need state subsidized legal representation if they could prevent involuntary placement through a Ulysses arrangement.<sup>244</sup>

Ninth, Ulysses arrangements provide for more cost-effective intervention for whoever shoulders the financial burden. Many patients with Ulysses arrangements will obtain intervention in private hospitals of their choosing.<sup>245</sup> In these instances, the taxpayer does not shoulder the cost of care.<sup>246</sup> Because mental illness may disrupt the ability to obtain employment and preclude employment sponsored private insurance, some patients may receive treatment through Medicaid or at a state hospital.<sup>247</sup> Regardless of who pays, intervention through a Ulysses arrangement is less expensive than involuntary placement.<sup>248</sup> This is because Ulysses arrangement intervention occurs early and can be accomplished with a shorter hospital stay.<sup>249</sup> When intervention is delayed until the time the person meets involuntary placement criteria, the episode will have had a more serious impact on cognitive functions.<sup>250</sup> This may be why the average length of stay in a

243. *Id.*; Karen Houppert, *Legal Aid for Indigent Clients Needs Help*, WASH. POST, Mar. 15, 2013, [http://www.washingtonpost.com/opinions/legal-aid-for-indigent-clients-needs-help/2013/03/15/65dcbe56-8cc9-11e2-b63f-f53fb9f2fcb4\\_story.html](http://www.washingtonpost.com/opinions/legal-aid-for-indigent-clients-needs-help/2013/03/15/65dcbe56-8cc9-11e2-b63f-f53fb9f2fcb4_story.html).

244. Clausen, *supra* note 1, at 61.

245. *See* Clausen, *supra* note 1, at 13-14; Stracher, *supra* note 222.

246. Bergal, *supra* note 216.

247. Rheinstein, *supra* note 198; Dylan Scott, *Study: Medicaid Improves Mental But Not Physical Health*, May 2, 2013, <http://www.governing.com/news/state/gov-study-medicaid-improves-mental-wellbeing-but-not-physical-health.html> (asserting uninsured adults who receive Medicaid coverage, as many will under the Affordable Care Act, experience substantial improvement in their mental well-being according to report from researchers at Harvard School of Public Health and The Massachusetts Institute of Technology).

248. *See* Bergal, *supra* note 216; Dylan Scott, *supra* note 247.

249. Scott, *supra* note 247 (supporting states accepting Medicaid expansion because "if people are covered, they'll be able to nip things in the bud and get treatment earlier," says Debbie Plotnick, senior director of state policy at Mental Health America, an advocacy group).

250. *Id.* (urging states like Florida to accept the Affordable Care Act's Medicaid expansion "especially for people with mental health conditions, the further upstream you can step in and intervene, the better the outcomes for the patients").

state mental health hospital is 1.7 years.<sup>251</sup>

Finally, Ulysses arrangements are a needed alternative to involuntary placement because there is a shortage of psychiatric hospital beds.<sup>252</sup> Florida ranks forty-ninth of all fifty states in its spending per capita on mental health agencies.<sup>253</sup> The National Alliance on Mental Illness found “Florida residents face ‘uphill battles [in getting] appropriate care’ . . . partly because [Florida] has a shortage of inpatient psychiatric beds. Many of these beds are used to ‘restore competency’ for people facing criminal charges.”<sup>254</sup> Empowering patients to prevent involuntary placement through Ulysses arrangements would enable public mental health hospitals to focus on restoring competency.

## II. FLORIDA’S FAILURE TO PROVIDE THE ULYSSES ARRANGEMENT OPTION

This Section first sets forth components of a Ulysses enabling statute. Then this Section explores why Florida’s generic directive statute does not provide patients with the Ulysses arrangement option.

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251. DCF Fact Sheet, *supra* note 4.

252. Mary Zdanowicz and Bruce Rheinstein, *Florida’s Mentally Ill Left Out in the Cold*, ORLANDO SENTINEL (Mar. 23, 2000), <http://mentallillnesspolicy.org/imd/hospital-bed-shortage-4-states.html> (Florida threatening to close 350 hospital beds for the most severely mentally ill citizens; a person in Florida with severe mental illness is five times more likely to be behind bars than receiving treatment in a state hospital; there are at least 15,870 inmates in Florida’s jails who are mentally ill; the Miami Dade County jails alone hold nearly 1000 mentally ill inmates many of whom are locked up because of behavior caused by untreated illness).

253. *Mental Health Spending: State Agency Totals*, GOVERNING, <http://www.governing.com/gov-data/mental-health-spending-by-state.html> (last visited Jan. 8, 2015).

254. Kevin A. Kepple, *Mental Health Grades by State*, USA TODAY (Jan. 8, 2013 10:13 PM), [http://www.usatoday.com/story/news/nation/2013/01/07/states-mental-health/1805023/\(reporting from National Alliance on Mental Illness that Florida residents face uphill battles to get care partly because the state has a shortage of inpatient psychiatric beds, many of which are used to restore competency for people facing criminal charges\).](http://www.usatoday.com/story/news/nation/2013/01/07/states-mental-health/1805023/(reporting%20from%20National%20Alliance%20on%20Mental%20Illness%20that%20Florida%20residents%20face%20uphill%20battles%20to%20get%20care%20partly%20because%20the%20state%20has%20a%20shortage%20of%20inpatient%20psychiatric%20beds,%20many%20of%20which%20are%20used%20to%20restore%20competency%20for%20people%20facing%20criminal%20charges))

## A. COMPONENTS OF A ULYSSES ENABLING STATUTE

Before illustrating how Florida deprives patients of the Ulysses arrangement tool, it is necessary to describe the essential components of a Ulysses enabling statute. First, the enabling statute must allow patients to choose whether their directives will be revocable when they lack capacity.<sup>255</sup> For a patient to form a self-binding arrangement, she must be able to create a directive that is irrevocable when an episode has destroyed her capacity.<sup>256</sup> To obtain intervention, the patient must be able to prevent herself from: (1) refusing care to which she has consented in the arrangement, and (2) revoking the arrangement when an episode causes her to do so.<sup>257</sup>

Simply allowing patients to form irrevocable directives does not empower patients to form Ulysses arrangements. The enabling statute must have a process to ensure patients who form Ulysses arrangements do so knowingly and voluntarily.<sup>258</sup> Moreover, the enabling statute must set forth procedural protections for administering treatment in the face of contemporaneous objections.<sup>259</sup> Without a well-defined process and clear authority, a doctor will not force treatment on a refusing patient based only on consent provided in an irrevocable directive.<sup>260</sup> Even with the typical statutory grant of provider immunity, doctors will be justifiably concerned about liability for unlawfully administering involuntary treatment.<sup>261</sup>

Physician reluctance to treat in the face of patient refusals is not the paramount concern. A more serious concern involves risks of coercion, undue influence, and fraud when doctors

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255. Clausen, *supra* note 1, at 27; Roberto Cuca, *Ulysses in Minnesota: First Steps Toward a Self-Binding Psychiatric Advance Directive Statute*, 78 CORNELL L. REV. 1152, 1173 (1993).

256. Cuca, *supra* note 255, at 1173.

257. *Id.*

258. *Id.*

259. *Id.* at 1181-1185.

260. *See supra* notes 156-161 and accompanying text.

261. *Id.*

forcibly hospitalize and treat a patient, even when the patient does not meet involuntary placement criteria.<sup>262</sup> The enabling statute must provide procedural protections to ensure doctors implement arrangements in strict compliance with patient instructions.

Finally, the enabling statute should provide patients the option to arrange for transportation to a facility. Episodes that cause treatment refusals also cause patients to refuse transportation to a hospital.<sup>263</sup> If the patient is unable to obtain transportation in contravention of refusals, she cannot secure intervention through her Ulysses arrangement.

## B. FLORIDA'S GENERIC DIRECTIVE STATUTE

### 1. *Purports to Address Mental Health*

Half of the states recognize that mental illness implicates different issues than end-of-life treatment and have enacted separate mental health directive statutes.<sup>264</sup> Florida has not enacted a separate mental health directive statute, but relies on a generic directive statute to govern advance planning for end-of-life and mental health treatment.<sup>265</sup> The Florida statutory scheme entitled Health Care Advance Directives (Florida's generic directive statute) purports to address all types of advance health care planning, including planning for mental illness.<sup>266</sup> For example, Florida's generic directive statute defines an advance directive as a document or statement in which the principal gives instructions or designates a surrogate to address

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262. Dresser, *supra* note 202, at 800.

263. *Moraes v. Horizons of the Treasure Coast, Inc.*, 2013 WL 4009438 (S.D. Fla.).

264. Clausen, *supra* note 1, at 24-25, n.213 (listing Arizona, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Montana, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Washington, and Wyoming).

265. FLA. STAT., Ch. 765 (2013).

266. FLA. STAT. § 765.101(1) (2013) (defining advance directive to include instructions concerning any aspect of health care).

*any aspect* of the principal's health care.<sup>267</sup> The statute defines a health care decision to encompass informed consent, refusal, or "withdrawal of consent to *any and all* health care, including life-prolonging procedures and *mental health treatment*."<sup>268</sup> Finally, the Florida generic directive statute addresses a few issues unique to mental illness. For example, the statute prohibits a surrogate from authorizing the principal's electroshock therapy, psychosurgery, or voluntary admission to a mental health facility without express authority from the principal or court approval.<sup>269</sup>

Despite the fact Florida's generic directive statute purports to address advance planning for mental illness, the statute focuses primarily on end-of-life treatment.<sup>270</sup> For example, the legislative findings address end-of-life and palliative care but do not mention mental health treatments.<sup>271</sup> Moreover, the statute gives instructions for the creation of living wills.<sup>272</sup> The statute does not even mention, much less give instructions for, creating mental health directives.<sup>273</sup> The statute defines a living will as a declaration directing "the providing, withholding or withdrawal of *life-prolonging procedures* in the event that such person has a *terminal condition, has an end-stage condition, or is in a persistent vegetative state*" or "a witnessed oral statement . . . expressing the principal's instructions concerning *life-prolonging procedures*."<sup>274</sup> As defined in Florida, living wills do not address any issues faced by people with episodic mental illness.<sup>275</sup>

The entire generic directive statute is divided into five parts, each of which contains several statutory sections.<sup>276</sup> Of

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267. FLA. STAT. § 765.101(1) (2013).

268. FLA. STAT. § 765.101(5)(a) (2013).

269. FLA. STAT. § 765.113(1) (2013) (emphasis added).

270. FLA. STAT. § 765.102 (2013).

271. *Id.*

272. FLA. STAT. § 765.302 (2013).

273. FLA. STAT., ch. 765 (2013).

274. FLA. STAT. §§ 765.101(11), 765.302(1) (2013) (emphasis added).

275. FLA. STAT. § 765.101(11) (2013).

276. FLA. STAT., ch. 765 (2013).

these five parts, one concerns life-prolonging procedures.<sup>277</sup> Another concerns anatomical gifts.<sup>278</sup> Moreover, there is a statutory section concerning persistent vegetative states.<sup>279</sup> There is no part or section concerning mental health directives.<sup>280</sup> This is another example of the generic directive statute's focus on end-of-life treatment, not episodic mental illness.<sup>281</sup>

Although there are other ways in which the Florida generic directive statute fails people with mental illness,<sup>282</sup> this Article explores its failure to empower patients to form Ulysses arrangements. The key reasons the statute fails to empower Ulysses arrangements are explored in this Section. First, Florida does not enable patients to determine whether their directives are revocable when they lack capacity.<sup>283</sup> Second, Florida fails to provide safeguards to ensure Ulysses arrangements are formed knowingly and voluntarily.<sup>284</sup> Third, Florida does not provide authority and a well-defined process for administering treatment in the face of contemporaneous refusals.<sup>285</sup> Finally, patients have no mechanism to arrange for transportation to a facility to obtain intervention pursuant to a Ulysses arrangement.<sup>286</sup>

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277. FLA. STAT. §§ 765.301-765.309 (2013).

278. FLA. STAT. §§ 765.510-765.547 (2013).

279. FLA. STAT. § 765.404 (2013).

280. FLA. STAT., ch. 765 (2013).

281. *Id.*

282. *See e.g.*, FLA. STAT. § 765.113 (2013) (prohibiting a surrogate from consenting to the principal's voluntary admission to a mental health facility absent express written authority from the principal. This arbitrary limitation on a surrogate's ability to consent to the principal's inpatient treatment could result in principals not receiving care they need and to which they consented. It essentially requires the principal to use magic words conveying authority to a surrogate. This imposes a unique burden only on people with mental illness). For further discussion, *see* Clausen, *supra* note 1, at 25-26 (discussing *Cohen v. Bolduc*, 760 N.E 2d 714, 715 (2002)).

283. FLA. STAT. § 765.104(1) (2013).

284. *See infra* p. 65.

285. FLA. STAT., ch. 765 (2013).

286. *Id.*



## 2. *Inadequate Safeguards to Ensure Voluntary Formation*

### a. No Choice Regarding Revocation

The Florida generic directive statute requires the principal to be competent (or have capacity) to revoke or amend her directive or designate a surrogate.<sup>287</sup> Florida fails mental health patients when it deprives them of the right to designate whether they can revoke their directives when they lack capacity.<sup>288</sup> Ulysses arrangements only protect patient autonomy if they are formed knowingly and voluntarily.<sup>289</sup> No patient should have an irrevocable directive as her only advance planning option. There is a legitimate concern that family and providers will use Ulysses arrangements as coercive tools to force treatment on vulnerable patients.<sup>290</sup> Doctors implement Ulysses arrangements without the due process protections afforded in civil commitment.<sup>291</sup> To ensure the patient wishes doctors to administer treatment despite objections, the patient must have the right to choose whether her directive remains revocable when she lacks capacity. A key reason Florida does not have a process to support Ulysses arrangements is Florida fails to ensure that when patients form irrevocable directives, they do so knowingly and voluntarily.<sup>292</sup> Florida patients do not have the option to revoke directives when they lack capacity.<sup>293</sup> A patient without this option cannot make a knowing and voluntary decision as to whether her directive should remain revocable

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287. In this way, Florida departs from the majority of state generic directive statutes which allow patients to revoke their generic directives even when they lack capacity. However, the majority of states with specialized mental health directive statutes also require capacity for revocation. See Clausen *supra* note 1, at 29-31.

288. FLA. STAT. § 765.104(1) (2013).

289. Cuca, *supra* note 255, at 1172.

290. Dresser, *supra* note 202, at 852; *Advance Directive Instruments*, *supra* note 212, at 87, 94.

291. Dresser, *supra* note 202, at 800.

292. FLA. STAT. § 765.104 (2013).

293. FLA. STAT. § 765.104(1) (2013).

when she lacks capacity.<sup>294</sup>

#### b. Requirement for a Signed, Witnessed Writing

Whether a principal may orally designate a surrogate or issue health care instructions is debatable in Florida.<sup>295</sup> Florida's generic directive statute defines an advance directive as "a witnessed written document or [*an*] *oral statement* in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care, [including] . . . designation of a . . . surrogate."<sup>296</sup> The statutory definition implies principals may issue oral instructions and may orally designate surrogates.<sup>297</sup> However, the Florida generic directive statutory section governing designation of a surrogate states a written document designating a surrogate must be signed by the principal in the presence of two adult witnesses.<sup>298</sup> The statute also precludes the surrogate from acting as a witness and requires at least one witness to be unrelated to the principal.<sup>299</sup> Some Florida courts have interpreted this provision to require designations of surrogates to be in a signed, witnessed writing.<sup>300</sup> However,

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294. *Id.*; See Clausen *supra* note 1, at 30 (asserting restricted revocation only for mental health directives deters patients from advance planning because almost half of patients surveyed indicated they wanted the authority to revoke their mental health directives when they lack capacity. Such patients will avoid forming directives if they can only form irrevocable directives).

295. FLA. STAT. § 765.101(1) (2103).

296. *Id.*

297. *Id.*

298. FLA. STAT. § 765.202(1) (2013).

299. FLA. STAT. § 765.202(2) (2013).

300. See generally *Estate of Jenner v. Manor Pines Convalescent Center, L.L.C.*, 112 So.3d 648, 649-650 (Fla. Dist. Ct. App. 2013) ("holding designation of surrogate executed by nursing home resident which named resident's husband as surrogate was not completed in conformance with the statutory requirements and did not grant husband authority to enter into nursing home agreement for the care of the resident. The court stated FLA. STAT. § 765.202 governs the means by which an individual may designate a surrogate and requires a writing signed by the principal in the presence of two witnesses, or a principal unable to sign the instrument may in the presence of witnesses, direct another person to sign the principal's name. The court found the designation of the husband as surrogate was not completed in

arguably, the definition of advance directives seems to authorize oral instructions and designations of surrogates.<sup>301</sup> Moreover, the fact the Florida generic directive statute authorizes patients to *orally* amend or revoke their directives supports the interpretation allowing patients to orally designate a surrogate and issue health care instructions.<sup>302</sup>

With its focus on end-of-life, the Florida generic directive statute fails to provide guidance on the creation of a mental health directive.<sup>303</sup> Rather, it specifies the procedures for creating a living will.<sup>304</sup> A living will is a witnessed writing or oral statement directing the providing, withholding, or withdrawing of life-prolonging procedures in the event the principal has a terminal condition, an end-stage condition, or is in a persistent vegetative state.<sup>305</sup> According to this definition, living wills do not include mental health directives which do not address end-of-life care, but treatment to be administered during mental illness episodes.<sup>306</sup> Therefore, Florida fails to provide adequate guidance on forming a directive that contains instructions about mental health treatment or designates a surrogate to direct the patient's mental health care.<sup>307</sup> Moreover, it completely fails to address the procedures for forming a Ulysses arrangement through which a patient directs mental health treatment to be administered despite her illness-induced refusals.<sup>308</sup>

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conformance with FLA. STAT. § 765.202 because the husband testified he signed the designation for his wife. He did not indicate he did so in front of witnesses. He seemed to indicate his wife did not have the capacity at the time to make any decisions, much less the decision to appoint a surrogate." See Clausen, *supra* note 1, at note 301).

301. FLA. STAT. § 765.101(1) (2013).

302. FLA. STAT. § 765.104(1)(c) (2013).

303. FLA. STAT., ch. 765 (2013).

304. FLA. STAT. §§ 765.302-765.304 (2013).

305. FLA. STAT. § 765.101(11) (2013).

306. Richard A. Van Dorn et. al., *Reducing Barriers to Completing Psychiatric Advance Directives*, 35 ADMIN. POL'Y MENTAL HEALTH 440, 441 (2008).

307. FLA. STAT., ch. 765 (2013).

308. *Id.*

Although allowing patients to issue oral instructions and orally designate a surrogate makes sense in the end-of-life context, it is problematic in the context of Ulysses arrangements.<sup>309</sup> When a clinician implements a Ulysses arrangement, she treats the patient despite the patient's contemporaneous refusals.<sup>310</sup> It is essential that there is clear evidence the patient formed the Ulysses arrangement free from undue influence, coercion, or fraud. Mental illness can leave loved ones desperate to conquer the patient's illness.<sup>311</sup> That is why scholars have expressed concern about the potential for family members to use the Ulysses arrangement to coerce a desired treatment on a patient.<sup>312</sup> Mental health patients are especially vulnerable to undue influence and coercion because of their concern over involuntary commitment and forced treatment.<sup>313</sup> Therefore, Ulysses arrangements should only be implemented when they are embodied in a signed, witnessed writing. When a disinterested witness attests that the patient provided identification and did not appear to be under duress, there is a safeguard against fraud, coercion, or undue influence.<sup>314</sup>

Mental health treatment is especially susceptible to health care fraud for several reasons.<sup>315</sup> First, Florida courts have recognized the practice of psychiatry is subjective.<sup>316</sup> This

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309. FLA. STAT. § 765.101(1) (2013).

310. Gallagher, *supra* note 13, at 780 (setting forth a sample Ulysses arrangement).

311. Dresser, *supra* note 202, at 851-852; *Advance Directive Instruments*, *supra* note 212, at 58, 88.

312. Dresser, *supra* note 202 at 852; *Advance Directive Instruments*, *supra* note 212, at 87.

313. Bruce J. Winick, *Outpatient Commitment: A Therapeutic Jurisprudence Analysis*, 9 PSYCHOL. PUB. POL'Y & L. 107, 112 (2003).

314. *See infra* Part III.

315. Elizabeth A. Rosenfeld, *Mental Health Advance Directives: A False Sense of Autonomy for the Nation's Aging Population*, 9 ELDER L. J. 53, 77 (2001); Pamela H. Bucy, *Healthcare Fraud and the False Claims Act*, A.B.A. CTR. CONTINUING LEGAL EDUC. 9 at 6-7 (1998).

316. *Paddock v. Chacko*, 552 So.2d 410, 414 (Fla. Dist. Ct. App. 1988) (stating, "The science of psychiatry represents the penultimate gr[a]y area" and "[a]

subjectivity makes it easier for providers to administer unnecessary treatment.<sup>317</sup> Second, mental health patients whose capacities often fluctuate may be less able to chronicle their treatment than patients with physical illness.<sup>318</sup> Finally, patient confidentiality is of paramount importance in mental health care.<sup>319</sup> This cloak of secrecy makes health care fraud more difficult to detect.<sup>320</sup> A clinician with a financial interest in administering treatment should not administer mental health treatment in contravention of a patient's objections when the patient does not meet involuntary placement criteria without clear evidence the patient wanted treatment despite refusals.<sup>321</sup> A writing requirement helps prevent clinicians from fraudulently claiming the patient orally requested to receive treatment despite objections. Moreover, even when the clinician has no fraudulent intention, it is easy for a surrogate or a clinician to recollect incorrectly an oral statement or to misinterpret the patient's oral statement.<sup>322</sup> Written statements are much less susceptible to misinterpretation and cannot be recollected incorrectly.

A requirement for a signed, witnessed writing also protects clinicians who implement Ulysses arrangements from liability for fraudulent claims they unlawfully forced treatment on a patient. When a clinician implements a Ulysses arrangement, he treats in contravention of the patient's objections<sup>323</sup> and is vulnerable to claims he unlawfully forced treatment on the patient. The written, signed, and witnessed Ulysses

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substantial body of literature suggests that the psychiatric field cannot even agree on [an] appropriate diagnosis, much less [a recommended] course of treatment") (quoting *Nesbitt v. Cmty. Health of South Dade, Inc.*, 467 So.2d 711, 717 (Fla. Dist. Ct. App. 1985)).

317. Bucy, *supra* note 315, at 6.

318. *Id.*

319. *Id.*

320. *Id.*

321. See Clausen, *supra* note 1, at 48-49.

322. *Id.* at 36-37.

323. Andreou, *supra* note 9, at 1.

arrangement provides a record that the patient requested treatment despite illness-induced refusals and protects clinicians from fraudulent claims. Therefore, as explored in Part III, Florida should adopt legislation authorizing patients to form Ulysses arrangements and require those arrangements to be evidenced by a written, signed, and witnessed instrument.

### c. No Requirement for Capacity Assessment

Florida does not require a principal to have an assessment of her capacity or competence in order to form an advance directive, which either issues health care instructions or designates a surrogate.<sup>324</sup> The Florida generic directive statute states the “principal is presumed to be capable of making health care decisions for herself or himself unless she or he is determined to be incapacitated.”<sup>325</sup> Moreover, “[I]ncapacity may not be inferred from the person’s voluntary or involuntary hospitalization for mental illness or from her or his intellectual disability.”<sup>326</sup> In Florida, only competent (which in Florida is synonymous with having capacity) adults may form advance directives.<sup>327</sup> This is because Florida defines a principal to be “a competent adult executing an advance directive”<sup>328</sup> and defines an advance directive as written or oral instructions given by a principal.<sup>329</sup> A living will or designation of a surrogate formed pursuant to the Florida generic directive statute “establishes a rebuttable presumption of clear and convincing evidence of the principal’s competent wishes.”<sup>330</sup> Unless the principal’s capacity to make health care decisions is called into question, there is no requirement for an assessment of competence/capacity at the

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324. FLA. STAT. §§ 765.202(1), 765.101(1) (2013).

325. *Id.* § 765.204(1).

326. *Id.*

327. *Id.* § 765.101(14).

328. *Id.*

329. *Id.* § 765.101(1).

330. *Id.* §§ 765.302(3), 765.202(7).

time of directive formation.<sup>331</sup>

Ulysses arrangements are different than other forms of mental health directives, such as directives refusing certain mental health treatments.<sup>332</sup> Ulysses arrangements are instruments of self-paternalism and self-coercion.<sup>333</sup> The arrangement respects the patient's self-determination by empowering her to control her treatment even during episodes that induce her to refuse intervention.<sup>334</sup> To prevent family and providers from using Ulysses arrangements as coercive instruments to force treatment on a patient,<sup>335</sup> there must be clear evidence the patient formed the arrangement when she had capacity. Therefore, there should be a requirement for a physician assessment and attestation of the patient's capacity at the time of Ulysses arrangement formation. Florida's failure to require such capacity assessment and attestation is another way in which it deprives patients of the Ulysses arrangement option and fails to ensure such arrangements are formed voluntarily and only by patients with capacity.<sup>336</sup>

#### d. No Automatic Expiration

Although states typically do not require automatic expiration of generic directives, many states with specialized mental health directive statutes impose automatic expiration of mental health directives after a specified time frame, usually between two and five years.<sup>337</sup> At the end of this time frame,

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331. *Id.* § 765.204(2).

332. *See, e.g., In re Rosa M.*, 597 N.Y.S.2d 544 (1991) (concerning patient's mental health directive refusing ECT).

333. Dresser, *supra* note 202, at 784-5.

334. Willigenburg & Delaere, *supra* note 9 (Ulysses arrangements "uphold the guidance provided by one's deepest identity conferring concerns" and prevent episodes from threatening a person's "self").

335. Winick, *supra* note 212, at 87.

336. *See* FLA. STAT. § 765.204(1) (2013) (the Florida statute for capacity does not require a physician assessment or attestation of the patient's capacity).

337. VHA Report, *supra* note 1, at 4; Clausen, *supra* note 1, at 41; *see, e.g., TEX. CIV. PRAC. & REM. CODE ANN.* § 137.002(c) (2013); *TENN. CODE ANN.* § 33-6-1003

patients must reaffirm their mental health directives or they expire.<sup>338</sup> In Florida, no directive expires automatically. This is probably because Florida does not have a specialized mental health directive statute.<sup>339</sup> The Florida generic directive statute asserts that “[u]nless [the designation of a surrogate] states a time of termination, the designation shall remain in effect until revoked by the principal.”<sup>340</sup>

Another illustration of the way that Florida’s generic directive statute fails to set forth a process for forming Ulysses arrangements is its failure to provide for automatic expiration in any instance.<sup>341</sup> Automatic expiration is warranted for Ulysses arrangements for two reasons.<sup>342</sup> First, Ulysses arrangement critics are concerned the arrangements do not provide true informed consent because consent provided through the arrangement is expired and not contemporaneous.<sup>343</sup> When a doctor implements a Ulysses arrangement, he does so in accordance with informed consent provided months or years before the treatment is administered.<sup>344</sup> Automatic expiration does not make the patient’s informed consent truly contemporaneous, but it does ensure informed consent is relatively recent.<sup>345</sup> The patient must reaffirm consent to intervention despite contemporaneous objections every couple of years.<sup>346</sup>

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(2014); OR. REV. STAT. ANN. § 127.702(2) (2011); OHIO REV. CODE § 2135.03 (2013).

338. VHA Report, *supra* note 1, at 4.

339. FLA. STAT., ch. 765 (2013).

340. FLA. STAT. § 765.202(6) (2013).

341. *Id.*

342. See Clausen, *supra* note 1, at 42-43. However, automatic expiration is not warranted for mental health directives when the jurisdiction does not provide for automatic expiration for generic directives because imposing this administrative burden only on mental health patients: (1) requires only mental health patients to track the age of directives; (2) stigmatizes mental illness; and (3) undermines parity for mental healthcare.

343. Dresser, *supra* note 202.

344. Clausen, *supra* note 1, at 42-43; Dresser, *supra* note 202, at 830.

345. Clausen, *supra* note 1, at 42-43.

346. VHA Report, *supra* note 1, at 4.



Moreover, Ulysses arrangement critics express concern about the possibility of unanticipated consequences due to a patient's change of heart or failure to predict all contingencies.<sup>347</sup> A patient may execute a Ulysses arrangement consenting to a certain psychotropic medication. Months later, when doctors implement the arrangement, the patient has changed her medication regimen. Automatic expiration requires reaffirmation of the mental health crisis intervention plan.<sup>348</sup> Patients and doctors must engage in ongoing dialogue.<sup>349</sup> This process helps ensure the arrangement is a living document that is kept current with the patient's illness and evolving treatment options.<sup>350</sup> The patient must periodically re-examine whether she needs or wants to continue to direct doctors to override her illness-induced treatment refusals.

### 3. *No Process for Implementing Ulysses Arrangements*

#### a. *No Procedures for Treating Despite Objections*

When doctors implement a Ulysses arrangement, they treat a patient in accordance with her irrevocable directive even though she voices contemporaneous objections.<sup>351</sup> Ulysses arrangement opponents argue the arrangement violates due process because doctors forcibly hospitalize and treat the patient even when she does not meet involuntary placement criteria.<sup>352</sup> Moreover, doctors forcibly treat without the procedural protections afforded in involuntary placement such as a full adjudicatory hearing in which the patient is represented by counsel.<sup>353</sup>

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347. *Advance Directive Instruments*, *supra* note 212, at 88.

348. VHA Report, *supra* note 1, at 4.

349. *Id.*

350. *Id.*

351. Gallagher, *supra* note 13, at 780.

352. Dresser, *supra* note 202, at 800.

353. *Id.* at 813-814.

Despite this legitimate concern, the liberty deprivation implicated when doctors implement a Ulysses arrangement is far less than the massive deprivation of liberty involved in long-term involuntary placement.<sup>354</sup> As Florida courts have recognized, long-term institutionalization may actually cause, or intensify, mental illness.<sup>355</sup> Ulysses arrangements offer patients a mechanism to prevent long-term institutionalization. When the physician implements the arrangement, the physician follows the patient's advance written instructions.<sup>356</sup> The involuntarily committed patient has not provided advance consent.<sup>357</sup>

Because of these due process concerns, a Ulysses enabling statute must provide procedural protections and a clear process for administering treatment pursuant to an irrevocable directive, despite illness-induced refusals.<sup>358</sup> Florida's generic directive statute, with its focus on end-of-life, fails to do so.<sup>359</sup> The statute does not lay out a process to follow when a patient with an irrevocable directive—requesting inpatient treatment—arrives at a hospital in the midst of an episode that has induced her to refuse intervention.<sup>360</sup> The statute fails to set forth procedures for administering treatment pursuant to an irrevocable directive when the patient voices contemporaneous objections.<sup>361</sup>

A comparison between the Washington mental health directive statute and Florida's generic directive statute reveals the shortcomings of Florida's statute.<sup>362</sup> The Washington statute lays out procedures doctors must follow when implementing an

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354. *Cuca*, *supra* note 255, at 1153.

355. *Tuten v. Fariborzian*, 84 So.3d 1063, 1067 (Fla. Dist. Ct. App. 2012) (quoting *Paddock v. Chacko*, 552 So.2d 410, 413-414 (Fla. Dist. Ct. App. 1988)).

356. *Gallagher*, *supra* note 13, at 780.

357. FLA. STAT. § 394.467(1) (2013).

358. *Willigenburg & Delaere*, *supra* note 9, at 396.

359. FLA. STAT., ch. 765 (2013). FLA. STAT. Ch. 765

360. *Id.*

361. *Id.*

362. *Id.*

irrevocable directive.<sup>363</sup> When a patient's mental health directive is irrevocable during periods of incapacity and the patient consents to inpatient mental health treatment, but the patient refuses admission, the facility may admit the patient even if the patient refuses.<sup>364</sup> Such self-binding admission may only be done in compliance with strict criteria.<sup>365</sup> First, one physician, in conjunction with another, must evaluate and determine whether the patient lacks capacity.<sup>366</sup> Second, the physician must obtain the informed consent of the patient's surrogate if the patient has designated one.<sup>367</sup> Next, the physician must evaluate, determine, and make a written finding that the patient needs inpatient evaluation or treatment that cannot be accomplished in a less restrictive setting.<sup>368</sup> Then, the physician must document, in the patient's medical record, a summary of her findings and recommendations.<sup>369</sup>

If the physician determines the patient has capacity, the physician may only admit the patient, or the patient may only remain in inpatient treatment, if the patient consents or is detained under involuntary commitment law.<sup>370</sup> If two doctors determine the patient lacks capacity, the facility may retain the patient for up to two weeks, but only for the number of days the patient consented to inpatient treatment in her irrevocable directive.<sup>371</sup> After that time, the facility must discharge the patient unless she regains capacity and consents to more treatment, or the facility detains the patient under involuntary commitment law.<sup>372</sup> The patient may seek injunctive relief if she

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363. WASH. REV. CODE § 71.32.140 (2013).

364. *Id.* § 71.32.140(2).

365. *Id.*

366. *Id.* § 71.32.140(2)-(3).

367. *Id.* § 71.32.140(2)(b).

368. *Id.* § 71.32.140(2)(c).

369. *Id.* § 71.32.140(2)(d).

370. *Id.* § 71.32.140(4)(a).

371. *Id.* § 71.32.140(5).

372. *Id.*

contests her admission.<sup>373</sup> Washington's well-defined process helps protect against coercion and abuse.<sup>374</sup> In many ways, Washington's process is a model for Florida.

However, Washington's process is flawed because it fails to empower patients to form truly self-binding arrangements. First, even if the patient's irrevocable directive consents to inpatient treatment despite her contemporaneous objections, Washington requires a facility to discharge the patient if she takes actions demonstrating a desire to be discharged in addition to requesting discharge.<sup>375</sup> According to the legislative history, because this is a voluntary admission, a patient who takes action by demanding discharge must be discharged unless she meets involuntary commitment criteria.<sup>376</sup> However, the legislature does not explain why the patient's illness-induced demands must override her consent in her irrevocable directive.<sup>377</sup> In this way, Washington deprives patients of the right to form a Ulysses arrangement and deprives patients of a useful crisis prevention tool.<sup>378</sup>

Another shortcoming of the Washington statute is its failure to address whether a patient's refusal of admission and treatment in contravention of the irrevocable directive supports a determination that the patient lacks capacity.<sup>379</sup> Episodes often induce people to refuse intervention.<sup>380</sup> A written directive provides evidence that the patient, when she had capacity, wanted intervention. Washington fails to assist the doctor in assessing capacity.<sup>381</sup> When a patient arrives at a facility refusing admission, which she requested in her irrevocable

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373. *Id.* § 71.32.140(4)(b).

374. *Id.* § 71.32.230.

375. *Id.* § 71.32.140(6)(b).

376. 2003 WASH. SESS. LAWS 1496, 1504.

377. *Id.*

378. Clausen, *supra* note 1, at 32-33.

379. WASH. REV. CODE §§ 71.32.140, 71.32.110 (2013).

380. JAMISON, *supra* note 1, at 37; Davoli, *supra* note 1, at 1009; VHA Report, *supra* note 1, at 8; Clausen, *supra* note 1, at 4-5.

381. WASH. REV. CODE §§ 71.32.140(2)(a), 71.32.110(1)-(2)(a).

directive, she necessarily exhibits incapacity. The reason the patient formed an irrevocable directive requesting intervention is to override her refusals. Florida doctors will be reluctant to implement Ulysses arrangements.<sup>382</sup> Only a small percentage of patients execute mental health directives.<sup>383</sup> Doctors have little experience implementing mental health directives, much less Ulysses arrangements.<sup>384</sup> Psychiatrists are extremely familiar with the strict criteria for involuntary evaluation and placement.<sup>385</sup> Unless the Ulysses enabling statute clearly instructs otherwise, Florida doctors will likely try to insulate themselves from liability for unlawfully involuntarily detaining and treating a patient.<sup>386</sup> Therefore, they will discharge patients whose illnesses cause them to refuse intervention requested in their directives. Such discharge disrespects the patient's autonomy because it does not follow the patient's written instructions in her directive and potentially endangers the patient and others.

Florida cases illustrate premature discharge can be dangerous. For example, in *Tuten v. Fariborzian* discussed in Part I, Ms. Tuten sued the psychiatrist and hospital for discharging her husband, James, pending his involuntary placement hearing.<sup>387</sup> The discharge occurred because James demanded discharge, and Dr. Fariborzian believed James had become able to function in a less restrictive environment, no longer meeting involuntary placement criteria.<sup>388</sup> The day after

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382. See Clausen, *supra* note 1, at 33.

383. Maria J. O'Connell & Catherine H. Stein, *Psychiatric Advance Directives: Perspectives of Community Stakeholders*, 32 ADMIN. & POL'Y MENTAL HEALTH 241, 242 (2005) (less than 7% of people surveyed with schizophrenia had directives); Jeffrey Swanson et al., 34 J. AM. ACAD. PSYCHIATRY & L. 43, 54 (2006) (between four and 13% of mental health patients surveyed had directives).

384. O'Connell & Stein, *supra* note 383, at 242; Swanson et al., *supra* note 383, at 54-55.

385. FLA. STAT. §§ 394.463, 394.467 (2013).

386. See *supra* p. 123 & nn.156-161.

387. *Tuten v. Fariborzian*, 84 So.3d 1063, 1065 (Fla. Dist. Ct. App. 2012)..

388. *Id.*

discharge, James killed himself and shot his wife.<sup>389</sup>

Similarly, in *Moraes v. New Horizons of Treasure Coast, Inc.*, the plaintiff, the personal representative of the estate of his mother, Mariangela, brought suit for negligence against New Horizons, a Baker Act receiving facility, for allegedly negligently discharging Mariangela, resulting in her suicide.<sup>390</sup> Mariangela experienced an acute mental illness episode while in a hospital emergency room.<sup>391</sup> Port St. Lucie police subsequently involuntarily committed Mariangela to an inpatient facility, New Horizons, pursuant to the Baker Act.<sup>392</sup> Under the influence of the episode, Mariangela did not recognize her need for treatment and refused to sign consent for treatment or informed consent forms.<sup>393</sup> She also revealed paranoid delusions when she stated her roommate was trying to poison her and the facility should not send a killer to her room.<sup>394</sup> Almost a day later, a physician involuntarily examined Mariangela and determined she was incompetent to provide informed consent and should remain hospitalized for emergency treatment.<sup>395</sup> However, later that day, the physician apparently determined she no longer met Baker Act criteria and approved Mariangela's release.<sup>396</sup> It was the doctor's impression that being in the facility would increase her paranoia.<sup>397</sup> He released her to the custody of her son, the plaintiff.<sup>398</sup> Her son allowed Mariangela to drive home.<sup>399</sup> She drove extremely dangerously.<sup>400</sup> A bystander called 9-1-1. Police arrived and took Mariangela back

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389. *Id.* at 1066.

390. *Id.* at 1065.

391. *Moraes v. Horizons of the Treasure Coast, Inc.*, 2013 WL 4009438 (S.D. Fla.).

392. *Id.*

393. *Id.*

394. *Id.*

395. *Id.*

396. *Id.*

397. *Id.*

398. *Id.*

399. *Id.*

400. *Id.*

into custody, pursuant to the Baker Act.<sup>401</sup> While en route to New Horizons, Mariangela attacked the police officers.<sup>402</sup> They arrested her and took her to jail for resisting arrest with violence and battery on a law enforcement officer.<sup>403</sup> She was placed in the jail infirmary for observation. She committed suicide in her cell the next day.<sup>404</sup>

What if James and Mariangela had previously executed Ulysses arrangements directing their physicians to keep them hospitalized for twenty-one days following an acute mental illness episode, even if they no longer met involuntary placement criteria? What if the Florida legislature had adopted the legislative relief proposed in Part III which empowers patients to form Ulysses arrangements? The physicians would have had clear authority to hospitalize and treat James and Mariangela longer, giving the vulnerable patients more time to heal. This extra time might have saved their lives.

The final shortcoming of the Washington statute, explored in Part II(3)(d) is its failure to empower patients to request involuntary transportation to a hospital to effectuate a Ulysses arrangement.

#### b. Insufficient Safeguards

To explain why Florida's generic directive statute fails to set forth safeguards sufficient to support Ulysses arrangements, it is necessary to describe some mental health treatments. Psychiatric drugs can effectively treat mental illness, and one type of psychiatric medication, called antipsychotic medication, can be particularly effective in limiting psychosis.<sup>405</sup> However,

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401. *Id.*

402. *Id.*

403. *Id.*

404. *Id.*

405. Douglas Mossman, *Unbuckling the "Chemical Straitjacket": The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis*, 39 SAN DIEGO L. REV. 1033, 1054 (2002).

antipsychotic drugs potentially cause serious side effects.<sup>406</sup> In the 1990s, new antipsychotic drugs emerged called “atypical” because they were different than the older antipsychotic medications in that they alleviate psychotic symptoms with fewer side effects.<sup>407</sup>

Electroconvulsive therapy (electroshock treatment or ECT) is generally considered to be more invasive than pharmaceutical therapy.<sup>408</sup> It directs electric currents to parts of the brain, which then causes seizures.<sup>409</sup> Although the modern medical community acknowledges ECT as an effective and safe treatment for certain patients, ECT is still controversial.<sup>410</sup> Critics posit ECT can permanently damage the brain and cause permanent memory gaps.<sup>411</sup>

Psychosurgery includes operations referred to as lobotomy, psychiatric surgery, behavioral surgery, or any surgery doctors perform to modify or control thoughts, feelings, or behavior rather than treating a diagnosed physical disease of the brain.<sup>412</sup> The modern medical community views many of these procedures as discredited and dangerous because they risk permanent brain damage.<sup>413</sup> More modern psychosurgery techniques involve creating small lesions in the brain.<sup>414</sup> Even modern techniques are highly intrusive and are reserved for

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406. *Id.* at 1126.

407. *Id.* at 1039-40.

408. Mike E. Jorgensen, *Is Today the Day We Free Electroconvulsive Therapy?*, 12 QUINNIPIAC HEALTH L.J. 1, 39 n.234 (2008) (quoting *In re Branning*, 674 N.E.2d 463, 468 (Ill. App. Ct. 1996), “The two fundamental concerns’ that led the Supreme Court of Illinois to find a fundamental liberty interest in refusing psychotropic medication are present in regard to performing ECT. The first, that the treatment is of a ‘substantially invasive nature’ and has ‘significant side effects’....”).

409. *Id.* at 3.

410. Helia Garrido Hull, *Electroconvulsive Therapy: Baby Boomers May Be in for the Shock of Their Lives*, 47 U. LOUISVILLE L. REV. 241, 251 (2008).

411. *See Id.*

412. CAL. WELF. & INST. CODE § 5325(g-h) (West 2014).

413. Henry T. Greeley, *Neuroscience and Criminal Justice: Not Responsibility but Treatment*, 56 U. KAN. L. REV. 1103, 1111 (2008).

414. *Id.* at 1112.



very mentally ill patients when other treatments have failed.<sup>415</sup>

Florida extensively regulates both psychosurgery and ECT.<sup>416</sup> The Baker Act prohibits a guardian from consenting to the patient's ECT or psychosurgery "[u]nless the guardian . . . has sought and received *express court approval* in [a] *proceeding separate* from the proceeding to determine the competence of the patient to consent to medical treatment."<sup>417</sup> "The court must base its decision [whether to authorize ECT or psychosurgery] on evidence [demonstrating] that the [given] treatment or procedure is essential to the care of the patient and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects."<sup>418</sup> For both ECT and psychosurgery, Florida law requires a physician to obtain the prior written consent of the patient after disclosure to the patient of the purpose of the procedure, the common side effects, alternative treatment modalities, and the approximate number of procedures considered necessary.<sup>419</sup> It further requires that any consent may be revoked by the patient prior to or between treatments.<sup>420</sup> If the patient is not competent, these disclosures must be made to the guardian.<sup>421</sup> Before the doctor administers psychosurgery or ECT, he must review the patient's treatment record and another physician, not directly involved with the patient, must agree with the proposed treatment.<sup>422</sup> The two doctors must document and sign their agreement in the patient's medical records.<sup>423</sup>

In light of these strict regulations, Florida's generic directive

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415. BENJAMIN J. SADOCK ET AL., KAPLAN & SADOCK'S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1914 (9th ed. 2009).

416. FLA. STAT. §§ 394.4598(6), 458.325 (2013).

417. *Id.* § 394.4598(6) (2013).

418. *Id.*

419. *Id.* § 458.325.

420. *Id.*

421. *Id.*

422. *Id.*

423. *Id.*

statute is misleading.<sup>424</sup> This is because Florida's generic directive statute states, "Unless the principal expressly delegates such authority to the surrogate in writing, *or* a surrogate . . . has sought and received court approval . . . a surrogate . . . may not provide consent for: [ECT and psychosurgery]." <sup>425</sup> Considering the Baker Act requirement for court approval in each instance in which a guardian approves ECT or psychosurgery,<sup>426</sup> "or" in Florida's generic directive statute should be "and."<sup>427</sup> Interpreting Florida's current generic directive statute to authorize Ulysses arrangements for ECT or psychosurgery exposes mental health patients to significant risks. This is because the Florida generic directive statute requires the principal's express written authority to authorize a surrogate to consent to the patient's ECT or psychosurgery.<sup>428</sup> Implied in this requirement is a grant of authority to surrogates to consent to the patient's ECT or psychosurgery if the patient expressly authorizes.<sup>429</sup> Every Florida patient who executes a directive necessarily creates a directive that is irrevocable when she lacks capacity.<sup>430</sup> If, from this irrevocability fact alone, one interpreted the Florida generic directive statute to authorize Ulysses arrangements, patients would be at risk of being subject to highly intrusive mental health treatments despite their objections.

For example, Patient designates Surrogate and expressly authorizes Surrogate to consent to Patient's ECT and/or psychosurgery. If one interpreted Florida's generic directive statute to authorize Ulysses arrangements, Surrogate could consent to Patient's ECT and/or psychosurgery when Patient

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424. *See Id.* § 765.113(1).

425. *Id.* §765.113 (emphasis added).

426. *Id.* § 394.4598(6).

427. *Id.* § 765.113.

428. *Id.*

429. *Id.*

430. *Id.* § 765.104.

lacks capacity even if Patient adamantly refuses.<sup>431</sup> Considering psychosurgery is dangerous and discredited, and ECT is intrusive and controversial, no surrogate should have the authority to authorize either treatment, especially without court authority, when a patient objects. Ulysses arrangements are inappropriate for psychosurgery and unwise for ECT. Rather, the patient can form a Ulysses arrangement for less intrusive pharmaceutical and inpatient treatment until she regains capacity. With capacity, she can decide for herself whether she needs psychosurgery or ECT.

Despite its shortcomings, Washington's statute is a good starting point for a process governing the admission of mental health patients pursuant to irrevocable directives in contravention of contemporaneous objections.<sup>432</sup> However, probably because Washington does not truly authorize Ulysses arrangements,<sup>433</sup> Washington neglects to set forth procedures for administering medication pursuant to an irrevocable directive when the patient objects.<sup>434</sup> Part III recommends how Florida should address administering medication pursuant to a Ulysses arrangement and prohibiting Ulysses arrangements for ECT and psychosurgery.<sup>435</sup>

### c. Patients Cannot Designate Activation Standard

Activation refers to the point at which the directive governs the patient's care.<sup>436</sup> In Florida, the directive becomes active when the patient loses capacity.<sup>437</sup> The directive no longer governs care once the patient regains capacity.<sup>438</sup> Therefore, the patient's surrogate makes health care decisions for the patient

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431. *Id.* §765.113.

432. WASH. REV. CODE § 71.32.140 (2014).

433. *Id.* § 71.32.140(6)(b).

434. *Id.* § 71.32.140.

435. *See infra* Part III.

436. Clausen, *supra* note 1, at 62; VHA REPORT, *supra* note 1, at 8.

437. FLA. STAT. § 765.204(3) (2013).

438. *Id.*

only after the patient loses capacity – not before.<sup>439</sup> This incapacity activation standard is far preferable for mental health patients to an involuntary placement standard.<sup>440</sup> If a patient is forced to wait for intervention until she meets involuntary placement criteria, intervention will likely come too late.<sup>441</sup>

If a patient's capacity is in question, Florida's generic directive statute requires the attending physician to evaluate the patient's capacity and enter that evaluation in the patient's record.<sup>442</sup> If the attending physician has any question as to whether the principal lacks capacity, the statute requires another doctor to evaluate the patient's capacity and agree the patient lacks capacity before the directive becomes active.<sup>443</sup>

Determining incapacity is difficult because capacity is fluid for mental health patients, and a physician capacity determination takes time.<sup>444</sup> These delays, although not as significant as delays involved in court hearings and rulings for involuntary placement, still postpone intervention.<sup>445</sup> For this reason, some states have empowered patients to create directives that take effect before patients lose capacity.<sup>446</sup> Even in these states, a patient with capacity may override her directive or the instructions of her surrogate.<sup>447</sup> This is called early activation because it allows the directive to govern care even before a physician has determined the patient has lost capacity.<sup>448</sup> The patient designates the circumstances under which her directive becomes active.<sup>449</sup>

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439. *Id.*

440. FLA. STAT. § 394.467, 394.4655 (2013).

441. *See supra* text accompanying note 194.

442. FLA. STAT. § 765.204(2) (2013).

443. *Id.*

444. Clausen, *supra* note 1, at 39.

445. *Id.*

446. VHA Report, *supra* note 1, at 8; N.J. STAT. ANN. § 26:2H-108 (West 2013); N.M. STAT. ANN. § 24-7B-4 (2014); 20 PA. CONS. STAT. § 5825 (2013).

447. VHA Report, *supra* note 1, at 8.

448. *Id.*

449. *Id.*

For example, consider *Moraes v. New Horizons of Treasure Coast, Inc.*, the case discussed above in which Mariangela committed suicide after she was released from the hospital, but was still suffering from an episode that caused paranoid delusions.<sup>450</sup> Maybe the suicide could have been prevented if Mariangela, when she had capacity, could have formed a Ulysses arrangement, which by its terms became active when her son executed a sworn affidavit asserting she was having paranoid delusions and describing evidence of the delusions. Then, after activation, the arrangement could have required three weeks hospitalization even if she did not meet involuntary placement criteria and demanded discharge. This is patient designated activation because the Ulysses arrangement becomes active under the circumstances Mariangela describes instead of after a physician has determined she has lost capacity. Mariangela, who physically resisted police officers' attempts to hospitalize her under the Baker Act,<sup>451</sup> would have refused to see her psychiatrist for a capacity evaluation in the midst of an episode. Therefore, the incapacity activation standard would not have worked for Mariangela. She needed early activation.

Patient designated activation enables patients who best understand the patterns of their mental illnesses to obtain early intervention to prevent a mental health crisis.<sup>452</sup> By preventing early activation of directives, Florida does not allow patients to create individualized prevention plans.<sup>453</sup>

As explored in Part III, Florida should enact a Ulysses arrangement enabling statute that authorizes patients to specify the criteria upon which their Ulysses arrangements become

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450. *Moraes v. New Horizons of the Treasure Coast*, 2013 U.S. Dist. LEXIS 109552 (S.D. Fla. Aug. 5, 2013).

451. *Id.*

452. Early activation is controversial because it creates opportunities for coercion. However, patients should have the power to create individualized intervention plans. For this reason, it is important the physician, patient, and surrogate are sure of what the mental health crisis prevention plan entails. See VHA Report, *supra* note 1, at 8.

453. See FLA. STAT. § 765.204(3) (2013).

active. However, after a patient arrives at a facility and refuses treatment, the enabling statute should require a physician to assess capacity. If the patient has capacity, the enabling statute should prohibit administration of treatment in contravention of the patient's refusals, even if such treatment is requested in the Ulysses arrangement. This helps address concerns about a patient's change of heart or unanticipated contingencies.<sup>454</sup> Ulysses arrangements only support patient autonomy if patients with capacity are free to change their minds.

#### d. No Transportation Option

The final reason Florida, either through the generic directive statute or the Baker Act, fails to empower patients to form and effectuate Ulysses arrangements is Florida provides no means for a patient to secure involuntary transportation to implement a Ulysses arrangement.<sup>455</sup> Florida is not unique in this failure. Research uncovered no state statute empowering a patient to arrange for involuntary transportation to a hospital to secure intervention pursuant to her Ulysses arrangement. Even Washington's statute does not address how the patient arrives at the hospital.<sup>456</sup> Part III's proposed legislative relief empowering patients to arrange involuntary transportation to a hospital can serve as a model for other states.<sup>457</sup>

Again, consider *Moraes v. New Horizons of Treasure Coast, Inc.*, the case discussed above.<sup>458</sup> Assume Mariangela had a Ulysses arrangement that was properly activated under its terms when her son executed an affidavit asserting she was suffering from paranoid delusions. In the case, she convinced her son to let her drive and she drove recklessly and dangerously. Her son

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454. Clausen, *supra* note 1, at 22-23.

455. FLA. STAT., ch. 765 (2013); FLA. STAT., ch. 394 (2013).

456. WASH. REV. CODE § 71.32.140 (2014).

457. *See infra* Part III.

458. *Moraes v. New Horizons of the Treasure Coast, Inc.*, 2013 WL 4009438, at \*1 (S.D. Fla. Aug. 5, 2013).

could not transport Mariangela against her will to a hospital because doing so would be dangerous. In the case, when police tried to involuntarily transport her to a hospital, she committed battery and physically resisted.<sup>459</sup> Moreover, in Florida, her son does not have the authority to involuntarily transport her to a hospital.

As explored in Part I, in Florida, only a law enforcement officer or a transportation contractor can transport a refusing patient to a receiving facility for involuntary examination.<sup>460</sup> Transportation is only authorized based upon a finding the person meets involuntary examination criteria as reflected in: (1) personal recorded observations, (2) an ex parte order of the court, or (3) a physician's certificate.<sup>461</sup> The Baker Act's transportation criteria and procedures do not contemplate Ulysses arrangements.<sup>462</sup> Only officers and transportation contractors may transport to a facility the person who appears to meet involuntary examination criteria.<sup>463</sup> The Baker Act does not contemplate Ulysses arrangements because the purpose of the Ulysses arrangement is to secure early intervention to stave off a crisis even if the patient refuses and does not meet involuntary examination criteria.<sup>464</sup> Even if the Florida legislature amended the generic directive statute to authorize Ulysses arrangements, the arrangements will prove ineffective if patients cannot secure involuntary transportation to a facility.

It would be illegal for a private person,<sup>465</sup> such as a family member, to transport a refusing patient pursuant to the patient's Ulysses arrangement.<sup>466</sup> For example, in *Administrator, Retreat*

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459. *Id.*

460. FLA. STAT. § 394.462 (2013).

461. FLA. STAT. § 394.463 (2013).

462. Fla. Stat. §§ 394.462, 394.463(2) (2013).

463. *Id.* § 394.463.

464. *See* FLA. STAT. § 394.453 (2013).

465. Of course transportation contractors may do so. *See* FLA. STAT. § 394.453 (2013).

466. *See* FLA. STAT. § 394.462 (2013).

*Hospital v. Johnson In and For Broward County.*, the Fourth DCA of Florida clarified only an officer (and now also a transportation contractor) may detain and transport a patient under the Baker Act.<sup>467</sup> The Baker Act prohibits private parties from detaining and transporting a patient for involuntary examination.<sup>468</sup> Not just any officer may transport the person who appears to meet involuntary examination criteria. The Florida Attorney General opined the Baker Act only authorizes municipal police department officers (and now also transportation contractors) to transport patients to receiving facilities for involuntary examination.<sup>469</sup> University police do not have the authority.<sup>470</sup> Moreover, federal law enforcement officers are not law enforcement officers for the purposes of the Baker Act and have no authority under the Act to initiate the involuntary examination of a person or to transport the person to a facility for involuntary examination.<sup>471</sup>

Under current Florida law, even police officers and transportation contractors may not transport a person to a facility who does not meet involuntary examination criteria.<sup>472</sup> Therefore, to truly enable patients to form and effectuate Ulysses arrangements, Florida should adopt the recommended approach in Part III, which allows patients to secure involuntary transportation.<sup>473</sup>

However, there are risks in allowing patients to secure

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467. Administrator, *Retreat Hospital v. Johnson*, 660 So.2d 333, 340 (Fla. Dist. Ct. App. 1995).

468. *Id.*; FLA. STAT. § 394.462 (2013).

469. Advisory Legal Opinion - AGO 74-108, Costs of Transporting Mental Patients, FLORIDA OFFICE OF THE ATTORNEY GENERAL (April 9, 1974), <http://www.myfloridalegal.com/ago.nsf/Opinions/3CDA1409B57941FB852566B20057A07D>.

470. *See Id.*

471. Advisory Legal Opinion - AGO 99-68, FLORIDA OFFICE OF THE ATTORNEY GENERAL (NOV. 8, 1999), <http://www.myfloridalegal.com/ago.nsf/Opinions/3F509A3A10AB24898525682400759885>.

472. FLA. STAT. § 394.462(1) (2013).

473. *See infra* Part III.



involuntary transportation to a facility to effectuate their Ulysses arrangements. First, police apprehension of mental health patients can be dangerous. For example, in *Drummond v. City of Anaheim*, police responded to Drummond's fiancée's call that Drummond, diagnosed with schizophrenia and bipolar disorder, was in need of involuntary examination.<sup>474</sup> Ultimately, police apprehension resulted in police brutalizing a passive Drummond, leaving him in a permanent vegetative state.<sup>475</sup> Second, empowering patients to use Ulysses arrangements to secure involuntary transportation creates more opportunities for loved ones to use the Ulysses arrangement as a coercive tool to force treatment on a vulnerable patient.<sup>476</sup> Third, responding to requests to transport patients pursuant to their Ulysses arrangements could cause a drain on law enforcement resources and divert law enforcement from other emergencies. Florida must take steps to prevent people from "crying wolf" and harassing police when there is no true mental health crisis. A Ulysses enabling statute, which provides patients with the involuntary transportation option, must safeguard against such abuse and protect patient safety. As explored below, Part III's recommended approach has such protective measures.

### III. SOLUTION: BRING ULYSSES TO FLORIDA

This Section urges the Florida legislature to amend the Florida generic directive statute to authorize mental health patients to form and effectuate Ulysses arrangements.<sup>477</sup> Currently, Florida

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474. *Drummond v. City of Anaheim*, 343 F.3d 1052, 1054 (2003).

475. *Id.* at 1055.

476. *Advance Directive Instruments*, *supra* note 212, at 87.

477. Clausen, *supra* note 1, Appendix A (recommending a model statute for the Uniform Law Commissioners which also contained provisions enabling Ulysses arrangements. This model statute was the inspiration for the described statute in this Article. However, this Article's described statute improves on the previous model statute by authorizing patients to arrange for involuntary transportation. This feature was not present in the previous model and requires amendment of involuntary placement law as well as advance directive law because of the involvement of police).

does not empower patients to form Ulysses arrangements.<sup>478</sup> First, Florida's generic directive statute fails to empower patients to determine whether their directives will be irrevocable when they lack capacity.<sup>479</sup> Second, the statute provides no safeguards to ensure patients form Ulysses arrangements voluntarily.<sup>480</sup> Third, the statute has no process governing administration of treatment in contravention of contemporaneous refusals.<sup>481</sup> Finally, there is no mechanism for a patient to arrange for transportation to a hospital to obtain intervention once an episode has caused treatment refusals.<sup>482</sup>

Section III (A) below recommends changes (to the "General Provisions" (Part I) portion of Florida's generic directive statute<sup>483</sup>) which define Ulysses arrangements and make legislative findings concerning the need for such arrangements. Sections III (B-C) below propose legislative relief, which ensures Ulysses arrangements are formed knowingly and voluntarily and defines a clear process for implementation of such arrangements. This legislative relief should be incorporated as Part VI of Florida's generic directive statute, which currently has five parts.<sup>484</sup> Proposed Part VI of the generic directive statute should be entitled "Mental Health Advance Directives" because the generic directive statute fails to give guidance on mental health directives.<sup>485</sup> Proposed Part VI should contain provisions concerning all aspects of mental health directives. Because this Article addresses only Ulysses arrangements, the text below recommends provisions related only to Ulysses arrangements. Providing patients the involuntary transportation option will require the Florida legislature not only to amend Florida's

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478. *See supra* Part II(B).

479. *Id.* at note 283.

480. *Id.* at note 284.

481. *Id.* at note 285.

482. *Id.* at note 286.

483. FLA. STAT., ch. 765 (2013); Part I.

484. FLA. STAT., ch. 765 (2013).

485. *See supra* Part II(B).

generic directive statute but also the involuntary examination<sup>486</sup> and transportation<sup>487</sup> provisions of the Baker Act.

### A. LEGISLATIVE FINDINGS AND DEFINITIONS

Part I of Florida's generic directive statute contains all of the definitions and legislative findings related to advance directives.<sup>488</sup> The Florida legislature should amend Part I to define a Ulysses arrangement as: a special type of mental health directive through which a patient authorizes doctors to administer treatment during a future mental illness episode even (1) in contravention of the patient's illness-induced refusals, (2) if the patient lacks capacity to provide informed consent, and (3) if the patient does not meet involuntary examination criteria under the Baker Act.<sup>489</sup>

The Florida legislature should amend the legislative findings to recognize that mental illness episodes can cause people to refuse treatment to which they would consent if they were unimpaired. Allowing such patients to create Ulysses arrangements to overcome illness-induced refusals protects patient safety, autonomy, and health. These legislative findings would notify all stakeholders that supporting Ulysses arrangements empowers patients to prevent crisis.

### B. ENSURE FORMATION IS VOLUNTARY

The text below describes provisions the Florida legislature should adopt to ensure Ulysses arrangement formation is voluntary and knowing. The Florida legislature should include these provisions in a proposed Part VI of Florida's generic directive statute.

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486. FLA. STAT. § 394.463 (2013).

487. FLA. STAT. § 394.462 (2013).

488. FLA. STAT. §§ 394.453, 394.455 (2013).

489. Sheetz, *supra* note 3, at 403.

### 1. *Empower Patients to Decide Whether They Can Revoke*

A patient cannot form a Ulysses arrangement unless she has the right to form a directive that is irrevocable when she lacks capacity.<sup>490</sup> However, Ulysses arrangements are only appropriate for patients who have the right to choose whether their directives will be revocable when they lack capacity.<sup>491</sup> The primary reason the Florida generic directive statute deprives patients of the Ulysses arrangement tool is its requirement for competence for a patient to revoke or amend a directive.<sup>492</sup> Patients who do not have the power to choose whether their directives should be revocable when they lack capacity cannot voluntarily form a Ulysses arrangement.<sup>493</sup>

Proposed Part VI of the generic directive statute should contain a provision that requires the principal to designate whether she wants to be able to revoke her mental health directive when she lacks capacity. Failure to clarify whether the mental health directive is revocable should not render it unenforceable. Rather, if the mental health directive fails to address revocation without capacity, the patient should be free to revoke at any time. The provision should explain that opting to make a mental health directive irrevocable during periods of incapacity forms a Ulysses arrangement. This proposed provision helps ensure patients contemplate whether they want to form Ulysses arrangements and do not inadvertently do so.<sup>494</sup>

### 2. *Require Signed, Witnessed Writing*

It is unclear in Florida whether a principal may orally

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490. *See supra* Part II(B)(2)(a).

491. *Id.*

492. FLA. STAT. § 765.104(1) (2013).

493. *See supra* Part II(B)(2)(a).

494. *See supra* note 477 (providing a model provision similar to this as a proposed amendment to the Uniform Healthcare Decisions Act).

designate a surrogate or issue health care instructions.<sup>495</sup> This is because Florida's advance directive definition implies principals may orally issue instructions and designate surrogates.<sup>496</sup> However, the generic directive statute requires written documents designating a surrogate to be signed by the principal in the presence of witnesses.<sup>497</sup>

Proposed Part VI of the Florida generic directive statute should contain a provision requiring Ulysses arrangements to be in writing and signed by the principal. The proposed provision should require the principal's affirmation that the principal was aware of the nature of the document and signed freely and voluntarily. The provision should require Ulysses arrangements to be witnessed in writing by at least two adults. Neither of the witnesses should be (1) on the principal's treatment team; (2) related to the principal by blood, adoption, or marriage; (3) in a romantic relationship with the principal; (4) the surrogate of the principal; or (5) the owner, operator, employee, or relative of an owner or operator of a treatment facility in which the principal is a patient. The provision should require the witnesses to attest the following three facts: (1) they were present when the principal signed; (2) the principal did not appear incapacitated or under undue influence or duress when signing; and (3) the principal presented identification or the witness personally knows the principal.<sup>498</sup> These Ulysses arrangement execution requirements safeguard against health care fraud, misinterpretation of patient wishes, undue influence, abuse, and coercion.<sup>499</sup>

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495. *See supra* note 295.

496. FLA. STAT. § 765.101(1) (2013).

497. *Id.* § 765.202(1).

498. *See supra* p. 162 and note 477, at Appendix A (providing similar language for a recommended mental health directive statute for the Uniform Law Commissioners).

499. *See supra* Part II(B)(2)(b).

### 3. *Mandate Capacity Assessment and Attestation*

In Florida, unless the principal's capacity is in question, there is no requirement for a capacity/competency assessment at the time of directive formation.<sup>500</sup> Moreover, "Incapacity may not be inferred from . . . voluntary or involuntary hospitalization for mental illness."<sup>501</sup> Proposed Part VI of the generic directive statute should contain a provision requiring a written, signed attestation from a mental health professional that the principal had capacity at the time of Ulysses arrangement formation.<sup>502</sup> Ulysses arrangements are instruments of self-paternalism, which create opportunities for family and clinicians to coerce patients to accept a treatment regimen.<sup>503</sup> Doctors administer treatment pursuant to the arrangement without procedural protections involved in involuntary placement.<sup>504</sup> Capacity is often fluid for mental health patients because episodes disrupt capacity.<sup>505</sup> A capacity assessment helps address these concerns because it helps ensure the patient voluntarily formed the arrangement when she had capacity, free from the undue influence of loved ones and clinicians or an episode.<sup>506</sup>

### 4. *Provide for Automatic Expiration*

Florida does not provide for automatic expiration of directives.<sup>507</sup> Automatic expiration is warranted for Ulysses arrangements for a few reasons. First, automatic expiration addresses the concern that Ulysses arrangements provide

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500. FLA. STAT. § 765.204(1)-(2) (2013).

501. *Id.* § 765.204(1) (2013).

502. *See supra* p. 162 and note 477, at Appendix A (providing a model provision similar to this as a proposed amendment to the Uniform Health-Care Decisions Act).

503. *Advance Directive Instruments, supra* note 212, at 87-88; Dresser, *supra* note 202, at 851-852.

504. Dresser, *supra* note 202, at 800.

505. Clausen, *supra* note 1, at 39.

506. *Id.*; Cuca, *supra* note 255, at 1171-1172; Dresser, *supra* note 202, at 851-852.

507. FLA. STAT. § 765.202(6) (2013).

expired, outdated informed consent.<sup>508</sup> Automatic expiration ensures consent is relatively recent.<sup>509</sup> Second, “automatic expiration helps address concerns [over the possibility of] unanticipated consequences due to a patient’s change of heart or failure to” predict contingencies.<sup>510</sup> This is because automatic expiration requires patients and doctors to periodically reevaluate the need for self-binding intervention and to update treatment protocols.<sup>511</sup> Proposed Part VI of the generic directive statute should contain a provision providing for automatic expiration of Ulysses arrangements two years after execution unless the principal reaffirms the arrangement. If the principal is incapacitated at the end of the two-year time frame, the Ulysses arrangement should remain in effect until the principal regains capacity — when she can decide whether to reaffirm the arrangement or not.<sup>512</sup>

### C. DEFINE PROCESS FOR IMPLEMENTATION

This Section outlines proposed legislative relief that defines safeguards and a clear process for implementing Ulysses arrangements that the Florida legislature should incorporate as provisions in Part VI of Florida’s generic directive statute. To effectuate their Ulysses arrangements, patients will need to arrange for involuntary transportation. Providing such an option requires the Florida legislature not only to amend the Florida generic directive statute,<sup>513</sup> but also the Baker Act’s provisions for involuntary evaluation and transportation.<sup>514</sup>

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508. Dresser, *supra* note 202, at 830-832.

509. Clausen, *supra* note 1, at 43.

510. Clausen, *supra* note 1, at 42.

511. *See supra* note 477.

512. *Id.*

513. FLA. STAT., ch. 765 (2013).

514. FLA. STAT. §§ 394.462, 394.463(1) (2013).

1. *Provide for Patient Designated Activation and Transportation Option*

Proposed Part VI of the generic directive statute should contain provisions empowering a principal to (1) designate her directive's activation standard, and (2) secure involuntary transportation to a hospital to effectuate her Ulysses arrangement. Currently in Florida, directives only become active after the principal loses capacity.<sup>515</sup> Florida does not authorize a principal to designate an activation standard other than incapacity.<sup>516</sup> This failure prevents patients from obtaining early intervention.<sup>517</sup> Under Florida law, a patient who expresses illness-induced refusals but does not meet involuntary examination criteria has no mechanism to obtain intervention.<sup>518</sup> Only an officer or transportation contractor may transport a patient who appears to meet the criteria for involuntary examination to a receiving facility.<sup>519</sup>

If Florida adopts the recommendations explored below, it will move to the forefront of patient empowerment and crisis prevention. Proposed Part VI of the generic directive statute will serve as a model for other states. Proposed Part VI of the generic directive statute should safeguard against abuse and articulate a clear process as follows. First, all patients should have the authority to designate the activation standard of their directives. Unless the principal otherwise designates in the directive, the directive shall become active when the principal loses capacity. To prevent involuntary treatment of a principal with capacity, the provision should clarify a directive does not prevail over contemporaneous preferences expressed by a principal with capacity.<sup>520</sup>

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515. *Id.* § 765.204(2)-(3).

516. *Id.* § 765.204(3).

517. *See supra* Part II(B)(3)(c).

518. FLA. STAT. § 394.463(1) (2013).

519. *Id.* §§ 394.462(1)(a), 394.463(1).

520. *See supra* p. 162 and note 477.



Second, Part VI shall give every patient the right to arrange for involuntary transportation to effectuate her Ulysses arrangement.<sup>521</sup> Only patients who specifically request involuntary transportation in their Ulysses arrangements shall be subject to involuntary transportation, unless they meet involuntary examination criteria under the Baker Act.<sup>522</sup> A patient who wants to arrange for involuntary transportation must designate a surrogate to whom the patient grants express authority to consent to the patient's involuntary transportation if the directive becomes active.<sup>523</sup> When the directive becomes active, the surrogate shall execute a written, sworn affidavit stating the directive has become active and disclosing the basis upon which the surrogate made this conclusion. The surrogate shall then petition the court for an ex parte order authorizing involuntary transportation and attach the affidavit and the directive.<sup>524</sup> The court shall review the petition and attachments within forty-eight hours after submission.<sup>525</sup> Within such forty-eight hour period, the court shall issue an ex parte order for transportation if the court finds by clear and convincing evidence the directive (1) has become active, and (2) requests involuntary transportation.<sup>526</sup>

Just as under the Baker Act, Part VI's involuntary transportation provision should clarify: Officers operating in accordance with a court order authorizing involuntary transportation pursuant to a Ulysses arrangement "may use such reasonable physical force as is necessary to gain entry to the premises, and any dwellings, . . . on the premises, and take . . . custody of the [patient]."<sup>527</sup> As with transportation for involuntary examination under the Baker Act, patients should

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521. FLA. STAT. § 394.463 (2013).

522. *Id.*

523. *Id.* § 394.462(1)(a)(3).

524. *Id.* § 394.462.

525. *Id.*

526. *Id.*

527. FLA. STAT § 394.463(2)(d) (2013).

pay for involuntary transportation pursuant to a Ulysses arrangement.<sup>528</sup>

When the law enforcement agency has delegated transportation responsibilities to transportation contractors in circumstances outlined by the Baker Act, the agency may also delegate transportation pursuant to a Ulysses arrangement court order to transportation contractors.<sup>529</sup> All of the requirements of the Baker Act for using transportation contractors apply.<sup>530</sup> For example, transportation contractors may only transport the person if the jurisdiction has contracted with the contractor, and the agency and the contractor agree the continued presence of law enforcement personnel is not necessary for the safety of the person or others.<sup>531</sup> The only difference will be the Ulysses arrangement based court order will authorize the transportation instead of a Baker Act certificate that the patient meets involuntary examination criteria.

Requirements for a surrogate affidavit and petition and court order admittedly delay intervention. However, these delays are minimal because the court must make its determination within forty-eight hours after petition.<sup>532</sup> Moreover, this minor delay is warranted to prevent abuse. A surrogate affidavit requirement helps ensure involuntary transportation is what the patient decided she needs and wants.<sup>533</sup> Only the patient can choose her surrogate. She has the power to choose a surrogate she trusts to follow her instructions.<sup>534</sup> Only the patient may designate the directive activation standard.<sup>535</sup> This helps ensure the patient maintains

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528. *Id.* §394.462.

529. FLA. STAT. §§ 394.462, 394.463 (2013).

530. *Id.*

531. *Id.*

532. FLA. STAT., Ch. 765 (2013).

533. *Id.* § 394.462.

534. Fla. Dep't of Children & Families, TRANSPORTATION TO RECEIVING FACILITY CF-MH 3100 (MANDATORY FORM) (Feb. 2005). By Authority of FLA. STAT. § 394.462(1)(a)

535. *Id.*

control over her transportation and treatment even in the midst of an episode.

The court order requirement to justify involuntary transportation also helps safeguard against abuse.<sup>536</sup> The court shall review the directive and affidavit to ensure there is clear and convincing evidence the directive is activated and the patient wants involuntary transportation.<sup>537</sup> Court involvement also helps prevent a surrogate from “crying wolf” by activating the Ulysses arrangement before it becomes active under its terms or squandering law enforcement resources when there is no emergency.<sup>538</sup> A surrogate who recognizes a court must review her petition and make a determination will likely exert caution in activating the Ulysses arrangement.<sup>539</sup>

Therefore, the Florida legislature should enact Part VI of the Florida generic directive statute, which includes provisions empowering patients to arrange for involuntary transportation.<sup>540</sup> To notify all stakeholders, the Florida legislature should also amend the Baker Act to cross-reference Part VI of the generic directive statute. In its current form, the Baker Act only authorizes involuntary transportation if the person meets involuntary examination criteria.<sup>541</sup> The legislature should amend the involuntary examination and transportation sections of the Baker Act to authorize involuntary transportation pursuant to a court order based on Ulysses arrangement activation.<sup>542</sup> This cross-reference will help notify law enforcement and transportation contractors who are familiar with involuntary examination criteria with which they routinely

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536. FLA. STAT. § 394.463(2) (2013) (stating that a physician’s only method of admitting a patient is by “executing a certificate that he or she has examined a person . . . and finds that the person appears to meet the criteria for involuntary examination”).

537. FLA. STAT. §§ 394.4655, 394.467 (2013).

538. *Id.* §§ 394.4655, 394.467.

539. Clausen, *supra* note 1 at 58.

540. FLA. STAT., ch. 765 (2013).

541. FLA. STAT. § 394.463 (2013).

542. FLA. STAT. §§ 394.463, 394.462 (2013).

work.<sup>543</sup> Officers need express authorization to justify involuntary transportation pursuant to a court order based on Ulysses arrangement activation.<sup>544</sup> Law enforcement officials and transportation contractors are unlikely to be familiar with Florida law governing advance directives.<sup>545</sup> Express authority embodied in the Baker Act is necessary.<sup>546</sup> Moreover, officers execute statutory forms when they transport a patient based on the patient meeting involuntary examination criteria.<sup>547</sup> The Florida legislature should amend the statutory forms to address instances in which a court order based on Ulysses activation authorizes involuntary transportation.<sup>548</sup>

2. *Set Forth Procedures for Admission and Treatment Over Contemporaneous Objections*

The legislature should amend the Florida generic directive statute to provide a process for treating a patient pursuant to her Ulysses arrangement, despite contemporaneous objections. Safeguards are required because implementing a Ulysses arrangement involves forcibly hospitalizing and treating a patient when she does not meet commitment criteria and without procedural protections afforded in civil commitment.

a. *Admission Procedures*

Under Florida law, doctors have no authority to admit a patient pursuant to a Ulysses arrangement.<sup>549</sup> The Ulysses

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543. FLA. STAT. §394.463 (2013).

544. FLA. STAT. §§ 394.462, 394.463 (2013).

545. FLA. STAT., ch. 765 (2013).

546. FLA. STAT., ch. 394 (2013).

547. Fla. Dep't of Children & Families, TRANSPORTATION TO RECEIVING FACILITY CF-MH 3100 (MANDATORY FORM) (Feb. 2005). By Authority of FLA. STAT. § 394.462(1)(a).

548. *Id.*

549. FLA. STAT. § 394.463(2) (2013) (stating that a physician's only method of admitting a patient is by "executing a certificate that he or she has examined a person . . . and finds that the person appears to meet the criteria for involuntary

arrangement is designed to help the patient who does not yet meet involuntary placement criteria,<sup>550</sup> but is in the midst of an episode that has destroyed her capacity and caused her to refuse admission. The arrangement is a mechanism for this patient to obtain intervention. Currently in Florida, doctors cannot admit this patient either as a voluntary or involuntary patient.<sup>551</sup>

As explored in Part I, the Baker Act prohibits voluntary admission of this patient.<sup>552</sup> “A voluntary patient who is unwilling or unable to provide express and informed consent to mental health treatment must either be discharged or transferred to involuntary status.”<sup>553</sup> This patient, in the midst of an episode, lacks the capacity required to give informed consent. Moreover, her illness has caused her to refuse admission.<sup>554</sup> The physician cannot admit this patient because, even though she is in the midst of an episode, she does not meet involuntary outpatient or inpatient placement criteria.<sup>555</sup>

The legislature should provide a process for admission of a patient pursuant to a Ulysses arrangement when the patient arrives at the facility and voices illness-induced refusals. When such a patient arrives at the facility, the facility should obtain the informed consent of the surrogate, if any is designated, as soon as practicable. If law enforcement or a transportation contractor transported the patient to the hospital, the facility shall review and maintain in the patient's medical records a copy of the court order authorizing such transportation. Two mental health professionals shall evaluate the patient's capacity and record their findings in the patient's records within twenty-four hours of the patient's arrival.<sup>556</sup> This safeguard of a capacity

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examination”).

550. *Id.* §§ 394.4655, 394.467 (2013).

551. *Id.* §§ 394.4655, 394.467.

552. *See supra* Part I.

553. FLA. STAT. § 394.4625(1)(e) (2013).

554. *Id.* § 394.4625(1)(e-f).

555. *Id.* §§ 394.467, 394.4655.

556. *Id.*

evaluation from multiple professionals helps ensure patients with capacity are not unduly deprived of liberty.<sup>557</sup>

Statements in the directive requesting inpatient treatment combined with directive activation and contemporaneous admission refusals create a rebuttable presumption that the patient lacks capacity.<sup>558</sup> The incapacity presumption helps doctors assess capacity and recognizes a patient who arrives at a facility refusing admission requested in an irrevocable directive exhibits signs of incapacity.<sup>559</sup> The purpose of the Ulysses arrangement is to empower the patient to obtain intervention despite illness-induced refusals.<sup>560</sup> Without the incapacity presumption, it will be difficult to overcome physician reluctance to implement Ulysses arrangements. Because they are familiar with criteria for involuntary admission,<sup>561</sup> doctors will likely discharge a patient who does not meet such criteria, even if she lacks capacity and even if her irrevocable directive requests admission. Doctors will likely try to insulate themselves from personal and professional liability for unlawfully involuntarily hospitalizing a person.<sup>562</sup> The incapacity presumption helps ensure doctors respect the directive, which the patient formed when she had capacity instead of her illness-induced refusals. If, despite the presumption, the physician determines the patient has capacity, the facility must discharge the patient.

#### b. Retention Procedures

Not only should proposed Part VI of the generic directive statute articulate procedures for admission, it should provide

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557. See *supra* p. 162 and note 477 (providing statutory language to amend the Uniform Healthcare Decisions Act which is substantially similar to this described amendment to Florida law and is based on the Washington approach).

558. Clausen, *supra* note 1, at 56.

559. *Id.*

560. *Id.*

561. FLA. STAT. §§ 394.467, 394.4655 (2013).

562. See *supra* p. 123.

procedures and safeguards for retention of the patient. Unless the hospital follows procedures to transfer the patient to involuntary status,<sup>563</sup> or the patient regains capacity and consents to voluntary admission, the hospital may retain the patient *only* for the time frame the directive consents to inpatient treatment. The hospital may not retain a patient without capacity based only on consent provided in a Ulysses arrangement for more than twenty-one days.<sup>564</sup> After twenty-one days from the date of admission, regardless of whether the patient has regained capacity, if the patient refuses treatment, the facility shall release the patient during daylight hours unless the patient meets involuntary placement criteria.<sup>565</sup> Any patient who has been determined to lack capacity and continues to refuse treatment may immediately seek injunctive relief for release from the facility.

These safeguards help address the due process concerns that Ulysses critics raise about hospitalizing a patient against her objections without procedural protections afforded in civil commitment.<sup>566</sup> From a therapeutic perspective, for many episodic mental illnesses, three weeks of inpatient treatment is long enough to stabilize the patient and restore capacity.<sup>567</sup> Moreover, hospitalizing a person despite contemporaneous refusals for any longer would pose too significant a deprivation of liberty when the person does not meet involuntary placement criteria. The three-week deadline helps address concerns Ulysses critics raise about family and providers using the arrangement as a coercive tool to force the patient to accept a treatment regimen.<sup>568</sup> No patient will be forced to accept inpatient treatment to which she consented in her Ulysses arrangement for more than twenty-one days.

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563. FLA. STAT. §§ 394.4655(2), 394.467(2), 394.467(7) (2013).

564. Clausen, *supra* note 1, at 65.

565. FLA. STAT. §§ 394.4655, 394.467 (2013).

566. Dresser, *supra* note 202, at 800.

567. *Supra* pp. 128-9 and note 202.

568. *Advance Directive Instruments*, *supra* note 212, at 87-88.

c. Procedures for Administering Treatment

Florida's generic directive statute has no process for administering treatment pursuant to an irrevocable directive.<sup>569</sup> Interpreting Florida's generic directive statute to authorize mental health treatment to an incapacitated patient pursuant to a Ulysses arrangement exposes patients to serious risks of abuse.<sup>570</sup>

Proposed Part VI of the generic directive statute should contain provisions prohibiting Ulysses arrangements for ECT or psychosurgery. Psychosurgery is controversial, largely discredited, and already highly regulated in Florida.<sup>571</sup> Psychosurgery should not be administered pursuant to consent provided in an advance directive.<sup>572</sup> ECT should not be forced on a refusing patient based on consent provided in advance through a Ulysses arrangement.<sup>573</sup> This limitation helps address concerns about a patient's change of heart or unanticipated contingencies.<sup>574</sup> ECT has potential side effects, such as memory loss.<sup>575</sup> There is too significant of a risk that a patient may have a change of heart about ECT. This is why doctors should respect contemporaneous refusals of ECT, even from patients without capacity.

However, the Ulysses arrangement will be ineffective if patients cannot use the arrangement to override their contemporaneous refusals of pharmacological therapy. A few weeks of pharmacological therapy will enable the patient to regain capacity and prevent a full-blown mental health crisis.<sup>576</sup> Patients should have the power to form Ulysses arrangements to

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569. See *supra* p. 146.

570. *Id.*

571. See *supra* p. 153.

572. See *Advance Directive Instruments, supra* note 212, at 86.

573. *Supra* p. 153 and note 410.

574. *Advance Directive Instruments, supra* note 212, at 87-88.

575. See Hull, *supra* note 410 at 251.

576. See *supra* p. 128 and note 202.



secure pharmacological therapy. Because administering medication pursuant to a Ulysses arrangement involves forcing medication on a patient pursuant to her advance request, procedural protections are necessary.<sup>577</sup> Proposed Part VI of the generic directive statute should set forth the following safeguards for administering medication pursuant to a Ulysses arrangement. First, if a patient with a Ulysses arrangement — consenting to psychiatric medication — refuses through words or actions such medication in the midst of an episode, then only a licensed psychiatrist may administer the medication. The following circumstances must be present: (1) the patient expressly consented to psychiatric medication in her Ulysses arrangement; (2) the surrogate, if one was designated, consented to the medication; and (3) two licensed psychiatrists recommend, in writing, treatment with the specific psychiatric medication.

This process strikes the right balance between safeguarding against abuse and empowering patients to secure intervention. The requirement that multiple psychiatrists recommend in writing the medication protects patient safety and health and prevents fraud and coercion.<sup>578</sup> Malpractice is less likely to occur when two licensed psychiatrists approve in writing the medication, as opposed to one physician who is not a licensed psychiatrist.<sup>579</sup> The requirement that two psychiatrists recommend the medication in writing prevents administration of medication that is unnecessary, and therefore safeguards against fraud. The requirement protects the patient from the coercive use of the Ulysses arrangement by a physician who wants to force a treatment regimen on a patient.<sup>580</sup> The requirement for written consent from the surrogate before administering medication also safeguards against fraud and

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577. *Advance Directive Instruments*, *supra* note 212, at 87-88.

578. Clausen, *supra* note 1 at 56-8

579. *Id.*

580. *Advance Directive Instruments*, *supra* note 212, at 87-88.

abuse. The surrogate is the patient's chosen decision-maker responsible for implementing the patient's instructions.<sup>581</sup> Finally, the prohibition against administering medication pursuant to a Ulysses arrangement, unless the patient expressly consented to such medication, helps ensure medication is what the patient truly wanted.

Finally, in Florida, physicians initiate almost half of all involuntary examinations under the Baker Act by execution of a certificate initiating such examinations.<sup>582</sup> Of course, these certificates do not contemplate evaluation, admission, retention, and treatment administered pursuant to a Ulysses arrangement.<sup>583</sup> Therefore, the Florida legislature should create certificates to be executed by physicians who evaluate, admit, retain, and treat patients pursuant to Ulysses arrangements. The forms should reflect all of the requirements concerning evaluation, admission, retention, and treatment specified above.

## CONCLUSION

Florida should amend the Florida generic directive statute and the Baker Act to empower mental health patients to form and effectuate Ulysses arrangements.<sup>584</sup> Such arrangements empower people to obtain intervention when an episode has caused treatment refusals.<sup>585</sup> The current combination of Florida's involuntary examination criteria and failure to authorize Ulysses arrangements postpones intervention so as to endanger the health and safety of the patient and others.<sup>586</sup> The

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581. Nat'l Conference of Comm'rs on Unif. State Laws, *Uniform Health-Care Decisions Act*, UNIFORM L. COMMISSION 22 (Jan. 12, 1994), [http://www.uniformlaws.org/shared/docs/health%20care%20decisions/uhcda\\_final\\_93.pdf](http://www.uniformlaws.org/shared/docs/health%20care%20decisions/uhcda_final_93.pdf) [hereinafter UHCDA].

582. DCF Fact Sheet, *supra* note 4.

583. By Authority of FLA. STAT. §§ 394.455(18), 394.463(2)(a)(3), 394.4655(2)(a)(1), 394.467(1)-(2) (2013).

584. FLA. STAT., ch. 765 (2013); *see supra* pp. 146-162.

585. Clausen, *supra* note 1 at 4.

586. FLA. STAT., ch. 765 (2013); *see supra* pp. 146-162.

Ulysses arrangement offers hope of preventing such tragedies as James Tuten's suicide, which occurred the day after his psychiatrist heeded his discharge demands because James no longer technically met involuntary placement criteria.<sup>587</sup> For many patients, Ulysses arrangement intervention is preferable to involuntary placement because Ulysses arrangement intervention is both more timely, effective, therapeutic, and less traumatic, intrusive, and time-consuming.<sup>588</sup> For Florida, Ulysses arrangement intervention preserves scarce judicial, public defender, medical, and hospital resources.<sup>589</sup>

Proposed Part VI of the generic directive statute described in this Article ensures patients form arrangements voluntarily and knowingly because it empowers patients to decide whether they can revoke their directives when they lack capacity. It requires a signed, witnessed writing and a capacity assessment and attestation at the time of arrangement formation. These measures help prevent fraud, undue influence, coercion, and duress. Moreover, proposed Part VI of the generic directive statute provides for automatic expiration, which helps ensure informed consent is relatively recent.

The summarized legislative relief also empowers patients to make their arrangements effective intervention tools by authorizing patient designated activation and involuntary transportation to a facility. The involuntary transportation option is novel and necessary. A patient whose illness causes treatment refusals will also refuse transportation to a hospital. Requirements for a surrogate affidavit, petition, and court order to authorize involuntary transportation help ensure involuntary transportation is what the patient decided she needs and wants, and helps safeguard against abuse.

Proposed Part VI of the generic directive statute also sets forth procedures for admission, retention, and treatment over

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587. Tuten v. Fariborzian, 84 So.3d 1063, 1065 (Fla. Dist. Ct. App. 2012).

588. See *supra* Part I(B)(2).

589. See *id.*

contemporaneous objections, which safeguard against abuse. The described provision provides a rebuttable presumption of incapacity in the event a patient's Ulysses arrangement consents to treatment the patient then refuses in the midst of an episode. This presumption is necessary to facilitate treatment because it recognizes Florida doctors, concerned about liability for hospitalizing and treating a patient who does not meet Baker Act criteria,<sup>590</sup> will be reluctant to treat in the face of illness-induced refusals.

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590. FLA. STAT. § 394.463(1) (2013).