2023 Baker Act User Reference Guide

Department of Children and Families

Office of Substance Abuse and Mental Health

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Original Publication Date August 2023

Recommended Citation:

Florida Department of Children and Families (2023). 2023 Baker Act User Reference Guide. Tallahassee, FL Department of Children and Families, Office of Substance Abuse and Mental Health.

For More Information:

Florida Department of Children and Families, Baker Act Website:
https://www.myflfamilies.com/crisis-services/baker-act

Florida Alcohol and Drug Abuse Association (FADAA) Training Website:

www.FloridaLearner.org

Copies of this Manual:

This manual is available in electronic form at the Florida Department of Children and Families Baker Act Website:
https://www.myflfamilies.com/crisis-services/baker-act/baker-act-training

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PREFACE

I. Purpose

The Baker Act User Reference Guide (Guide) was developed by the Florida Department of Children and Families' (Department) Office of Substance Abuse and Mental Health. The purpose of the Guide is to serve as a user-friendly resource for the public and professionals regarding the Florida Mental Health Act, more commonly referred to as the Baker Act. The Guide was developed as a reference tool to assist with understanding procedures related to the Baker Act, to describe the rights of individuals receiving services under the Baker Act, and to identify the responsibilities of mental health service providers.

II. Format and Layout

The Guide displays relevant federal and state laws, administrative rules, and the Baker Act forms within the text of each chapter. These are shown in colored bars for a quick reference.

- Federal laws are shown in grey bars. ■■■
- Florida laws are shown in blue bars. ■■■
- Florida administrative rules are shown in green bars. ■■■
- Baker Act forms are shown in yellow bars. ■■■

Detailed information on certain topics are hyperlinked and will redirect readers to either another section within the Guide or to an external website. For example, the individual Baker Act forms will not be included in the Guide but will instead be accessible with a hyperlink that will direct to the most current forms available on the Department's website. This ensures that facilities have access to the most up-to-date forms. Some information, such as corresponding laws, forms, charts, or online courses, may include links to additional reference materials.

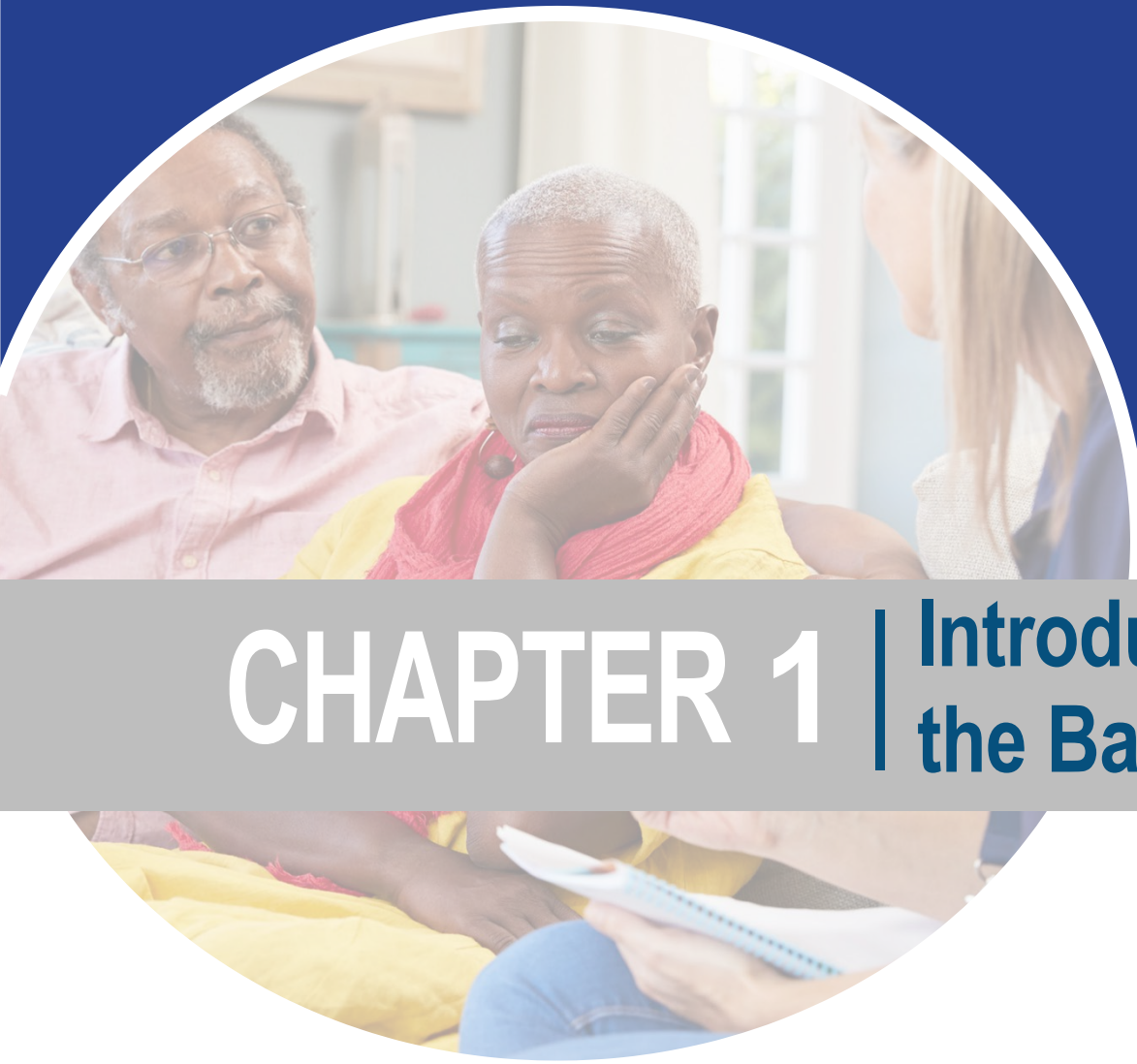
Contact information, such as phone numbers and websites of organizations/agencies, can be found in Appendix A and Appendix B, which list all web addresses of sources hyperlinked within the Guide for those using a hard copy.

III. Florida Certification Board - Baker Act Online Courses

The Department underwrites free behavioral health courses in partnership with the Florida Alcohol and Drug Abuse Association (FADAA). These online, self-paced, interactive courses are open to the public at no cost. Continuing education credits are also provided at no cost to eligible learners. Courses can be accessed on the FADAA's Leaning Management System website.

IV. Disclaimer

The Guide has no legal authority and should not be used as legal advice. Statutes and rules relating to the Florida Mental Health Act can be modified and have many nuances that may not be covered in their entirety in the Guide. It is important to keep apprised of any changes to the legislation, administrative rule, as well as reader's agency policies and procedures and professional Code of Ethics. Additionally, there are special considerations and interpretations of the law. If there are further questions on a topic, reader should refer to organization's risk manager, legal counsel, or the appropriate governing authority.



CHAPTER 1 | Introduction to the Baker Act

I. Background

II. Terminology

III. Oversight

I. Background

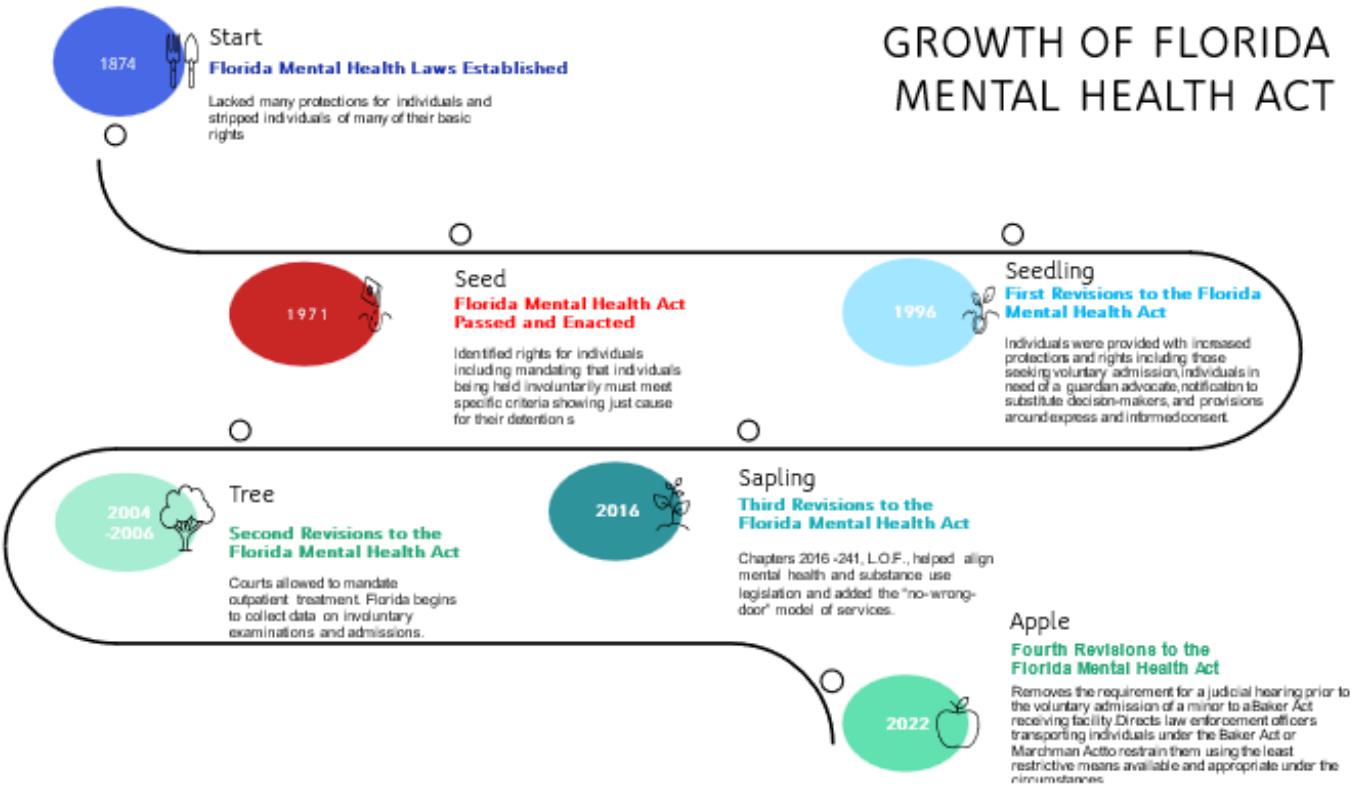
History of the Mental Health Act

The intent of the Baker Act is to provide short-term evaluation, treatment, and stabilization for individuals struggling with acute mental health symptoms. The Baker Act is primarily thought of as applying to individuals under involuntary status. However, the intent is to encourage individuals to engage in services voluntarily when they are willing and competent. The Baker Act provides guidelines and procedures for the way services are delivered including required timeframes for evaluation and treatment, rights of individuals served, and maintenance of the treatment environment.

Statutes governing the evaluation and treatment of mental health conditions in Florida date back to 1874. Amendments to Florida's mental health laws were passed several times in the 20th century, but no significant changes went into effect until the 1970's. In 1971, the Florida Legislature passed the first major overhaul of mental health laws in the state's history with the Florida Mental Health Act. Sponsored by State representative Maxine Baker, the Florida Mental Health Act is more commonly referred to as the Baker Act. These laws changed both the criteria for involuntary placement and significantly improved due process by increasing the civil rights of individuals receiving services in mental health facilities.

> "In the name of mental health, we deprive them of their most precious possession – liberty."
> *– Representative Maxine Baker referring to the treatment of individuals with mental health conditions before the 1971 passage of the Florida Mental Health Act.*

The revised laws provided more stringent standards for the separation of children and adults in facilities delivering services. Minors did not receive age-appropriate services and children as young as 12 could live with and receive the same programming as adults, resulting in poor outcomes. Discharge and correspondence procedures also changed for individuals admitted to a Baker Act facility. For example, prior to 1972 only a judge could discharge an individual from a Baker Act facility. Currently, a physician, judge, psychologist, psychiatric nurse, or hospital administrator can authorize a discharge. In addition, individuals who were previously restricted to correspondence with one specific individual outside the facility are now able to communicate with anyone they choose during their admission to a Baker Act receiving facility.



A. Current Law

The legal authority for the Baker Act is found in part one, chapter 394, Florida Statutes (F.S.). Administrative rules related to the Baker Act include 65E-5 and 65E-12 Florida Administrative Code (F.A.C.), which address Public Mental Health Crisis Stabilization Units (CSUs) and short-term residential treatment (SRTs) programs. There are additional laws that overlap and interact with the Baker Act including those regulating other facilities, such as hospitals and long-term care facilities, and laws governing services to individuals with co-occurring conditions, such as developmental disabilities, substance use disorder (SUD), exposure to abuse, and the presence of a substitute decision-maker. More information on these related laws can be found in Appendix C.

Since 1972, the Baker Act has undergone several noteworthy amendments including:

- Additional provisions for Involuntary Outpatient Placement in 2005 (in 2016, Involuntary Outpatient Placement was renamed Involuntary Outpatient Services).
- The enactment of chapters 2016-241, 2016-135, and 2016-127, Laws of Florida in 2016.
    - Chapter 2016-241, Laws of Florida (Senate Bill 12)
        - Identified the "no-wrong-door" model of service delivery increasing access to behavioral health services allowing individuals to enter the service system at a variety of access points and connect with the most appropriate behavioral health services for current needs.
        - Expanded who could enact a petition for involuntary placement.
        - Amended the rights of individuals who receive services in a designated receiving facility or Baker Act treatment facility.
        - Streamlined the process for individuals receiving services in a designated receiving facility or Baker Act treatment facility.
        - Improved care by delivering more comprehensive and coordinated services.
        - Increased the oversight responsibilities of the Department.
        - Standardized the Report of Law Enforcement form when a law enforcement officer initiates an involuntary examination.
        - Standardized the training for Guardian Advocates.
        - Clarified duties for Managing Entities and their interactions with the Department.

Information on how the Baker Act and the Marchman Act compare to one another are located in Appendix D. A comprehensive chart can also be found on the Department's webpage.

- Chapter 2016-135, Laws of Florida (House Bill 769) addressed additional statutes relating to mental health treatment including:
    - Reduced the maximum time an individual with specific nonviolent offenses can be held in forensic facilities.
    - Identified circumstances justifying the continuation of psychotropic medication for incompetent individuals when transitioning from a jail to a designated receiving facility or State Mental Health treatment facility.
- Chapter 2016-127, Laws of Florida (House Bill 439) provided amendments to several statutes regarding involuntary outpatient and mental health services in the criminal justice system including:
    - Further defined elements of involuntary outpatient services.
    - Authorized the establishment of mental health courts and mental health probation.
    - Provided increased eligibility for court and behavioral health programs serving veterans.

- The enactment of chapter 2018-3, Laws of Florida (Senate Bill 7026) in 2018.
    - Chapter 2018-3, Laws of Florida, addressed firearms protections following the Marjory Stoneman Douglas High School shooting including prohibitions on owning or possessing firearms and ammunition for individuals who are either:
        - Adjudicated mentally defective.
        - Involuntarily admitted to a designated receiving facility for posing a credible physical threat to self or

others.
        - Made the firearm restriction temporary for as long as the individual meets all of the following criteria:
            - Is admitted to a designated receiving facility or State Mental Health treatment facility.
            - Is receiving involuntary inpatient or outpatient services.
            - Has a firearm disability or risk protection order executed by the court.
    - The enactment of Chapter 2022-36, Laws of Florida (House Bill 1262).
        - Prohibited restrictions on visitors, phone calls, and written correspondence for individuals in a Baker Act receiving facility unless certain qualified medical professionals document specific conditions are met.
        - Defined telehealth to provide clear authority for professionals to provide Baker Act services and release; and required law enforcement officers to report any known contact information for relatives of persons detained under the Baker Act.
        - Required the Baker Act discharge procedures to consider and document the individual's access to transportation, aftercare services, housing, and psychotropic medication.
        - Required law enforcement officers to search certain electronic databases for emergency contact information of Baker Act and Marchman Act patients being transported to a receiving facility.
        - Required that individuals admitted voluntarily under the Marchman Act be provided the opportunity to authorize the release of information to their health care surrogate or proxy, attorney, representative, or other known emergency contact.
        - Required the Department receive and maintain reports relating to the transportation of individuals.
    - The enactment of Chapter 2022-41, Laws of Florida (House Bill 1844).
        - Removed the requirement for a judicial hearing prior to the voluntary admission of a minor to a Baker Act receiving facility; instead required a clinical review of the minor assent once the parent or legal guardian applied for the minor's admission.
        - Directed law enforcement officers transporting individuals under the Baker Act or Marchman Act to restrain them using the least restrictive means available and appropriate under the circumstances.

B. No-Wrong-Door Model and Warm Hand-Offs

In 2016, Florida enacted new laws to improve the coordination and delivery of behavioral health services. One provision directed the managing entities (MEs) to assist counties in developing and implementing an effective receiving system. Receiving systems must operate as a no-wrong-door model providing individuals with optimal access to an array of behavioral health services despite their point of entry. Putting this concept into practice requires providers in a receiving system to work together by facilitating a warm hand-off to the correct level of care with the appropriate provider and integrating services between multiple providers.

The no-wrong-door model incorporates many elements essential to linking individuals to the most appropriate provider and level of care for their needs. For example, all individuals who present at a designated receiving facility for evaluation do not necessarily need an inpatient level of care. Based on an assessment, it may be determined that the individual requires a different level of care such as intensive outpatient services or partial hospitalization. The triage and assessment process should identify not only what services the individual seeks, but also determine what services the individual needs and provide warm hand-offs to primary or supplementary services providers to the extent possible.

The no-wrong-door model does not only consist of providing the individual with contact information for another provider or service. Instead, the model embodies several components to successfully link the individual with a service. This process is often referred to as a warm hand-off. A warm hand-off means a transition process from a receiving facility to a less restrictive behavioral health provider that is conducted face-to-face, either in-person or via telehealth, between facility staff and a community behavioral health provider, peer specialist, case manager, or care coordinator while the individual is present. In the warm hand-off process, ongoing treatment and discharge plans are coordinated.

The primary elements of a warm hand-off process are:

- Providing transparency of the referral process and the information being shared.
- Engaging the individual in the referral process by:

- Allowing the individual to provide feedback on information shared.
- Allowing the individual to contribute information that is being shared with the new provider.
- Providing the individual with an opportunity to ask questions about the referral process or the new service or provider.

Warm hand-offs are believed to increase the individual's trust in the provider and improve both quality and safety of services rendered. Often, a warm hand-off engages the individual's support system, such as family members or close friends. In these instances, both the individual and their natural supports are informed of the individual's treatment needs and the plan for meeting those needs. This often strengthens the individual's support system by making them a more integral part in the individual's treatment.

Using the no-wrong-door model and warm hand-offs ensure that the individual is linked with the most appropriate service and engaged in the referral process. More information about linking to other services and the referral processes can be found in chapter two (2).

Warm hand-offs are often used in the context of the no-wrong-door approach.

II. Terminology

s. 394.455, F.S. • Definitions

The Guide intentionally uses terminology to promote a person-centered approach. Person first language is encouraged to empower individuals and reduce stigma. For example, an "individual with a mental health condition" would be used instead of a more objectifying term such as "the mentally ill." A few key terms are provided below to help understand the criteria for examination, admission, and treatment.

Term	Definition and Use
The Department	Used to refer to the Florida Department of Children and Families.
The Baker Act	The Baker Act will be used to refer to the Florida Mental Health Act. This includes rights and procedures for individuals receiving services in a designated receiving facility or State Mental Health Treatment Facility, the initiation of an involuntary examination, court orders, and notifications.
Designated Receiving Facility	All involuntary examinations under the Baker Act are required to occur at a Baker Act receiving facility designated by the Department. A designated receiving facility that is authorized to receive involuntary examinations under the Baker Act may be classified as a hospital or a Crisis Stabilization Unit. Public Baker Act facilities receive funding from the Department whereas private Baker Act facilities are funded through private pay sources such as commercial insurance coverage and do not receive departmental funding.
State Mental Health Treatment Facility	A State Mental Health Treatment Facility provides extended treatment to an individual in a state owned, operated, or otherwise supported hospital. State Mental Health Treatment Facilities are typically reserved for individuals experiencing the most acute and chronic symptoms. Most individuals who receive services in a designated receiving facility will never have contact with a State Mental Health Treatment Facility.
Hospitals and CSUs	A hospital is any facility that carries the designation as a medical, psychiatric, or other specialty hospital. Hospitals are licensed under chapter 395, Florida Statutes, by the Agency for Health Care Administration (AHCA) and may be designated by the Department as a Baker Act receiving facility. A Crisis Stabilization Unit (CSU) or Children's Crisis Stabilization Unit (CCSU) is licensed under chapter 394, Florida Statutes, by AHCAand designated by the Department as a Baker Act Receiving Facility.
Term	**Definition and Use**
Individual	Refers to the individual's receiving services. Unless specifically quoted from legislation, the terms patient and client will not be used.

Express and Informed Consent	Express and informed consent means that the individual or person authorizing services is competent and the consent for examination or treatment is voluntary and given in writing. This consent may only occur after sufficient explanation and disclosure of the subject matter involved has been received. This level of disclosure enables a competent individual to make a knowing and willful decision regarding the authorization for services requested. The decision to consent to services or to share protected health information must occur without any form of constraint or coercion.
Incompetent to Consent to Treatment	An individual may be deemed incompetent to consent to their own treatment by a physician. Incompetence can be determined when the individual's mental capacity is impaired causing a significant and detrimental impact on their judgment. As a result of this impairment, the individual is considered to lack the capacity to make a well-reasoned, willful, and knowing decision concerning his or her own medical or mental health treatment.
Legal Status	An individual's legal status under the Baker Act indicates whether they are voluntary and agreeing to their own admission and treatment or involuntary due to the inability or unwillingness to provide their own express and informed consent for services. Legal status can change throughout a single admission.
Parent	Often used to refer to any legal guardian of a minor including a biological parent, foster parent, or other legal guardian.
Substitute Decision-Maker	A substitute decision-maker refers to anyone who is actively making mental health decisions for another individual. This may be a person appointed by the court, someone identified in an advanced directive, or a parent of a minor. The authority of the substitute decision-maker is determined on a case-by-case basis and outlined in an advance directive or order of the court. The substitute decision-maker is often granted authority to make all healthcare decisions for the individual, not just behavioral health decisions.
Behavioral Health	Used to refer to mental health and/or substance use disorder or services.
Mental Health Condition	A mental health condition, referred to in section 394.455, Florida Statutes, as a mental illness, meets all the following criteria: • An impairment of the mental or emotional processes that exercise conscious control of either: ▪ One's actions. ▪ The ability to perceive or understand reality. • This impairment substantially interferes with an individual's ability to meet the ordinary demands of living. The term does *not* include conditions or behaviors primarily due to any of the following: • A developmental disability as defined in chapter 393, Florida Statutes. • Substance use impairment or intoxication. • Conduct manifested only by dementia, traumatic brain injury, or antisocial behavior.
Substance Use	Used in place of addiction and substance abuse.

III. Oversight

s. 394.457, F.S. • Operations and Administration

There are several agencies that provide oversight for the Baker Act. Each agency has specific responsibilities and areas they monitor and supervise. Most of these duties are the responsibility of the Department with additional tasks delegated to AHCA, Disability Rights Florida, Managing Entities, and the Baker Act Reporting Center. All mental health programming in Florida, including residential, inpatient, and outpatient services, are provided with oversight from the Department and AHCA. These two organizations, and the Florida Department of Health (FDOH), who license and regulate medical and behavioral health professionals, provide executive and administrative oversight.

A. The Florida Department of Children and Families

The Department is the state agency that administers services in several areas including child welfare, mental health, substance use, domestic violence, and economic self-sufficiency. The Department is designated as the mental health authority of Florida and has several functions related to the Baker Act including: (1) directing mental health rulemaking in the F.A.C., (2) developing Baker Act forms; and (3) investigating complaints of abuse and neglect of vulnerable populations. The Department also provides oversight for the provision of treatment, crisis services, and prevention in mental health programs.

The Department engages in rulemaking and the implementation of rules in the F.A.C. pertaining to the rights of individuals receiving services. This includes maintaining forms, establishing minimum procedures for Baker Act facilities, and designating all public and private receiving facilities. Only those facilities designated by the Department as a Baker Act receiving facility may hold and provide services to an individual under involuntary examination or placement.

The Department has oversight of crisis stabilization units (public receiving facilities) and contracts much of the oversight responsibilities to MEs throughout the state. When the Department becomes aware of a potential violation by a mental health provider, those violations must be reported to AHCA for further investigation. AHCA is the governing authority for facility regulations, licensing, and fraud reports. Reports typically consist of a licensed facility or an individual healthcare provider violating legal policies or procedures in a mental health facility, such as the violation of an individual's rights. AHCA also provides direct oversight to hospitals (private receiving facilities).

1. Forms

ch. 65E-5.120, F.A.C. • Forms

The Department has developed a set of forms that address different voluntary and involuntary procedures under the Baker Act. Providers can make formatting modifications to all forms to better assimilate these forms into various electronic health records systems.

While it is standard practice to have the original Baker Act forms follow the individual and be retained in clinical records, the original forms are not required by law.[1] This situation could occur if an individual is transported by law enforcement to a receiving facility from a hospital's emergency department, and presents with a copy of the Certificate of Professional Initiating Involuntary Examination (CF-MH 3052b) instead of the original document. A copy could also be utilized if an individual is transported from another facility and the original paperwork is not sent with transport; the paperwork must be submitted electronically to the receiving facility after arrival. Regardless of the situation, the original Baker Act forms or copies of those forms must be retained in the individual's clinical record.

the Department's Substance Abuse and Mental Health website includes legislatively required reports and other helpful resources including:

- Links to the most current forms.
- The Baker Act Data Collection System (BADCS)
- An overview of current progress on policy and rule development.
- Reports and publications including The Baker Act Annual Report, the Task Force Report on Involuntary Examination of Minors, and the Report on Involuntary Examination of Minors.
- Information about upcoming events such as workshops and hearings relating to the Baker Act.
- Complaint process for facilities.
- Additional information and resources regarding prevention and treatment.

A myriad of topics relating to the Baker Act are addressed in the Frequently Asked Questions (FAQs) of the Department's website. These FAQs cover topics such as emergency medical conditions, long-term care facilities, involuntary examinations, and voluntary admissions.

B. Managing Entities

s. 394.9082, F.S. • Behavioral Health Managing Entities

The Department provides for the delivery of substance abuse and mental health services to underinsured and

uninsured individuals. In 2010, the Department instituted a regional model of services administered by Behavioral Health MEs. A ME is a nonprofit organization under contract with the Department to manage a network of behavioral health care providers in a specific region of the state. There are seven MEs for the Department's six regions. Each of these regions are comprised of several judicial circuits. A map can be referenced in Appendix E.

MEs manage the daily operations of behavioral health care for their region. Instead of providing direct services, a ME creates provider networks. Provider networks are developed by identifying specific behavioral health needs for the region and then contracting with local providers to meet those needs through a full array of prevention, recovery support, emergency, outpatient, inpatient, and residential services.

C. Baker Act Reporting Center

ch. 65E-5.280(5), F.A.C.	• Involuntary Examination
Form CF-MH 3118	• Cover Sheet to Department of Children and Families

The Baker Act Reporting Center is located at the University of South Florida and serves as a processing center for the Department for data from clerks of court, and provides technical assistance for compliance with statutory requirements for document submission to all receiving facilities. Designated receiving facilities that accept individuals for an involuntary examination must submit the initiating documentation into the BADCS. The data is analyzed and published on the Department's website, *The Baker Act Annual Report*.

The forms that are statutorily required to be collected by the Department are listed in the table below:

Form Number	Form Name	Related Statute
CF-MH 3118	Cover Sheet to the Department	s. 394.463, F.S.
CF-MH 3052b	Certificate of Professional Initiation Involuntary Examination	s. 394.463, F.S.
CF-MH 3052a	Report of Law Enforcement Officers Initiating Involuntarily Examination	s. 394.463, F.S.
CF-MH 3001	Ex-parte Order for Involuntary Examination	s. 394.463, F.S.
CF-MH 3100	Transportation to Receiving Facility	s. 394.463, F.S.

These forms must be transmitted to the Department within five working days.

Clerks of court must submit the following petitions and court orders to the Baker Act Reporting Center within five working days.

- Petition for Involuntary Inpatient Placement (CF-MH 3032)
- Order for Involuntary Inpatient Placement (CF-MH 3008)
- Petition for Involuntary Outpatient Placement (CF-MH 3130)
- Order for Involuntary Outpatient Placement or Continued Involuntary Outpatient Placement (CF-MH 3155)
- Certificate and Individualized Plan of Continued Services (CF-MH 3145)

The Baker Act Reporting Center can be contacted in the following ways.

Phone:	813-974-1010
Email:	bakeract@usf.edu
Website:	http://www.usf.edu/cbcs/baker-act/
Mailing Address:	Baker Act Reporting Center USF-CBCS 13301 Bruce B. Downs Blvd. Tampa, FL 33612

More information about the Baker Act Reporting Center including document submission requirements and options, FAQs about form submission, and the Baker Act Annual Report can be found on the website referenced above.

D. The Agency for Health Care Administration

s. 394.463(2)(b), F.S.	• Involuntary Examination
ch. 65E-5.280(6), F.A.C.	• Involuntary Examination
Form CF-MH 3119	• Notification of Non-Compliance

AHCA works in collaboration with the Department to provide oversight for all mental health services provided throughout the state. AHCA is responsible for licensing and investigating complaints for hospitals, crisis stabilization units, and residential treatment centers.

Receiving facilities are responsible for reporting to AHCA any long-term care facility licensed under chapter 400 or chapter 429, F.S., not fully complying with the Baker Act. Reports must be made by certified mail within one working day. These violations are often regarding voluntary admissions, involuntary examinations, or transportation requirements including when an individual is transported to a receiving facility without the required documentation.

AHCA also oversees provider compliance with federal regulations in accordance with the Centers for Medicare and Medicaid Services (CMS); identifying that any facility or provider that accepts Medicare or Medicaid payments falls under AHCA's jurisdiction. Anyone with concerns regarding a provider being in compliance with state or federal regulations may report these concerns by calling AHCA's compliance hotline at 888-419-3456.

E. The Joint Commission

Healthcare organizations, including most hospitals, follow the standards and guidelines of the Joint Commission. The Joint Commission is the primary agency that provides accreditation to healthcare organizations. The Joint Commission ensures that healthcare organizations under the commission jurisdiction meet minimum standards for continued accreditation.

The Joint Commission performs an on-site survey once every three (3) years to ensure organizations meet the minimum standards. Organizations may also be subject to surveys when auditors arrive unannounced or with very little notice. The organization's policies, procedures, and clinical records are reviewed for compliance.

Representatives from the Joint Commission speak with staff and individuals receiving services to further assess the performance of the operations and services of the organization. The Joint Commission primarily looks at measures of quality, safety, and individual rights.

1. Standards of the Joint Commission

A set of standards are developed for each type of organization that the Joint Commission accredits. The standards are largely dependent upon type of service and level of care provided such as crisis stabilization, partial hospitalization, or outpatient community-based services. Baker Act facilities must meet all the requirements for the organization (i.e., receiving, treatment, or hospital), level of care (i.e., inpatient), as well as the behavioral health care requirements.

The Joint Commission uses the National Patient Safety Goals to help guide the standards and surveys. The National Patient Safety Goals are frequently reviewed, revised, and provide very specific and focused goals for staff and organizations to use to measure level of compliance with providing safe, quality, person-centered treatment. This includes goals for infection control, reduction of medical errors, and identification of high-risk factors for suicide.

F. The Commission on Accreditation of Rehabilitation Facilities

The Commission on Accreditation of Rehabilitation Facilities (CARF) is an international, non-profit organization that provides voluntary accreditation to qualifying health and human service organizations, including 29 different types of behavioral health programs. These specific programs are recognized for accountability and adherence to internationally accepted standards that promote excellence in service. For more information about programs in Florida, CARF provides an online search tool for accredited programs.

CHAPTER 2

Facilities Providing Services Under the Baker Act

I. Requirements for Facilities Providing Baker Act Services

I. Requirements for Facilities Providing Baker Act Services

ch. 65E-5.1802, F.A.C.	• Designation of Baker Act Facilities and Receiving Systems
ch. 65E-5.350, F.A.C.	• Eligibility Criteria and Procedures for Designation

While many providers can deliver mental health services, Baker Act services, including all involuntary services, must be delivered in either a designated receiving facility or State Mental Health Treatment Facility. Designated receiving facilities and Baker Act treatment facilities must also provide voluntary services and the same Baker Act laws, rights, and protections apply.

A designated receiving facility **must** accept individuals transported for an involuntary examination by law enforcement and emergency transportation companies despite the facility's current capacity and capability. When the designated receiving facility accepts an individual for an evaluation, it does not dictate that the individual must be admitted to that facility. When appropriate, the designated receiving facility may arrange a subsequent transfer to another designated receiving facility or medical hospital for medical clearance. It is important to note that by virtue of designation as a designated receiving facility, the entire facility is designated, not just one specific unit(s).

Once an initial evaluation is complete, determining whether the individual needs to be admitted to a designated receiving facility or State Mental Health Treatment Facility, the facility must have both the capacity and capability to provide appropriate services.

Capacity of a facility specifies that it has a licensed bed available to provide appropriate services to the individual. While a designated receiving facility may have beds available, the facility may only have licensed beds available for a certain population. For example, if the facility is an adult facility without licensed beds for minors, the facility would be unable to admit an individual under the age of 18. When considering capacity, the normal accommodations that are made for individuals are taken into account. If a facility regularly makes certain accommodations for admission, those variations become part of the facility's normal capacity.

Capability is the facility's ability to provide necessary services to an individual during admission duration. This includes providing assessment and treatment for both psychiatric and medical needs. Most medical needs can be managed in a designated receiving facility or State Mental Health Treatment Facility; however, some conditions will require a referral to a medical hospital for appropriate medical examination and treatment. Designated receiving facilities licensed as CSU's tends to be more limited in their capability to provide medical services than those licensed as a psychiatric hospital. In addition, some designated receiving facilities licensed as hospitals may not be fully equipped to manage more complicated or acute medical conditions.

Due to the Emergency Medical Treatment and Labor Act (EMTALA), a facility licensed as a hospital must admit individuals experiencing an emergency medical condition when they have both the capacity and capability to meet the individual's needs. A mental health condition is considered an emergency medical condition if the individual meets criteria for an involuntary examination, even if the admission were voluntary. When an individual needs specialized services, such as psychiatric care, a hospital with the capability and capacity to meet the individual's needs must accept transfers from other facilities that do not have the same capability or are over capacity.

A. Designated Receiving Facilities

Most voluntary and involuntary Baker Act services are delivered in a designated receiving facility. Designated receiving facilities are structured to receive individuals under involuntary status while still providing voluntary services for those who are able and willing to provide express and informed consent. Receiving facilities are designated as either a public or private facility. The designation of receiving facilities as a public or private facility is determined by how the facility is funded and effects the way in which individuals can be transferred between facilities.

More information on facility transfers can be found in chapter seven (7).

1. Public Facilities

s. 394.875, F.S.	• CSUs and Residential Treatment Facilities
ch. 65E-12, F.A.C.	• Public Mental Health CSUs and SRTs

Public facilities are designated receiving facilities that receive public funds to provide mental health services under the Baker Act. While some public receiving facilities are hospitals, the majority of these facilities are licensed as CSUs. Public funds enable CSUs to provide services to individuals who are uninsured and underinsured, though individuals

with insurance can still access services at a CSU.

CSUs often have increased limited capacity and capability than a psychiatric hospital. A CSU that serves adults may be licensed for a maximum of 30 beds while those serving minors may be licensed for a maximum of 20 beds. CSUs cannot exceed capacity by more than 10 percent. Capacity cannot be exceeded for any longer than three (3) consecutive days and no more than seven (7) days in a 30-day period unless approved by AHCA.

s. 394.461, F.S.	• Designation of Receiving and Treatment Facilities and Systems
ch. 65E-5.351, F.A.C.	• Minimum Standards for Designated Receiving Facilities

CSUs are responsible for the central coordination of acute care services for mental health. This designates that CSUs are tasked with assisting and managing situations when there is difficulty placing or transferring an individual in a designated receiving facility. If there are challenges with transferring eligible individuals to a CSU, the Department's regional office and the Managing Entity can assist with checking the census of the CSU and other factors that may impact the refusal of an otherwise appropriate transfer.

2. Private Facilities

ch. 65E-5.350, F.A.C.	• Eligibility Criteria and Procedures for Designation

Most designated receiving facilities licensed as hospitals are private facilities. This means that the facility relies solely on private payments from individuals and insurance companies and does not receive any public funds to support the operation of the facility. However, private facilities often accept Medicare as an authorized insurance provider.

B. State Mental Health Treatment Facilities

s. 394.461, F.S.	• Designation of Receiving and Treatment Facilities and Systems

To be designated as a State Mental Health Treatment Facility, the facility must be either state-owned, state-operated, or state-supported. State Mental Health Treatment Facilities are intended to provide services for a longer duration than a receiving facility. These types of treatment facilities are commonly referred to as state hospitals.

Some individuals who are ordered to involuntary inpatient placement will remain in a receiving facility for the duration of their services, other individuals will be transferred to a State Mental Health Treatment Facility. State Mental Health Treatment Facilities are only accessible by a court order, almost exclusively for individuals under involuntary status, and provide more of a residential treatment setting for those who are struggling with serious and long-term symptoms of a mental health condition.

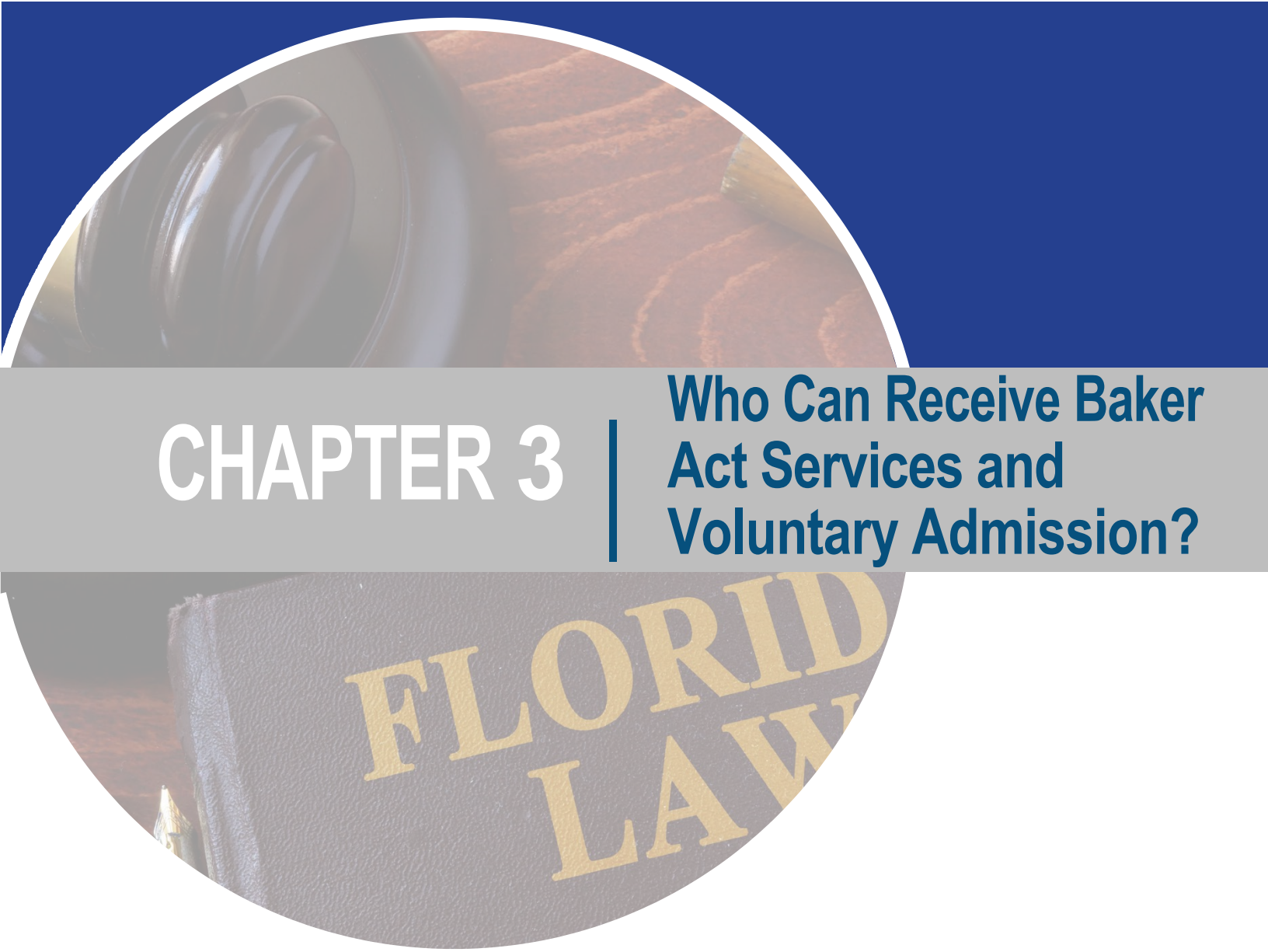
C. Medical Emergency Departments

s. 394.462, F.S.	• Transportation
s. 394.463, F.S.	• Involuntary Examination

An individual meeting the criteria for voluntary or involuntary Baker Act services is often evaluated and treated in a medical hospital. There are many scenarios allowing this to occur.

- An individual may be sent to a medical hospital immediately following the initiation of an involuntary examination for medical clearance prior to being transported to a receiving facility to complete the involuntary examination.
- An individual may be sent to a medical hospital from a designated receiving facility or State Mental Health Treatment Facility for medical clearance.
- An individual may be evaluated for mental health services in an emergency department. When appropriate, the individual may be encouraged to seek voluntary services, or an involuntary examination may be initiated based on their evaluation at the emergency department.

More information regarding how individuals meeting criteria for an involuntary examination are handled in an emergency department can be found in the section Medical Emergencies and Transports in chapter seven (7).



CHAPTER 3 | Who Can Receive Baker Act Services and Voluntary Admission?

I. Who Can Receive Baker Act Services?

Voluntary and involuntary Baker Act services are intended for individuals experiencing significant symptoms of a mental health condition. The criteria for accessing and receiving services in designated receiving facilities and Baker Act treatment facilities differs based on the legal status of the individual.
Individuals often enter inpatient services when the symptoms they are experiencing are so serious that their behaviors can no longer be safely managed on an outpatient basis. This admission may occur on a voluntary or involuntary basis. The criteria for voluntary admission and involuntary examination are similar but there are some key differences. Individuals who are competent to provide express and informed consent have a right to seek treatment on a voluntary basis if they are fully able to understand all of the following information:

- The decision they are making; and
- The potential consequences of proceeding with or declining services; and
- The individual's rights and how to apply and exercise those rights on their own behalf.

Even when an individual meets the criteria for an involuntary examination, they are encouraged to engage in services voluntarily and must provide informed consent for treatment if clinically competent. Many individuals initially admitted to a designated receiving facility under involuntary status may be transferred to voluntary status and continue services.

For more information on who is eligible for voluntary and involuntary admission to a designated receiving facility or State Mental Health Treatment Facility, please refer to Appendix F.

II. Voluntary Admission

s. 394.4625, F.S.	• Voluntary Admissions
Form CF-MH 3040	• Application for Voluntary Admission (Receiving Facility)

Individuals may apply for services at a designated receiving facility or State Mental Health Treatment Facility for voluntary admission, also referred to as voluntary legal status if they meet all the following criteria:

- Is competent to provide express and informed consent to treatment; and
- Can benefit from inpatient services; and
- Cannot receive the same benefit from receiving services at a lower level of care.

Consent must be deliberate and occur after there is sufficient explanation and disclosure by the facility about the services being provided. Sufficient explanation may include treatment risks, benefits, and other less restrictive alternatives to inpatient treatment. Consent must be in writing and documented in the clinical record. If there are physical limitations preventing the individual from signing admission forms, facilities may use other procedures, such as having the individual receiving services make a mark for their name where their signature is required, accompanied by staff initials. Please refer to the facility's policies and procedures to identify the proper procedures for recording signatures for individuals who are unable to provide a signature due to physical or cognitive limitations.

Designated receiving facilities have some discretion whether to admit an individual who is requesting voluntary admission. Admission decisions by designated receiving facilities for voluntary individuals may be based on the availability of beds, service needs, authorization from the individual's insurance company, and the clinical opinion of the professional. Treatment must be provided at the least restrictive level of care necessary for the significant improvement of the individual's symptoms. Unlike those admitted involuntarily, those who are admitted voluntarily do not always need to present as posing an imminent threat of inflicting significant physical harm to self or others. Professionals must determine if hospitalization is the most appropriate level of care.

Not everyone who requests admission to a designated receiving facility will be appropriate for services at an inpatient level of care.

An individual seeking voluntary admission is interviewed by facility staff to determine if inpatient services are appropriate. To qualify for voluntary admission, the individual must meet all the following criteria and be:

- Able to demonstrate evidence of an active mental health condition that could benefit from an acute psychiatric hospitalization as evidenced by symptoms of the mental health condition that are either:

    - Causing significant disruption to the individual's activities of daily living; or
    - Placing the individual or others at imminent risk of serious physical harm; and
- Willing to provide express and informed consent; and
- Able to provide express and informed consent by all the following:
    - Not having a substitute decision maker for health care; and
    - Not living in a facility that is designed to help meet the individual's activities of daily living; and
    - Being fully oriented to person, place, time, and situation.

It is important that the individual meet clinical criteria for inpatient services. While the criteria can vary, it generally means that the individual needs short-term intensive services for emotional or behavioral stabilization that cannot reasonably or safely be achieved in a lower level of care. For example, an individual who is experiencing acute symptoms of depression that are quickly worsening would likely be appropriate for inpatient treatment. Even though criteria for involuntary examination may not be met, providing services on a voluntary basis may provide stabilization and prevent the individual's symptoms from worsening, potentially avoiding an involuntary examination in the future.

Individuals who receive services voluntarily sign their own informed consent, consent for treatment, release of information forms, and participate in their treatment and discharge planning. Individuals will determine additional persons involved in treatment and to whom the facility can release information.

Within 24 hours of admission, the admitting physician must document both the individual's ability to provide express and informed consent and that this consent was provided voluntarily. This is to be documented on the Baker Act Form CF-MH 3104: Certification of a Person's Competence to Provide Express and Informed Consent. If at least one of the criteria for voluntary services is not met, the individual must either be transferred to involuntary status or released from the facility.

III. Exclusions to Voluntary Legal Status

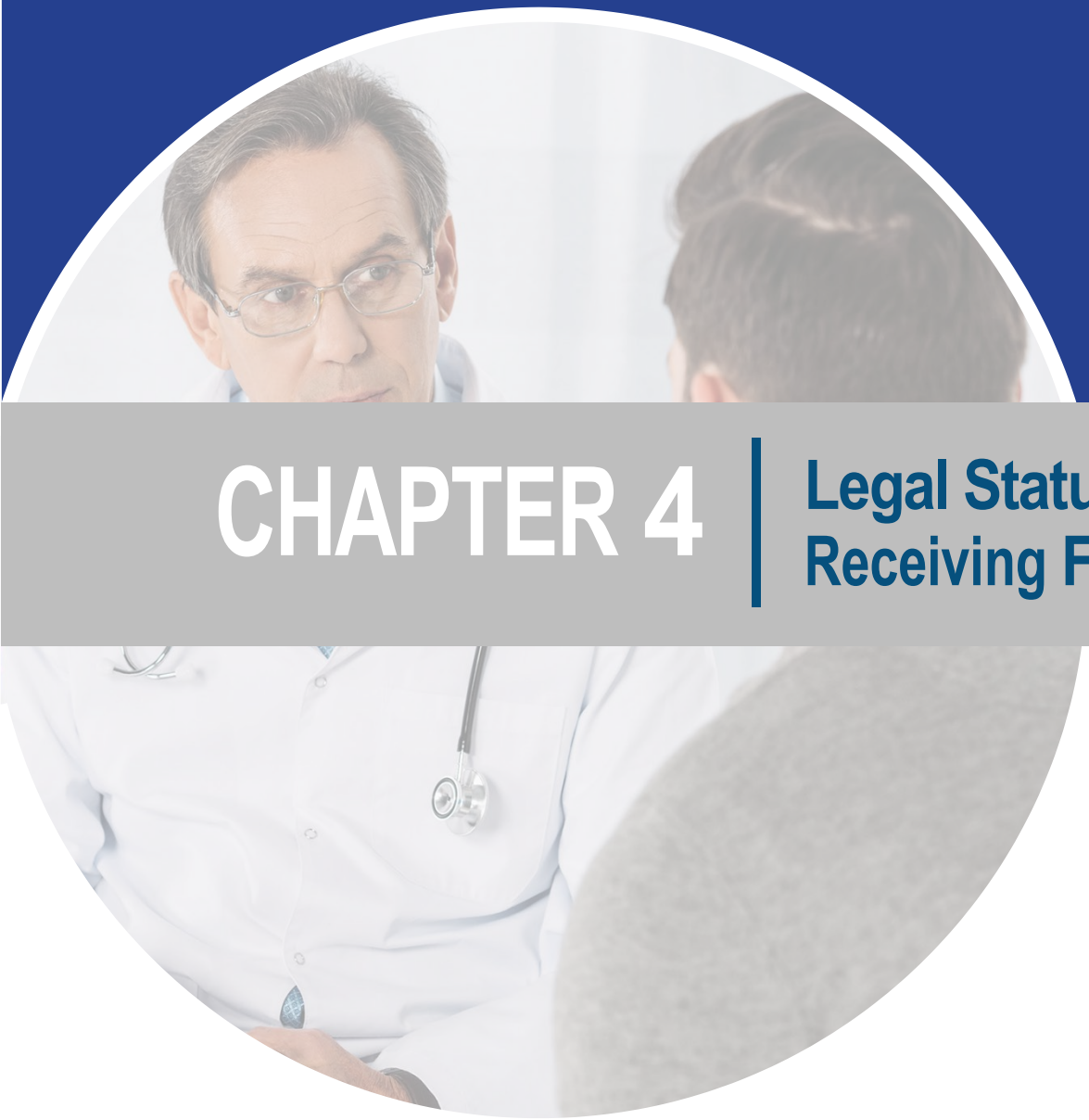
s. 394.4625(1), F.S.	• Authority to Receive Patients
s. 394.463(2), F.S.	• Involuntary Examination

An individual's request to be admitted voluntarily or transferred to voluntary status from involuntary status must be considered unless one of the following exclusions are present. If individuals cannot receive services voluntarily in a designated receiving facility or a State Mental Health Treatment Facility at any time; they must be admitted and discharged on involuntary status. Exclusions to voluntary legal status include any of the following:

- Refuses to provide express and informed consent.
- Is actively incompetent to provide express and informed consent.
- Is adjudicated incapacitated by a court.
- Is involuntarily placed for treatment by a court and continues to meet the criteria for involuntary placement.
- Has a substitute decision-maker who is actively authorized to make decisions for the individual's mental health care.
- Resides in a long-term care facility (unless the individual has just undergone an independent expert examination identifying they are competent to provide express and informed consent).
- Is currently charged with a felony or is in the custody of the Department of Corrections or the Department of Juvenile Justice.
- Is in the custody of the Department.
- Is a minor, except in circumstances where the minor participates in a clinical review to verify the minor's assent and both the minor, and their parent voluntarily agree to engage in services.

Voluntary admission for a minor has additional requirements and will be discussed in chapter 12 and in the online course Minors and the Baker Act. In addition, some individuals residing in a long-term care facility can provide their own express and informed consent. More information on how these individuals can receive services under voluntary status can also be found in chapter 12 as well as the online course Long-Term Care and the Baker Act.

It is important to note that there are times when an exclusion for voluntary legal status is present, and an individual is admitted under voluntary status. This is often due to receiving inaccurate information such as not reporting that the individual resides in a long-term care facility. If it is discovered that an exclusion is present and the individual is admitted on voluntary legal status, the individual must be transferred to involuntary legal status or released from the facility.



CHAPTER 4 | Legal Status in Designated Receiving Facilities

I. Baker Act Legal Status

II. Transfer of Legal Status

I. Baker Act Legal Status

An individual who receives services in a designated receiving facility or State Mental Health Treatment Facility will be identified as either receiving services under voluntary or involuntary status. Individuals who have signed into a facility for voluntary admission will receive services under voluntary status. Likewise, those under an involuntary examination or involuntary placement will receive services under involuntary status. An individual's legal status can impact procedures such as notifications, authorizations, and required forms. It is imperative for facility staff to remain aware of whether an individual is receiving services under voluntary or involuntary legal status and, for those receiving involuntary services, whether deemed competent or incompetent to provide their own consent. More information on express and informed consent and substitute decision-making can be found in chapter five (5).

II. Transfer of Legal Status

When an individual no longer appears to meet criteria for their current legal status it is important for a psychiatrist to evaluate the individual and determine if a legal status change or discharge needs to occur. Legal status may change for several reasons and an individual may undergo several legal status transfers during a single admission. The individual must be made aware the legal status has changed; notifications must also be made to the individual's guardian, guardian advocate, health care surrogate or proxy, representative, and attorney. If the individual is being transferred from involuntary to voluntary status and a guardian advocate was appointed, the guardian advocate will be dismissed from their duties.

A. Transfer from Involuntary Status to Voluntary Status

s. 394.4625(1)(f), F.S.	• Physician Documentation of Express and Informed Consent
s. 394.4625(4), F.S.	• Transfer to Voluntary Status
Form CF-MH 3104	• Certification of Express and Informed Consent

Transfer of legal status is most common when an individual's status is changed from involuntary to voluntary. Once an individual is both willing and able to provide express and informed consent for treatment in a designated receiving facility or State Mental Health Treatment Facility, the individual may be transferred to voluntary status and continue services without the oversight or involvement of the court. This transfer frequently occurs within the first couple days of admission to a designated receiving facility.

An individual who is transferred from involuntary to voluntary status could be the result of any of the following circumstances.

- The individual is both agreeable to and aware of the need for treatment, even if he or she didn't initially ask for or accept help.
- The uncomfortable thoughts and emotions associated with an involuntary examination have diminished and the individual agrees to continue services on voluntary status.
- The individual is discharged due to stabilization of symptoms and the criterion for involuntary services are no longer met.

An individual who wants to be transferred from involuntary to voluntary status may apply for a transfer of legal status at any time. If the individual is already admitted and receiving services under involuntary status, this application must be accompanied by the Baker Act form CF-MH 3104, Certification of a Person's Competence to Provide Express and Informed Consent. This transfer can occur as early as the completion of the mandatory initial involuntary examination.

When an individual arrives at an emergency room that is not part of a designated received facility, the individual can be discharged by an emergency department physician who has experience in diagnosing and treating mental illness after an examination is completed. Discharge by the emergency department physician can prevent an unnecessary transfer of an individual who does not meet the involuntary examination criteria; allowing them to receive services at a less restrictive level of care, if needed.

During the involuntary examination process at a designated receiving facility, if an individual is transferred to an emergency room due an emergency medical condition, the individual is typically transferred back to receiving facility when the emergency medical condition is stabilized.

> An individual cannot be released from involuntary status without the examination of a physician, clinical psychologist, or psychiatric nurse performing within the framework of an established protocol with a psychiatrist. This examination may be completed by an emergency department physician.

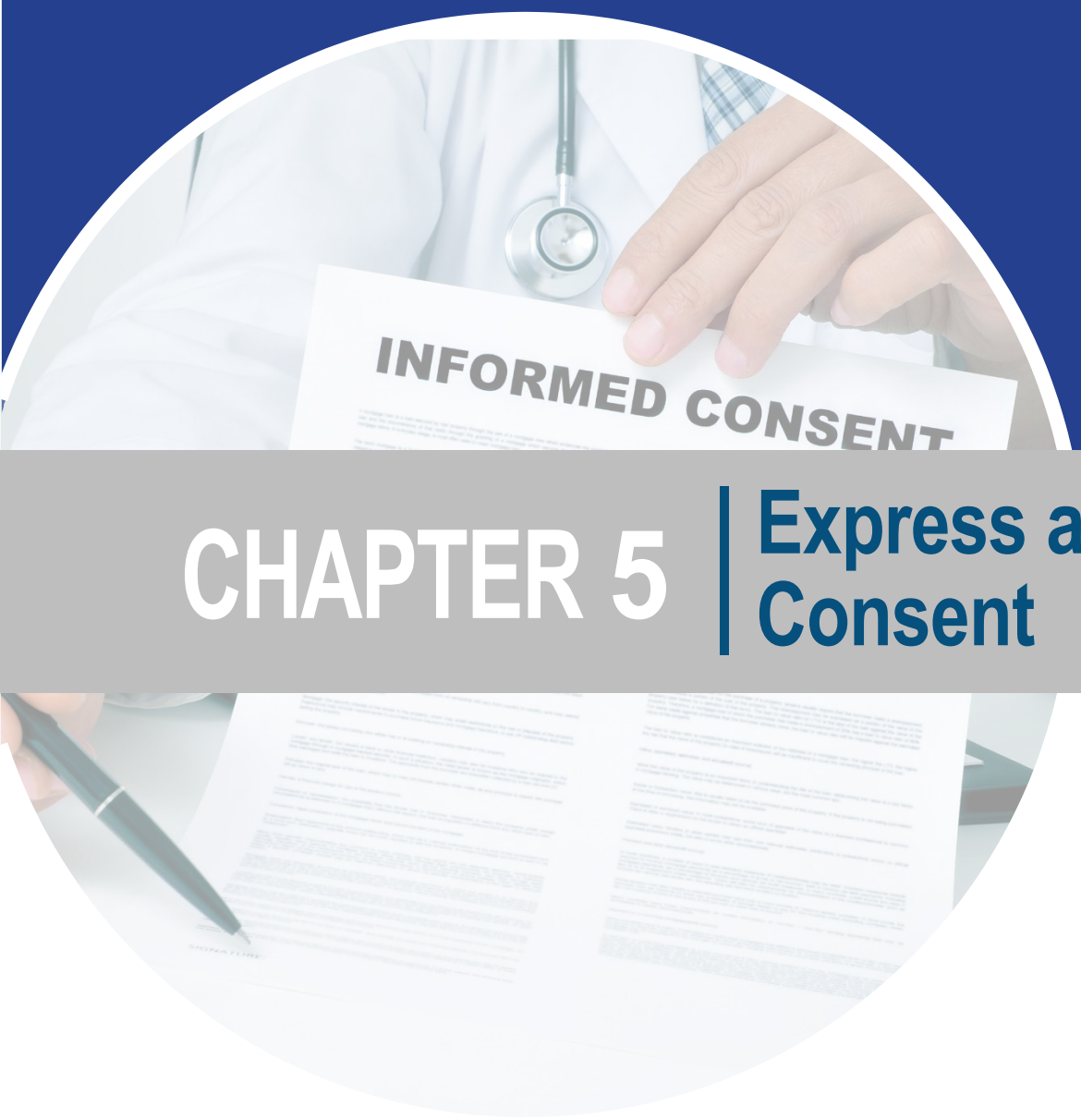
B. Transfer from Voluntary Status to Involuntary Status

s. 394.4625(5), F.S. • Transfer to Involuntary Status

Individuals may be transferred from voluntary to involuntary status while receiving services in a designated receiving facility or State Mental Health Treatment Facility if the individual meets criteria for involuntary inpatient placement or involuntary outpatient services and:

- Refuses examination or treatment,
- An exclusion for voluntary status is present, or
- Is found incompetent to provide express and informed consent.

A transfer from voluntary to involuntary status typically occurs when an individual is seeking discharge, the physician believes that the individual is not safe to be discharged and continues to meet the criteria for involuntary services.



CHAPTER 5 | Express and Informed Consent

I. Express and Informed Consent for Admission and Treatment

I. Express and Informed Consent for Admission and Treatment

s. 394.455, F.S.	• Definitions
s. 394.459, F.S.	• Rights of Patients

As discussed in the previous chapter, voluntary legal status depends on the individual's ability and willingness to provide express and informed consent for examination and treatment. An individual's ability to provide express and informed consent is determined by the individual's capacity and competency.

To receive services under voluntary status, and most treatment under involuntary status, the law requires that consent is both:

1. **Express**, ensuring consent is provided voluntarily, without coercion, and in writing by a competent individual; and
2. **Informed**, ensuring the individual is provided with sufficient explanation of benefits and risks of the proposed treatment, alternative treatments, and consequences of the lack of treatment, to make a well-reasoned, willful, and knowing decision.

Individuals providing express and informed consent must be informed that they can rescind their consent to treatment at any time either orally or in writing.

A. Voluntary Admissions

s. 394.4625, F.S.	• Voluntary Admissions
ch. 65E-5.170, F.A.C.	• Right to Express and Informed Consent
Form CF-MH 3104	• Certification of Person's Competence to Provide Express and Informed Consent
Form CF-MH 3040	• Application for Voluntary Admission (Receiving Facility)

The ability to provide express and informed consent is required for an individual to be eligible for a voluntary admission and treatment. A determination of competence is completed and documented by the psychiatric team within 24 hours of the individual entering a designated receiving facility under voluntary status or prior to transferring an individual from involuntary to voluntary status. This includes an individual applying for services, participating in the development of their own treatment and discharge plans, and determining when they want to change their level of care or conclude treatment altogether. This determination should be documented in the individual's clinical record and includes the following considerations:

- The provider must present with full disclosure of the treatment being proposed. This includes any pertinent collateral information such as similar treatments the individual has experienced in the past and potential side effects of the treatment being proposed. Before consent to admission or treatment can be provided there must be an opportunity to consider all the following.
  - The goal and purpose for the proposed treatment.
  - Description of the proposed treatment.
  - Approximate length of services. How progress in and success of treatment will be assessed and monitored
  - Risks and benefits of the proposed treatment
  - Other alternative treatment methods that are available
  - Potential consequences of declining or discontinuing treatment
- The individual must be provided with all the following information before express and informed consent is obtained for the administration of psychotropic medication.
  - A description of the prescribed medication
  - Therapeutic dosage range of the medication

- The proposed dosage, frequency, and method of administration
- Potential short-term and long-term side effects
- Potential interactions with other medications
- Alternative treatments that may be effective with fewer or less severe side effects
- Contraindications with medical conditions, prescription or over the counter medications, foods, or other substances.

B. Involuntary Services

An individual who meets Baker Act criteria but cannot, or will not, provide express and informed consent qualifies for an involuntary examination (also referred to as involuntary services or involuntary legal status). Many individuals under involuntary legal status will be able to provide their own express and informed consent. If the individual is determined to be incompetent or incapacitated, he or she will not be asked to provide consent; instead, a substitute decision-maker will provide the express and informed consent on the individual's behalf. An individual evaluated for involuntary examination cannot be forced to participate in treatment without his or her consent or the consent of the substitute decision-maker, except in documented cases where there is an immediate danger to the individual or others if the individual is left untreated.

If an individual is under voluntary legal status and cannot consent to their own treatment, the individual must either be released from the facility or transferred to involuntary status.

Incompetence to Provide Express and Informed Consent

There are several circumstances that automatically disqualify an individual from being able to provide express and informed consent. This typically includes individuals who are deemed clinically incompetent by a physician, adjudicated incapacitated by a court, or who already have a substitute decision-maker making their mental health decisions.

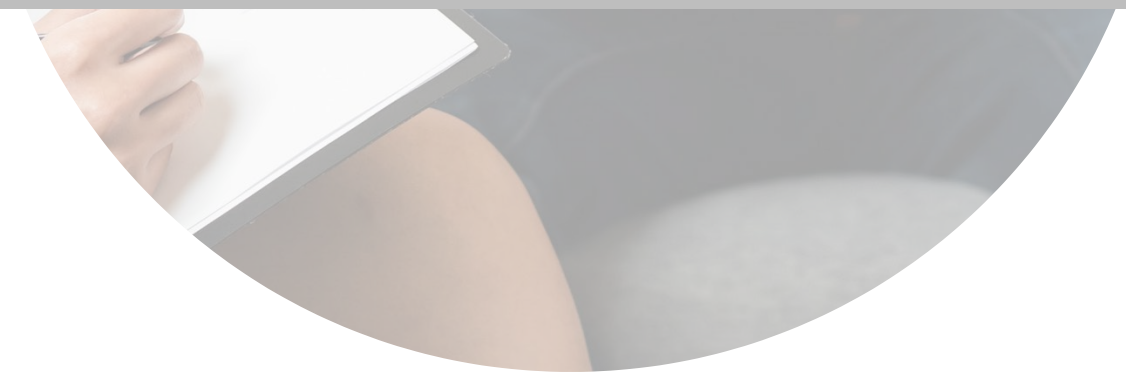
An individual is often deemed clinically incompetent by a physician when they experience an acute or chronic condition that significantly impairs their ability to make rational decisions. There does not need to be an imminent risk to safety if the individual's lack of ability to make a rational decision about treatment is determined. This could be directly related to a mental health condition, such as an episode of psychosis, or a more generalized medical or biological condition, such as a severe developmental disability or an advanced neurocognitive disorder such as Alzheimer's disease. If an individual is deemed incompetent to provide express and informed consent and does not already have a substitute decision-maker identified through a court order, the facility administrator must promptly file a petition with the court for both involuntary services and the appointment of a guardian advocate.

More information on an individual's capacity to consent to treatment and apply for voluntary services can be found in Appendix G, chapter 12, and the online courses Minors and the Baker Act and Long-Term Care and the Baker Act. More information on substitute decision-making can be found in the online course *Guardian Advocate and the Baker Act*.

C. Emergency Treatment Orders

Express and informed consent for individuals on voluntary or involuntary status may be temporarily overridden with an emergency treatment order (ETO). An ETO may be ordered by a physician in select documented cases where immediate action is needed to stop current behaviors that actively pose a significant physical threat to the individual or others at the facility. This is determined on a case-by-case basis and must be carefully documented when applied. An ETO can be administered to an individual on either voluntary or involuntary status and can impact an individual's legal status or decision-making ability. For example, if an individual is administered two (2) ETOs within seven (7) days, the facility must file a petition with the court to have a guardian advocate appointed to provide express and informed consent for the individual. If the individual is on voluntary status, he or she must also be transferred to involuntary status. More information can be found in chapter nine (9).

CHAPTER 6 | Criteria and Initiation of an Involuntary Examination



I. Involuntary Examination

II. Criteria for an Involuntary Examination Under the Baker Act

III. Initiation of an Involuntary Examination

IV. Examination and Evaluation

I. Involuntary Examination

s. 394.463, F.S.	• Involuntary Examination
ch. 65E-5.280, F.A.C.	• Involuntary Examination

It is the intent of the legislature that treatment programs for mental health conditions include, but not be limited to, comprehensive health, social, educational, and rehabilitative services to individuals requiring intensive short-term and continued treatment to encourage them to assume responsibility for their treatment and recovery. It is intended that:

1. Individuals are provided with emergency service and temporary custody for evaluation when required.
2. Individuals are admitted on a voluntary basis when extended or continuing care is needed and unavailable in the community.
3. Involuntary placement be provided only when expert evaluation determines it is necessary.
4. Any involuntary treatment or examination be accomplished in a setting that is clinically appropriate and most likely to facilitate the individual's return to the community as soon as possible.
5. Individual dignity and human rights be guaranteed to all individuals who are admitted to mental health facilities or who are being held under section 394.463, F.S.

An individual must meet specific criteria to be eligible for an involuntary examination. The involuntary examination is conducted to determine whether a person qualifies for involuntary services. Involuntary examinations are initiated due to the individual experiencing a mental health emergency. The individual must pose an imminent physical risk to self or others due to current symptoms of a mental health condition. This includes self-harming behaviors, episodes of aggression, suicidal or homicidal ideations, or self-neglect that poses a significant risk to the individual, or another's, well-being.

There should be a reasonable expectation that the individual will benefit from services that cannot be provided by the individual's current support system and other available resources. This includes the assistance of family, friends, or outpatient service providers. If found to meet the criteria for inpatient services after the examination, these services are expected to intervene in and prevent the imminent risk of physical harm by providing security while acutely stabilizing the individual's mental health emergency.

Individuals who are experiencing a mental health emergency may refuse services. Individuals have a right to determine their own course of treatment when they can determine for themselves that treatment is necessary. If this decision is influenced by symptoms of a mental health condition that appear to be placing the individual at risk of causing serious bodily harm to self or others, then that individual can be held for an involuntary examination for up to 72 hours.

This examination period is used to assess the individual's present state of mental health and determine whether they are safe to be released back into the community or if they meet the criteria for inpatient services. Assessing whether an individual has the competence to provide express and informed consent is part of this process. More information can be found in chapter five (5).

If the individual is determined to be competent with the capacity to apply for voluntary admission, they may be admitted on a voluntary status.

If the individual is found to be incompetent to provide express and informed consent to voluntary admission and thus incompetent to provide express and informed consent for treatment, they must be transferred to an involuntary status and a petition for guardian advocate filed with the court. If the individual refuses to provide express and informed consent to voluntary admission but is competent to provide express and informed consent for treatment, the individual must be discharged or transferred to involuntary status. More information can be found in chapter three (3).

II. Criteria for an Involuntary Examination Under the Baker Act

s. 394.463(1), F.S.	• Involuntary Examination - Criteria
s. 394.4625(1)(e), F.S.	• Authority to Receive Patients

An involuntary examination may be initiated if there is reason to believe that an individual is experiencing significant negative impact from symptoms of a mental health condition. An individual can be taken to a designated receiving

facility for an involuntary examination if there is reason to believe that they have a mental health condition and, because of that condition all the following criteria are met.

- **The individual either:**
  a. Refuses voluntary admission after careful explanation as to the reason for examination.
  b. Is experiencing an acute or chronic state where they are unable to determine for themselves whether examination is necessary excluding them from being able to provide express and informed consent.
- **And it is evident that either:**
  a. Without the immediate intervention of acute care or treatment, the individual is likely to experience neglect that poses a significant threat of substantial harm to the individual's well-being. This threat is not likely to be overcome with the aid of the individual's personal or community support system.

> Remember, the symptoms that are used to meet the criteria for the initiation of an involuntary examination must be the result of a mental health condition.

  b. Based on recent behaviors there is an imminent threat that, without immediate intervention, the individual will cause serious physical harm to self or others.

A mental illness, defined in section 394.455, F.S., as a mental illness, is said to occur when an individual experiences a mental or emotional impairment that hinders their daily functioning through the following criteria.

- A diminished ability to either:
  a. Regulate their own actions.
  b. Perceive or understand the world around them.
- As a result of these limitations, the individual experiences significant barriers in their ability to meet the ordinary demands of routine tasks and everyday living.

Mental health conditions impact a considerable portion of the population. Studies have found that approximately one out of every five adults meet criteria for a mental health condition.[1] While treatment may be warranted, most of those individuals will never be hospitalized for mental health services. In fact, more than half of the individuals with a mental health condition did not receive any treatment at all.[2]

The Baker Act does not apply if an individual's behaviors are the direct result of an intellectual or developmental disability, substance use, dementia, traumatic brain injury, or personality disorder. Individuals can still experience any of the preceding conditions in addition to a mental health condition, but the primary criteria for voluntary admission or an involuntary examination must be met because of symptoms from a mental health condition. This may not prevent a law enforcement officer from initiating an involuntary examination on an individual with an autism spectrum disorder or dementia. Law enforcement officers are not trained behavioral health experts and these disorders can have similar systems to mental health conditions. It is the responsibility of the clinical staff at the designated receiving facility to conduct the evaluation to determine if the criteria are met or the other conditions are present, making the individual ineligible and then returning the individual to the community with appropriate follow up supports and services.

III. Initiation of an Involuntary Examination

An involuntary examination may be initiated by any one of the following methods:

1. A qualified professional may initiate a certificate of a professional.
2. A law enforcement officer may initiate a report of a law enforcement officer.
3. A circuit or county court may issue an ex parte order.

The method of initiation determines the specific responsibilities of the person initiating the involuntary exam.

A. Certificate of a Qualified Professional

s. 394.463(2)(a)(3), F.S.	• Professionals Qualified to Initiate an Involuntary Examination
Form CF-MH 3052b	• Certificate of a Qualified Professional

Florida law allows certain professionals to initiate an involuntary examination of an individual if they believe that a mental health condition is the reason the individual cannot recognize their need for examination or treatment or the individual is not otherwise competent to consent to voluntary treatment. For purposes of the Baker Act, a professional qualified to initiate an involuntary examination must meet one of the following statutory qualifications.

- Physician – section 394.455, F.S.
- Physician Assistant – section 394.455, F.S.
- Psychiatrist – section 394.455, F.S.
- Clinical Psychologist – section 394.455, F.S.
- Clinical Social Worker – section 394.455, F.S.
- Mental Health Counselor – section 394.455, F.S.
- Marriage and Family Therapist – section 394.455, F.S.
- Psychiatric Nurse – section 394.455, F.S.
- Advanced Practice Registered Nurse - section 464.0123, F.S.

While all qualified professionals must hold an active Florida license within their profession to practice, some professionals must have additional criteria to meet the standards of a qualified professional under the Florida Mental Health Act. These additional qualifications include:

- Physicians* must have experience in the diagnosis and treatment of mental health or nervous system conditions.
- Physicians who are designated as psychiatrists must have at least three (3) years of experience diagnosing and treating mental and nervous conditions as a primary work function.
- Clinical psychologists* must have at least three (3) years postdoctoral experience in the practice of clinical psychology.
- Psychiatric nurses must hold a minimum of a master's degree in psychiatric nursing and have completed at least two (2) years of post-master's clinical experience under the supervision of a physician.
- Advanced Practice Registered Nurses must be registered under section 464.0123, F.S.

** This includes both qualified professionals working as civilians as well as those who are employed by a receiving or treating facility operated by the United States (U.S.) Department of Veterans Affairs.*

To initiate an involuntary examination, a qualified professional must:

1) Examined the individual within the preceding 48 hours, AND
2) Personally witnessed or have first-hand evidence of the symptoms or behaviors that are the basis for the involuntary examination.

The professional must identify the criteria that qualifies the involuntary examination. Unlike law enforcement officers, a third-party statement is not enough to meet the criteria to initiate an involuntary examination by a qualified professional. The professional must indicate their direct observations that pertain to criteria for an involuntary examination. A qualified professional, however, may base part of their determination on additional information such as previous statements or behaviors that have been made or characteristics of an individual's diagnosis.

Collateral information can be considered. This might include a situation in which an individual who denies all suicidality to a professional, but family members report the individual has voiced a desire or intent to die by suicide. While collateral information can provide credibility and support for the professional's findings, secondhand reports cannot be the sole or primary source of information for a professional certificate. Determinations are often made after careful consideration of both verbal statements and nonverbal behavior and, when available, review of an individual's past mental health symptoms and related coping skills.

Professionals must balance the rights of the individual with safety concerns. When an individual meets the criteria for an involuntary examination and agrees to go to a designated receiving facility voluntarily, it is important to consider whether the individual currently has the capability to make that decision.

Just as inpatient services may not be the most appropriate level of care, a designated receiving facility is not always

an appropriate intervention for individuals displaying unsafe behaviors. Individuals may display an outburst of behavior not associated with a mental health condition. This may occur in several populations including vulnerable adults with an intellectual or neurocognitive disorder, individuals experiencing intoxication, or someone with a traumatic brain injury. In those cases, the professional must ensure other services and supports are in place that are appropriate to the individual's needs.

Once a qualified professional has completed a certificate to initiate an involuntary examination, a law enforcement officer is the primary mode of transportation to deliver the individual to the designated receiving facility. There are exceptions to this mode of transportation when: the individual is sent to a medical facility via emergency medical personnel; is already in a secured facility; or there is an alternative method identified in the county's approved transportation plan. The person providing transport will deliver the initiating paperwork including the transportation form, CF-MH 3100 Transportation to a Receiving Facility. More information on transportation regulations and methods can be found in chapter seven (7) as well as the transportation FAQs.

Qualified professionals are not required to initiate an involuntary examination and are allowed to use their clinical discretion to determine if an involuntary examination is warranted even if the criteria is met.

B. Report of a Law Enforcement Officer

s. 394.463(2)(a)(2), F.S.	• Involuntary Examination
ch. 65E-5.280(2)(a), F.A.C.	• Involuntary Examination - Law Enforcement
Form CF-MH 3052a	• Report of Law Enforcement Officer

Law enforcement departments have become an important partner with the mental health system. The most recent comprehensive research study regarding this practice conducted in 2016, estimated that one in four people with mental health conditions has a history of police arrest and about one in 10 individuals have police involved in their pathway to mental health care.[3] Law enforcement officers are key in the identification of individuals who need services as well as transporting these individuals to designated receiving facilities. It is important for an officer to be aware of key indicators that an involuntary examination may be warranted such as complications with mood, behavior, speech, thought, perception, insight, or judgment.

Law enforcement officers, like qualified professionals, have specific qualifications to be able to initiate an involuntary examination and provide transport for individuals under involuntary status. To be considered a law enforcement officer under the Baker Act, the officer must have the authority to bear arms, make arrests, and work with the primary responsibility of identifying and preventing crime or enforcing penal, criminal, traffic, or highway laws. This is inclusive of direct supervisors of such officers who have the authority but do not have the same primary responsibilities. For the purposes of the Baker Act, a law enforcement officer must work for a local jurisdiction, such as a city or county law enforcement agency to have authority to initiate an involuntary examination and provide transportation to a designated receiving facility. An officer working as a federal law enforcement officer, including an officer working for the Department of Veteran's Affairs, cannot initiate an involuntary examination or provide initial transport of an individual to a designated receiving facility.[4]

U.S. Department of Veteran Affairs Police Officers are **not** considered a law enforcement officers under the terms of the Baker Act.

A law enforcement officer must initiate a Report of Law Enforcement Officer Initiating Involuntary Examination, Baker Act form CF-MH 3100, if there is reason to believe that the individual meets criteria for an involuntary examination.

This is true even if the individual agrees to go to the facility voluntarily or is engaging in behavior that would warrant an arrest for a minor offense. Unlike qualified professionals, law enforcement officers cannot use personal discretion. The information an officer uses to meet the criteria for an involuntary examination can be based on either direct observation or third-party report. When a law enforcement officer identifies that medical clearance is needed, the individual must first be transported to the nearest medical emergency department.

Any law enforcement officer that is unsure of the origin of an individual's behavior and believes that the individual meets criteria for a Baker Act must initiate an involuntary examination and transport the individual to the appropriate facility.

There are several factors to consider regarding law enforcement and the Baker Act. The Department has Frequently Asked Questions (FAQs) on the website that may assist with clarifying different practices of law enforcement, transportation, and involuntary examinations.

1. Crisis Intervention Teams

Crisis Intervention Team (CIT) programs originated in Memphis, Tennessee. Law enforcement agencies recognized that many interactions involved individuals who were experiencing active symptoms of a mental health condition, with some of those interactions turning violent.[5] Often referred to as the Memphis Model, CIT program officers undergo specialized training to provide more effective interventions for individuals experiencing a behavioral health condition than those traditionally used in law enforcement encounters. CIT programs teach officers about specific behaviors, mannerisms, and types of speech that indicate the individual is experiencing active symptoms of a behavioral health condition. CIT programs increase the safety of the individual, officers, and the community and provide alternatives to an arrest.[6] Individuals who struggle with mental health conditions spend less time in jail when interacting with a CIT program officer and are more likely to receive the behavioral health services that can benefit them.[7, 8] Most of Florida's law enforcement agencies provide CIT programs.[9] Someone who calls law enforcement may request a CIT officer to be sent if it is believed the individual is experiencing active symptoms of a mental health condition.

Regardless of whether law enforcement agencies provide specialized CIT training, there are two free online courses sponsored by the Department that may benefit law enforcement officers:

1) Law Enforcement and the Baker Act
2) Emergency Medical Treatment: Florida's Baker Act and Marchman Act

A strong and robust crisis care continuum should have a solid foundation and the ability to serve individuals with a variety of crisis care needs that range in severity from stress and anxiety to serious mental illness and acute crisis. Best practice in crisis care has shown that three essential elements are needed:

The first of these three elements should allow for a safe and confidential way for an individual in crisis to speak with someone trained in behavioral health crises in moments of need. It should also act as the front door into a crisis continuum that offers a full array of crisis services. The 988 Suicide and Crisis Lifeline was created for this purpose.

2. Someone to talk to – 988

The framework for a modernized crisis continuum of care begins with someone to talk to when an individual is experiencing emotional distress. The implementation of the 988 Suicide and Crisis Lifeline is an entry point that allows an individual to dial an easy-to-remember three-digit number and speak to a trained crisis counselor. All counselors at Florida's 13 centers receive specialized training in interacting with individuals in crisis, including those who are suicidal or in other acute emotional distress.

There are varying degrees of mental health crisis. Preliminary data from the first year of 988 shows that some of the top concerns from 988 callers are:

- Psychological Pain
- Hopelessness
- Loneliness
- Behavioral Changes
- Feeling Trapped
- Perceived Burden on Others
- Self-harm
- Substance Use

For those experiencing less acute crisis, counselors provide coping skills, resources, and referrals to non-acute follow-up services in the community. In addition to providing these services, for individuals experiencing higher levels of distress, the crisis counselors work on de-escalation and whenever possible, diversion from higher levels of care. Counselors work with callers to create safety plans and do regular follow up calls until an individual feels they no longer need that service.

In cases where a caller cannot be de-escalated and the crisis counselor determines the need for someone to respond, all 13 centers in Florida provide warm hand-offs to local mobile response teams (MRTs) or co-responder crisis teams in the caller's area. 988 centers also work in coordination with local 911 Public Service Answering Points (PSAPs) to dispatch immediate law enforcement officers or emergency medical services (EMS) response when there is a caller with an active suicide in progress.

When an individual in crisis contacts 911, a dispatcher will send law enforcement officers or EMS to the individual. Statistics show this results in individuals being Baker Acted or arrested at higher numbers than when behavioral health professionals are involved. In contrast, when an individual in crisis contacts 988, they receive someone trained in crisis counseling whose job is to listen, assess, and divert where possible.

Current available data from the first year of 988 implementations in Florida show a diversion rate of 96 percent of crisis callers from a higher level of care. Just over one percent of calls are imminent suicides in progress, requiring immediate dispatch of EMS. The remaining three percent are callers experiencing a mental health crisis that cannot be de-escalated over the phone and require a referral to MRTs.

988 is a vital service that, with appropriate investment, can support the reduction in the number of individuals that require higher levels of crisis care. For individuals who are not yet suicidal or experiencing an acute crisis event, having the ability to call and talk to someone confidentially when feelings of depression or overwhelmed are encountered, and receiving coping skills and other services focused on reducing stress and enhancing wellbeing, may reduce future risk of becoming suicidal or needing services such as crisis stabilization.

3. Someone to respond - Mobile Response Teams

MRTs provide crisis care in the community and increase opportunities to stabilize individuals in the least restrictive setting to avoid the need for hospital or emergency department utilization and divert from juvenile justice or criminal justice settings. MRTs are available 24-hours a day, 365 days per year to individuals of all ages. MRTs provide an array of crisis response services to individuals and their family including evaluation and assessment, stabilization services, safety and crisis planning, and brief care coordination with a warm hand-off to another service provider as clinically indicated. MRTs can effectively de-escalate individuals in crisis, with a goal of diverting individuals from higher levels of care such as involuntary crisis stabilization through the Baker Act. The diversion rate for fiscal year 2022/2023, was 82 percent of persons served. The current list of MRTs is located at : https://www.myflfamilies.com/services/substance-abuse-and-mental-health/samh-providers/managing-entities/managing-entities.

C. Ex Parte Court Orders

s. 394.463(2), F.S.	• Involuntary Examination
Form CF-MH 3001	• Ex Parte Court Orders

In addition to law enforcement officers and qualified professionals, the local circuit or county court can also order an individual for an involuntary examination. A family member or significant other of an individual must file a petition for an ex parte order for the court to hold a hearing. An ex parte hearing has several elements that are mandatory before an ex parte order can be issued. These elements include both:

1. The written or oral sworn testimony that was directly witnessed by the person filing the petition that describes the recent concerning behaviors the individual has been displaying.
2. The criteria used by the judge to make the determination to issue the ex parte court order. A court fee for filing a petition for an ex parte order is prohibited.

1. Executing an Ex Parte Court Order

A circuit or county court can initiate an involuntary examination through an ex parte order after a petition has been filed. Ex parte orders are usually issued without the individual who is the subject of the order present at the hearing. Once a county or circuit court issues an ex parte order for an involuntary examination, law enforcement officers are generally given the task of locating and transporting the individual to a designated receiving facility. This does not warrant an arrest, just the execution of an ex parte order.

The law enforcement officer has a specific timeframe and protocols to follow when executing an ex parte court order. Since the nature of an involuntary examination is to prevent physical injury or deterioration from a crisis, law enforcement officers have the authority to execute the order 24-hours a day, seven days a week. If necessary, the law enforcement officer may use reasonable force to enter the premises where the individual is presently believed to be and take the individual to a designated receiving facility. This will typically involve transportation to the nearest designated receiving facility; however, there may be some variations based on the information written in the court order as well as protocols identified in the specific county's approved transportation plan.

If the court does not specify a timeframe to execute the ex parte order, then the order is good for up to seven days. Once located, the individual is transported to a designated receiving facility or to a medical hospital for medical clearance. The same order may not be used more than once; therefore, once the individual is transported to a designated receiving facility or medical hospital under an ex parte order, that specific order no longer has any authority even if the individual is released before the ex parte order expires. Once an individual arrives at a designated receiving facility under an ex parte order, the individual becomes subject to the regular procedures for an involuntary examination.

IV. Examination and Evaluation

Once an involuntary examination is initiated, a determination must be made before the end of the 72-hour examination period. The end of the 72-hour examination period does not mean the Baker Act expires. that one of the following processes must take place within the 72-hour time frame:

- The facility must file a petition with the local circuit or county court for involuntary inpatient placement with Baker Act form CF-MH 3032 or involuntary outpatient services with Baker Act form CF-MH 3130.
- An individual who meets criteria for voluntary services with no exclusion present must be transferred to voluntary status with Baker Act form CF-MH 3040 and either continue inpatient services voluntarily or be discharged from the facility.
- The individual must be released from the facility under involuntary status with Baker Act form CF-MH 3111.

This determination depends on whether criteria is met for voluntary admission and if the individual has the ability and willingness to provide express and informed consent. Even if the individual continues to meet criteria for involuntary inpatient placement or involuntary outpatient services, a transfer to voluntary status may occur if the individual is deemed competent and willing to provide express and informed consent to treatment.

Assessments and Evaluations

To make a determination within the 72-hour examination period, the individual may receive several evaluations and assessments within specified time frames.

1. Initial Involuntary Examination

s. 394.463(2)(f), F.S.	• Involuntary Examination
ch. 65E-5.2801, F.A.C.	• Minimum Standards for Involuntary Examination

The initial mandatory involuntary examination must be completed without unnecessary delay. This examination must be completed by a physician, clinical psychologist, or a psychiatric nurse performing within the framework of a psychiatrist's established protocol. The exam will be used to determine if the individual meets voluntary or involuntary criteria for services and must include several elements including a:

- Personal observation and detailed review of the individual's recent behavior.
- Review of the required documentation initiating the involuntary examination including the transportation form.
- Brief psychiatric history.
- Face-to-face examination of the individual.

The initial examination is typically conducted within 24-hours for an adult, and for a minor, must occur no more than 12-hours after the minor's arrival at the facility. If the individual does appear to meet criteria for involuntary placement, a second opinion must take place within the initial 72-hour examination period. If the individual does not meet criteria for involuntary placement or the second opinion does not occur within the 72-hour timeframe, the individual must either continue services voluntarily or be released from the facility.

The examination will fulfill the requirements of a first opinion if the individual continues to meet criteria for involuntary services.

If the individual continues to meet criteria for involuntary services and is not able or willing to provide express and informed consent then a second professional, typically a psychiatrist, must complete the second opinion. Examinations for a second opinion may be conducted through a face-to-face examination either in person or by electronic means. If the second professional concurs that the individual meets criteria for involuntary placement and the individual is not competent, or is unwilling to sign in for services voluntarily, then the petition for involuntary inpatient placement or involuntary outpatient services can be filed with the court for a hearing.

2. Physical Examination

s. 394.459(2), F.S.	• Right to Treatment
ch. 65E-5.160(3), F.A.C.	• Right to Treatment

Individuals must have a physical examination to rule out any physical or medical causes of their behavior. Even if the individual does not have any current physical complaints, every individual who has been in a designated receiving facility or State Mental Health Treatment Facility for at least 12-hours must receive a physical examination within 24-hours of arrival. The exam must include a basic physical and identify whether the individual is medically stable. The examiner must collect and review information to help identify if there is any reasonable cause for the individual's symptoms or behaviors that are medical or organic in nature instead of psychiatric.

Several factors should be taken into consideration when trying to distinguish whether an individual's symptoms are stemming from psychiatric or medical causes including:

- Drug toxicity from a single or interaction of substances.
- A physical injury, such as a traumatic brain injury.
- A medical disorder, such as a urinary tract infection.
- A metabolic disorder, such as diabetes or Cushing's syndrome.

These initial examinations, coupled with subsequent assessments from other disciplines, will help to determine whether Baker Act services are the most appropriate services, if inpatient is the most appropriate level of care, and what course of treatment is expected to be the most effective for the individual under the current circumstances.

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CHAPTER 7 | Transportation and Transfers Under the Baker Act

I. Transportation Plan

s. 394.462, F.S.	• Transportation

Florida law identifies specific procedures that must be followed when transporting individuals on involuntary status under the Baker Act. In 2016, Florida's Senate Bill 12 required all counties to work with their Managing Entity to develop an approved county-wide transportation plan. Each county's transportation plan identifies the county's policies and procedures for transporting individuals under involuntary status for both the Baker Act and the Marchman Act. The transportation plan describes the method of transportation to a facility within the behavioral health receiving system for individuals subject to involuntary examination or involuntary admission. The plan may assign responsibility for alternate transportation to a participating facility when necessary and agreed to by the facility. This may include identifying emergency medical transport services or private transport companies as part of the transportation plan.

II. Transportation Responsibilities of Law Enforcement

s. 394.462, F.S.	• Transportation
ch. 65E-5.260, F.A.C.	• Transportation
Form CF-MH 3100	• Transportation to Receiving Facility

The transportation plan must identify a single law enforcement agency that is responsible for transporting individuals with a newly initiated involuntary examination. In areas where there are multiple law enforcement agencies with jurisdiction in a single geographic area, a local determination is made regarding which agency has the responsibility for transportation. A law enforcement officer from the designated agency must provide transportation for individuals who have any of the following conditions and documents initiating an involuntary examination.

- A certificate of a professional completed when the individual is not already on the campus of an inpatient or residential provider. This would mostly include individuals in an outpatient office.
- There is an encounter with law enforcement and the officer completes a report of a law enforcement officer.
- The court issues an ex parte order to take the individual to a designated receiving facility for an involuntary examination.

A law enforcement agency may decline to transport individuals to a designated receiving facility if the county has contracted with an emergency medical transport service or private transport company and both parties agree that the continued presence of law enforcement is unnecessary.

Other reasons law enforcement may not provide transportation include when any of the following circumstances are met.

- An emergency medical condition is suspected, or the individual's overall health is in a state that medical transport is deemed necessary.
- The individual is already at a secured facility such as a medical hospital, inpatient, or residential facility.
- The individual is a resident of a long-term care facility and all the following apply:
  - The transportation plan identifies a transport company.
  - A law enforcement officer personally arrives at the scene to review the situation.
  - Both the law enforcement officer and medical transport personnel agree that the individual can be safely transported by the medical transport company without the continued presence of a law enforcement officer.
  - The county is solely responsible for paying for the transportation services.
- The individual is appropriately transported by an authorized member of a mobile crisis response team or mental health overlay program when all the following apply:
  - An involuntary examination was initiated by a certificate of a professional.
  - The professional is a member of a state funded mental health overlay program or mobile crisis response service.
  - The professional is able and willing to transport the individual to the receiving facility.

s. 394.462, F.S.	• Transportation
ch. 65E-5.260, F.A.C.	• Transportation

Law enforcement officers may go to a certain designated receiving facility identified in the county transportation plan, such as a central receiving facility, the nearest, or the most appropriate facility when transporting an individual under involuntary status. This allows officers to bypass closer facilities that are not licensed for a specific population, such as minors, and would not subsequently be able to provide treatment to the individual. This approach may reduce the number of times an individual is transferred between facilities which can be frustrating to individuals and delay their mental health examination.

It is the responsibility of each law enforcement agency to have policies that clearly identify the safe and secure transport of individuals who are on involuntary status under the Baker Act. Law enforcement does not have the responsibility to transport individuals who do not meet criteria for an involuntary examination and instead seek voluntary admission. However, there is nothing to prevent a law enforcement agency from allowing their officers to provide such transport. Officers should refer to their agency policies and procedures for further guidance.

For safety and security reasons, individuals under involuntary status are transported by law enforcement or a medical transport service whereas an individual on voluntary status may be sent by private vehicle or public transportation, such as a personal vehicle or Uber.

More information on regulations regarding transportation of individuals who have had an involuntary examination initiated can be found in the online courses *Law Enforcement and the Baker Act* and *Emergency Medical Treatment: Florida's Baker Act and Marchman Act*.

A. Transportation Form

Form CF-MH 3100	• Transportation to Receiving Facility

The transportation form (CF-MH 3100) describes the circumstances under which the individual was taken into custody under involuntary status. This includes observations of the individual's current condition and collateral information obtained from others. Law enforcement must complete Part I of this form and Part II of this form when the law enforcement officer cosigns the transport to a medical transport company or contracted transport company. Part II of the form indicates the transport company is responsible for the transport of the individual and the continued presence of law enforcement is unnecessary. Law enforcement is responsible for completing this form even if the individual is transported by a medical transport company. This form is provided to the designated receiving facility and must be included in the individual's clinical record. A copy of the form may be retained by the law enforcing agency and the transport company.

In 2022, Senate Bill 1262 passed requiring the Department to receive and maintain copies of the transportation form and include data from the transportation forms in the Baker Act reports. These forms must be completed by the Law Enforcement Officer and provided to the receiving facility. The receiving facility must submit the form to the Departments Baker Act Data Collection System with the corresponding initiation form.

B. Memorandum of Understanding

Some counties agree to share portions of their transportation plan with other nearby counties by executing a memorandum of understanding (MOU). The MOU identifies how individuals who have had an involuntary examination initiated will be transported to a designated receiving facility.

Some law enforcement agencies also have an MOU with designated receiving facilities within its jurisdiction. The MOU identifies a routine set of protocols to assist with securing the safety of individuals when being transported to a designated receiving facility. These protocols may include information on crisis intervention techniques, transfer and transportation methods, and documentation requirements. A sample MOU can be found in Appendix H. Sample Memorandum of Understanding for Transportation.

C. Transfer of Custody to Facility Staff

s. 394.462(3), F.S.	• Transportation

It is the transporter's responsibility to provide a safe and complete hand-off when delivering an individual to a designated receiving facility, State Mental Health treatment facility, or emergency department in accordance with the county's transportation plan. The required documents for initiation of the involuntary examination must be completed and provided to the destination facility along with the transportation form (CF-MH 3100). Some receiving facilities prefer to be give the original copies of forms, however, electronic transmission is becoming more common, and electronically signed forms and copies that are properly completed must be accepted.

The transporter should engage in all the following actions to help support a smooth admission.

- Request that any valuables the individual has in their possession be left at home or with a trusted person.
- Transfer any of the individual's belongings directly to facility staff at the destination facility, such as cell phones, wallets, purses, lighters, cigarettes, and medications.
- Notify facility staff of any specific concerns or observations that may improve safety, communication, or assist with proper diagnosis.
- Provide any known demographic information that the individual might not know or be able to share such as name, date of birth, social security number, address and contact information for family members or others present that are supporting or caring for the individual.

D. Safe Transport

s. 394.459(1), F.S. • Individual Dignity

Everyone has a right to safe and secure transport. Every law enforcement agency providing transportation of individuals under the Baker Act is required to have a single set of protocols that reflect safe and secure transportation. These protocols are submitted to the Managing Entity for that county. When an individual is transported to a designated receiving facility, the county's transportation plan must be followed, and the individual's rights must be maintained.

It is important to remember that the initiation of an involuntary examination is not considered an arrest. Law enforcement must restrain the individual in the least restrict manner appropriate under the circumstances. For example, law enforcement officers should consider only using restraints, such as handcuffs, when deemed necessary to preserve safety or security. Restraints might be appropriate during transport for an individual who is highly combative, actively aggressive towards self (i.e., hitting self), an active flight risk, or being held under active legal charges. If restraints are used for the protection of the individual or others, the reasons justifying the restraints must be documented and the restraints must be used according to the agency's written policies and procedures. Some law enforcement agencies have come under scrutiny for handcuffing very young children as this level of restraint may not have been necessary to safely transport a young child and could have been a traumatic experience.

Baker Act receiving facilities must have policies and procedures in place that protect the individual rights of those being transported between facilities.

E. Co-Occurring Legal Charges

s. 394.462, F.S. • Transportation

When an individual meets the criteria for an involuntary examination and has a misdemeanor criminal charge the officer must complete a Report of a Law Enforcement Officer and transport the individual to the receiving facility identified in the county's transportation plan.

Individuals who appear to meet criteria for an involuntary examination and are believed to have engaged in felony activity are first transported to the local jail and processed in the legal system as other individuals with legal charges.

The jail is responsible to ensure that individuals in their custody after the initiation of an involuntary examination receive the proper services under the Baker Act in the specified time frames.

Additional information on required time frames is found in Appendix I. Time Frames.

III. Medical Transportation Companies

ch. 65E-5.260, F.A.C. • Transportation

Medical transportation companies may transport individuals on involuntary status under the Baker Act. This could be the result of practices outlined in the county's transportation plan, due to an existing physical condition, or actively experiencing an emergency medical condition. When deemed safe and appropriate, a law enforcement officer may 'cosign' an individual over to a medical transport company; however, this does not relieve law enforcement of their duties. Officers must complete the law enforcement portion of the transportation form even if the transportation is provided by a medical transport company.

A county transportation plan may identify that a specific transportation company can transport individuals under involuntary status instead of law enforcement. In this instance, or when an individual has an emergency medical condition, law enforcement will only be required to assist with transports for individuals under involuntary status when deemed necessary for safety reasons.

A law enforcement officer must respond to the scene and personally assess the situation to ensure that it is safe for the medical transport company to proceed without law enforcement, unless the individual is already in a secure facility, such as a hospital, inpatient, or residential facility.

Both the transporter and law enforcement must agree that law enforcement presence is not necessary. If law enforcement is not necessary to ensure the safety of the individual or the transporter, the officer may transfer custody of the individual to another transporter. If necessary for safety reasons, law enforcement still has a responsibility to be present during the transport even if they follow a medical transporter in a patrol car.

IV. Medical Emergencies

42 U.S.C. 1395dd	• Emergency Medical Treatment and Labor Act
s. 394.462, F.S.	• Transportation
s. 395.002(8), F.S.	• Definitions - Emergency Medical Condition
ch. 65E-5.260, F.A.C.	• Transportation

An individual may first be transported to a local emergency department if they appear to be experiencing an emergency medical condition and the transporter believes that both of the following conditions are met.

- The individual is medically unstable or needs medical attention beyond the capability of the designated receiving facility.
- The individual may experience worsening of symptoms, impairment, or dysfunction if medical care is not immediately provided.

Individuals should be transported to a designated receiving facility unless experiencing an emergency medical condition. If the individual was transported to a designated receiving facility and needs to go to an emergency department for medical clearance the staff at the designated receiving facility must arrange the transport even if the determination is made while the transporter is still on scene.

A designated receiving facility or State Mental Health treatment facility may also transfer an individual to a medical emergency department for examination, treatment, and medical clearance after admission. Individuals are often sent to a medical hospital from a designated receiving facility or State Mental Health treatment facility due to symptoms of an acute medical condition or injury. Transfers must follow the guidelines of the county's transportation plan as well as the facility's policies and procedures. Designated receiving facilities may call 9-1-1 when an individual is sent to the emergency department from their facility. Facility policies and procedures may identify a specific staff member that is required to place the 9-1-1 call, such as the charge nurse or nursing supervisor. Please refer to your facilities policies and procedures for further information on transferring an individual to a medical emergency department.

If an individual is admitted at a designated receiving facility and transferred to a local emergency department for medical clearance, the individual should only be discharged from the designated receiving facility if either of the following circumstances occur:

- The emergency department admits the individual to the medical hospital.
- The individual is on voluntary status and declines to return to the designated receiving facility for continued services.

V.Facility to Facility Transfers

42 U.S.C. 1395dd(e)(4)	• Transfer - Definition
s. 394.4685, F.S.	• Transfer of Patients Among Facilities

There are guidelines for transferring an individual under involuntary status between designated receiving facilities. A transfer is defined as moving an individual outside of a facility where he or she is receiving services to another facility at the direction of facility staff or the request of the individual. Transfers will typically be the result of a doctor's order and may occur if an individual needs more specialized services for which the sending hospital does not have the capability or capacity. A transfer may also occur if the individual, or someone on their behalf, requests the transfer. Florida Statutes requires that once an individual is in a secured facility, the staff of that facility must arrange any subsequent transports in accordance with the county's approved transportation plan. The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires the sending hospital to arrange the safe and secure transport of individuals between hospitals.

Transfers attempt to place the individual in the least restrictive environment that will safely meet their needs. Different types of treatment environments are often called 'levels of care'. A level of care refers to the intensity of services an individual is receiving and ranges from outpatient and home-based services to inpatient and residential services. Individuals can be transferred to a higher, lower, or a parallel level of care.

Transfers to a lower level of care will typically involve a discharge to the individual's home with continued outpatient or other community services. Transfers to a parallel, and sometimes higher level of care, are considered traditional transfers. Traditional transfers occur when the individual does not go home but goes directly to another facility for immediate services. While this does not always involve admission, such as when an individual is transferred from a rural emergency department to a hospital with additional capabilities, it often includes the direct admission of an individual to another facility. This may occur if an individual is in a medical hospital and needs to be transferred to a designated receiving facility for an involuntary examination. Transfers without a direct admission may occur when an individual is in a designated receiving facility or State Mental Health Treatment facility and needs to be transferred to a medical hospital for medical examination and clearance.

A. Hospital Transfers

Federal laws classify discharges under hospital transfers. When an individual is transferred or discharged from a medical or psychiatric hospital there are specific state and federal mandates that dictate transfer procedures. Discharge planning procedures must occur when the individual is discharged to a lower level of care. Transferring an individual to another facility for direct admission typically meets the requirements for a safe discharge. Additional discharge planning, such as coordinating community services and resources, is not required by the transferring facility although providing that information when know is a best practice, and all other transfer and discharge procedures must be followed. Discharge protocols and procedures are discussed further in chapter 11.

Transfer protocols may require the individual's consent to release information and the sending of any relevant records when the individual is being transferred to a designated receiving facility directly from another provider. Individuals under involuntary status, however, may be transferred. Individuals or their representative should be asked to sign a release of information, if they are unwilling or unable some confidential information about the individual can be shared with the designated receiving facility by the current provider to ensure care is coordinated, without having prior consent. These conditions are discussed further in chapter 14.

The Emergency Medical Treatment and Labor Act (EMTALA) governs how individuals are transferred from a hospital to another facility. Under EMTALA, an individual is considered stable for transfer if the treating physician determines the individual's condition will not worsen during the transfer between facilities. Once a transfer is arranged, EMTALA recognizes the sending hospital as the responsible party for arranging safe and appropriate transport.

EMTALA only applies to hospitals. It does not apply to designated receiving facilities that are licensed as CSUs.

In accordance with EMTALA, a hospital must accept a transfer from a facility that does not have the capacity or capability to care for the individual when the destination hospital can meet the individual's needs. This includes hospitals that are better able to serve that individual with more specialized services. If a specialized hospital can meet an individual's psychiatric needs, but not their medical needs, the hospital does not have the capability and does not have to accept the transfer. For example, a designated receiving facility may have limited medical capability and need to transfer an individual to a general medical hospital to treat a medical emergency such as a possible heart attack.

The original transferring facility has a responsibility to accept the individual back for continued services if the individual is still in need of mental health services once the emergency medical condition stabilizes. The designated receiving facility may transfer the individual back to a medical hospital for medical examination and clearance if they believe they are still unable to meet the individual's medical needs following transfer. If the destination hospital clearly has the capability to provide specialized services, EMTALA still applies.

The transferring hospital must notify the destination facility that a transfer is occurring, even if it is for an emergency medical condition. This notification can occur as the transfer takes place in circumstances where the destination hospital is required to accept the transfer. For example, when a psychiatric hospital sends an individual to a local emergency department for medical examination and clearance, it is considered best practice to contact the destination hospital as soon as possible, even if the transportation company has not arrived at the transferring hospital.

Florida laws have similar provisions regarding transfers under federal EMTALA law. Florida has laws that separately address designated receiving facilities licensed as hospitals and crisis stabilization units. Crisis stabilization units are licensed by AHCA and designated and regulated by the Department under chapter 394, Florida Statutes. Like the federal law, Florida generally mandates that medical transfers go to the geographically closest medical facility with capability. There are some exceptions in the law that may override this such as when the nearest hospital is at capacity or there is a specialty hospital that can better meet the individual's needs. The county's transportation plan may also allow for transport to a facility that is not the geographically closest in proximity.

1. Transfers Between Designated Receiving Facilities

s. 395.1041, F.S.	• Access to Emergency Services and Care
s. 394.4599(2), F.S.	• Notice
s. 394.4685, F.S.	• Transfer of Patients Among Facilities
ch. 65E-5.310, F.A.C.	• Transfer of Patients Among Facilities

There are specific protocols that must be followed when an individual is being transferred between designated receiving facilities. These procedures vary slightly based on whether the facilities are publicly or privately funded. For example, while an individual who is in a public designated receiving facility must provide consent for transfer to a private designated receiving facility, consent is not required from a private to a public facility.

Public Destination Facility to Public Destination Facility

- An individual receiving services, the substitute decision-maker, or a family member may request a transfer to another public designated receiving facility.
- When indicated by the individual's treatment needs or to increase the effective use of public resources, the transfer may be facilitated between public facilities; consent is not required for this transfer to occur.
- Notice must be provided to the destination facility as soon as possible, preferably before transfer is underway.

Public Destination Facility to Private Destination Facility

- An individual receiving services, or the substitute decision-maker may request transfer from a public designated receiving facility to a private designated receiving facility.
- The individual must be able to prove an ability to pay for treatment, such as insurance benefits, and the transfer will occur at the individual's expense.
- The private facility must accept the individual for transfer if they have the capacity and capability to provide appropriate services. If the private facility has more specialized services that are not available in the public facility a transfer may occur at the discretion of the public facility.
- The destination facility must receive notification prior to transfer.
- All records pertaining to the individual's transfer and treatment must be sent to the destination facility prior to, or at the time of, transfer.
- The public facility may send an individual to the private facility under these circumstances once the private facility accepts the transfer.

Private Destination Facility to Public Destination Facility

- An individual receiving services, the substitute decision-maker, or the private designated receiving facility may request transfer to a public designated receiving facility.
- The transfer may occur upon acceptance of the individual at the public facility; the public facility has two (2) working days to respond to the request.
- The costs of the transfer will be dependent upon the agreement between the facilities. For example, there may be an agreement that the private facility incurs the costs of all transfers.
- The individual may be transferred in the absence of consent.

Private Destination Facility to Private Destination Facility

- An individual receiving services, or the substitute decision-maker may request a transfer between private designated receiving facilities.
- The individual must be transferred upon the individual's acceptance at the destination facility.
- The costs of the transfer will be dependent upon the agreement between the facilities and may be the responsibility of either the transferring facility or the destination facility.

The sending facility should share relevant information with the destination facility when a transfer occurs or is being considered. While obtaining consent is always best practice, sharing pertinent information among providers for continuity of care is allowed under any of the following circumstances without obtaining the individual's consent.

- The individual being transferred is under involuntary status and the sending facility does not have capacity or capability to sufficiently provide the services.
- The individual is transferred from a private to a public facility.
- A physician documents that the benefits outweigh the risks of transfer.

Sharing relevant information is required by law when an individual is transferred from a public to a private facility.

If a public facility is not available to accept the transfer, a private receiving facility must accept an appropriate transfer regardless of the individual's ability to pay or health insurance coverage.

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a. Financial Considerations

An individual who experiences an emergency medical condition cannot be denied admission based on the inability to pay but may be provided with options based on their financial resources. An individual who is uninsured or underinsured may be transferred from a private designated receiving facility to a public designated receiving facility to help reduce the financial burden. If the private facility is unable to secure an appropriate transfer to another facility, the individual should be admitted despite financial concerns.

Medically necessary transfers should be made to the geographically closest facility with the capacity and capability to meet the individual's needs. If the individual is already in a medical hospital, the transfer does not have to be to the closest designated receiving facility and the hospital may route the individual to the most appropriate facility for his or her payment source. Most individuals with private insurance are sent to private receiving facilities to maximize capacity at public receiving facilities. Public receiving facilities are specifically funded to provide services for individuals who are uninsured and underinsured. This includes those individuals who have exhausted their insurance benefits, continued stay has been denied by their insurer and all appeal options have been exhausted, or who have insurance that is not accepted at the private facility.

b. Continuation of Services

Florida law stipulates that while an individual may be transferred from a designated receiving facility to a medical hospital for more specialized services, once those hospital services are no longer needed, the sending facility is required to readmit the individual if all of the following conditions apply:

- There is capacity and capability at the original facility.
- The individual is not ready for discharge.
- The individual continues to receive inpatient services for the same concerns that prompted the original admission.

The individual must be transferred back to the designated receiving facility to continue care for the individual's mental health needs once their medical needs are managed. The designated receiving facility is expected to re-admit the individual once the medical issues are within the facility's capability if criteria is still met.

There may be court involvement that needs to be continued at the same facility if the individual is receiving services under involuntary status. Returning the individual to the same facility also assists with continuity of care and discharge planning. More information on continuity of care can be found in chapter 11.

B. Medical Emergency Department Transfers

There are specific guidelines for individuals who are on involuntary status under the Baker Act and receiving services in a medical hospital. These guidelines help ensure the individual receives proper mental health care. For example, when an individual is sent to a medical hospital from a designated receiving facility or State Mental Health treatment facility, the individual needs to return to the same receiving facility upon medical clearance unless any of the following conditions apply:

- The individual was sent on voluntary status and chooses not to return.
- The individual was sent on involuntary status and a qualified professional conducted an examination and determined that the individual no longer meets Baker Act criteria.
- The individual was sent on involuntary status and all the following conditions apply.

- It is within the initial 72-hour examination period.
- A petition for involuntary placement or services had not been filed with the court.
- A qualified emergency department physician conducted an examination and determined that the individual no longer meets Baker Act criteria.

If the individual came directly to the emergency department after the initiation of an involuntary examination or the involuntary examination was initiated in the emergency department, the hospital must expedite and facilitate the transfer as soon as the individual is medically stable. The emergency department must notify the designated receiving facility of the intent to transfer the individual within two (2) hours of medical clearance and the transfer must occur within 12 hours of medical clearance. Per EMTALA, designated receiving facilities that are licensed as hospitals are required to accept the individual for evaluation if they have the capacity and capability to meet the individual's needs.

If a medical hospital is unable to meet the 12-hour transfer deadline, hospital staff are required to notify the Department's Regional Office of Substance Abuse and Mental Health as soon as possible. Public designated receiving facilities are required to assist with the coordination of care for individuals in their region who need assistance securing acute mental health services. The Department may be contacted if there are problems with the local crisis stabilization unit accepting or coordinating transfers. EMTALA violations should be reported to AHCA. More on EMTALA can be found in chapter 13 and the online course *Emergency Medical Treatment: Florida's Baker Act and Marchman Act.*

Law enforcement is not required to assess the scene or hand-off the transport to a medical transport company when an individual is being transferred between facilities unless the individual is being sent from a long-term care facility.

More information on regulations guiding transportation for individuals on involuntary status under the Baker Act can be found in the *Transportation Frequently Asked Questions*.

C. Methods of Transport for Facility Transfers

Transfers between secure facilities, unless currently part of the county's transportation plan, do not include law enforcement officers as an approved method of transportation. These transfers are completed by a medical transportation company. A secure facility is typically considered a facility with increased security measures such as those found in emergency departments, inpatient, and residential facilities. If the individual is currently in a facility for the primary reason of receiving medical or mental health services, such as a long-term care facility or group home, non- emergent medical transport companies are often called to perform the facility-to-facility transfer.

Long-Term Care Facilities

Law enforcement officers have a responsibility to arrive at the scene when an involuntary examination is initiated for a resident of a long-term care facility. The law enforcement officer must assess the situation and determine whether to hand-off the transport and cosign it to a medical transport company.

Under most circumstances' residents of a nursing home, assisted living facility, or adult family care home are not allowed to be transported to a designated receiving facility by law enforcement or non-emergent medical transport unless an involuntary examination is initiated. There are a few exceptions when the individual meets any of the following conditions.

- The individual resides in an independent living unit of an assisted living facility.
- The individual has an independent expert examination completed and is found competent to provide express and informed consent.

Many counties have a contract with non-emergent medical transport companies to provide transportation for residents of long-term care facilities after the initiation of an involuntary examination. When a contract for county-funded transportation services exists, the transportation service must give preference for transportation to residents of nursing homes, assisted living facilities, adult day care centers, and adult family care homes.

Information regarding individuals residing in long-term care facilities and other vulnerable adults can be found in chapter 12 and the online course *Long-Term Care and the Baker Act*.

CHAPTER 8

Rights of Individuals with Mental Health Conditions

I. Overview of Individual Rights

s. 394.459, F.S.	• Rights of Patients
s. 381.026, F.S.	• Florida Patient's Bill of Rights and Responsibilities
ch. 65E-5.140, F.A.C.	• Rights of Patients
ch. 59A-3.254, F.A.C.	• Patient Rights and Care

While individuals in designated receiving facilities and Baker Act treatment facilities have some of their liberties temporarily restricted for safety reasons, most of their rights remain intact. Individuals who are receiving services under the Baker Act must have specific rights afforded to them. Florida law requires that the dignity of the individuals with mental health conditions is always respected, including when the individual is taken into custody, held, or transported. This is to ensure that individuals are not mistreated simply for the fact that they have a mental health condition, most of them have not even committed any crime and deserve the same treatment as any other person seeking care for a medical condition.

Florida Statute and federal law require that the individuals are provided with due process rights regardless of whether the individual receives services voluntarily or involuntarily. The individual rights reviewed in this guide are extended to all individuals receiving services in a designated receiving facility, state mental health treatment facility, or receiving services under involuntary status in a medical hospital. There are only a few variations on how these rights are implemented based on the individual's legal status under the Baker Act.

Florida's Patient's Bill of Rights identifies requirements for all licensed health care professionals and health care facilities providing services to individuals. The Florida Mental Health Act adapts many of these rights for individuals receiving services in a receiving or treatment facility. Individuals who are receiving psychiatric examination or treatment in a general medical hospital also have the same rights as individuals receiving services in a receiving or treatment facility.

In addition to Florida law, federal regulations afford rights to individuals receiving services in facilities that receive Medicare or Medicaid reimbursement. Many receiving and treatment facilities accept Medicare and/or Medicaid payments. These facilities are regulated by several federal organizations including the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS). More information on these organizations is found in Appendix A. Oversight Organizations.

s. 394.459(12), F.S.	• Posting of Notice of Rights of Patients
ch. 65E-5.140, F.A.C.	• Rights of Patients
Form CF-MH 3103	• Rights of Persons in Mental Health Facilities and Programs

Rights of individuals receiving services must be posted on each unit in languages the individuals receiving services can understand. This often means that rights must be posted in English, Spanish, and Creole. Upon admission, designated receiving facilities and state mental health treatment facilities must provide a paper copy of the rights of patients to individuals receiving services.

Individuals who violate the rights of another may be held legally liable.

II. Inclusive Individual Rights Afforded Under the Baker Act

The rights of individuals being served under the Baker Act are explained in the section below and primarily include the right to individual dignity, including maintaining many of their personal belongings during admission, and the right to communicate with others outside the facility via phone, mail, and in-person visits. These rights protect individuals from mistreatment that may occur when a disadvantaged person is removed from their usual environment and protects all Floridians that could experience a Baker Act at some point during their lifetime from inhumane conditions that existed hundreds of years ago, resulting in the neglect, and suffering of individuals with behavioral health conditions.

Individuals meet temporary disability status for the duration of time they are receiving inpatient services under the Baker Act providing them with access to disability rights and services.

A. Individual Dignity

ch. 65E-5.150, F.A.C. • Person's Right to Individual Dignity

Individuals who receive services in a designated receiving facility or state mental health treatment facility must be provided all constitutional rights including the requirement that all individuals be treated in a humane way while being transported, examined, and treated for a mental health condition. Many of the other rights are related to specific instances in which individual dignity must be honored and maintained. Several of those rights will be discussed throughout this chapter.

B. Personal Belongings

ch. 65E-5.200, F.A.C. • Right to Care and Custody of Personal Effects

Individual dignity covers a broad range of subjects including the care and custody of the personal effects of individuals served. Individuals who are receiving services in a receiving or treatment facility have a right to their own personal belongings if they do not pose a potential safety hazard or confidentiality violation. This provides individuals with the right to keep their own personal belongings, including clothing, unless they are removed for safety, medical, confidentiality, or other liability reasons. Examples of items that are not allowed on a psychiatric unit often include the following items as noted in the table below.

Prohibited Items	Reason for Exclusion
Belts and shoelaces	Potential for strangulation
Make-up, perfume, and cologne	Toxicity if swallowed
Curling irons, straight irons, and blow dryers	Excessive heat/burn potential
Cell phones and laptops	Ability to easily document other individual's information, including still photographs and video recordings - also considered high value items with the potential for damage or theft
Valuables such as jewelry, money, credit cards, and identification	Potential for theft, including identity theft

Visitors may be prohibited from bringing most of these items to the psychiatric unit, except for jewelry, belts, and shoelaces. The facility must have policies and procedures for identifying what is allowed on the unit by staff, visitors, and individuals receiving services. The facility must also identify how they will inventory, secure, and return personal belongings that are prohibited.

When belongings are removed from the individual receiving services, an inventory must be completed and witnessed by two staff members and the belongings must be returned upon discharge. If the belongings are not returned to the individual, the reason must be clearly documented in the individual's clinical record.

C. Communication and Visits

ch. 65E-5.190, F.A.C.	• Right to Communication and Visits
Form CF-MH 3048	• Confidentiality Agreement

Individuals receiving services in a receiving or treatment facility have the right to determine who knows they are in the facility and who is allowed to visit. The specific circumstances that must occur for staff at the facility to be able to confirm or deny if an individual is admitted to a facility include when any of the following apply.

- The individual or his or her substitute decision-maker provides consent to release information to a specific person or entity.
- The individual has a substitute decision-maker or guardian who must be notified of the individual's location, such as a child under the age of 18.
- Law enforcement is searching for an individual who has been reported missing.
- Information is shared with another health provider for continuity of care either due to an emergency medical condition or for discharge.

While information cannot be provided without consent, it is important to inform the individual or their substitute decision maker each time someone attempts to make contact. Facility staff should try to obtain consent to release information (as described below) for concerned family members or supportive friends that reach out. It is important to ensure that someone has information about the individual's status, any assistance they might need and any support that would be helpful upon discharge. Even if there have been previous attempts to make contact from the same person and consent was not provided at that time, the staff should not make the determination that the same decision will be made.

Upon arrival at a designated receiving facility the individual must
be provided with an opportunity to notify others of their whereabouts without delay.

If a law enforcement officer has a warrant for the individual the officer may enter the facility and conduct a search. Facility staff is prohibited from identifying the individual or impeding the search.

A password or PIN number may be created so authorized persons are aware of the individual's admission. This maintains confidentiality and allows communication with others outside the facility. If this is generated by the facility, it is best to use a different identifier for each admission. Staff can also take messages for individuals letting a caller know that they will check the census and pass on the message if the individual is in the facility. Facilities may also have individuals complete a Confidentiality Agreement (CF-MH 3048) or an Authorization for Release of Information (CF- MH 3044). These forms identify who is notified of the individual's admission including information about authorized visitors, telephone calls, and access to medical records.

Individuals are guaranteed the right to private communication when contacting others outside the facility. This includes communication by phone, mail, and in-person visitation. Individuals have the right to send and receive their mail unopened. They also have a right to privacy during phone calls and face-to-face visits. While there are often restrictions on specific hours the phone is available for use, individuals have the right to promptly notify someone outside of the facility of his or her location during admission.

1. Designated receiving facilities and Baker Act treatment facilities typically have a central phone that is shared for individuals receiving services to make and receive phone calls. Individuals have a right to not be monitored by staff, such as recording phone calls or listening in on conversations. Individuals also have the right to be provided with space from other individuals waiting to make a phone call. This also applies to visits on the unit. While secluded areas for meeting may not be possible, privacy and confidentiality should be respected to the extent possible.

Restrictions
A physician may write an order for communication to be restricted or monitored if it is believed that the communication is detrimental to the well-being of the individual receiving services or others. Written notice must be provided to the individual and documented in the clinical record. This notification may be provided with the form Restriction of Communication or Visitors (CF-MH 3049). While communication restrictions are uncommon, they are typically implemented for one of the following reasons.

- The individual was verbally abusive or belligerent on the phone.
- The individual had several instances of becoming extremely distraught following communications with a specific individual.
- The individual repeatedly made inappropriate calls, such as dialing 911.

An order for a communication restriction must be reviewed every three (3) days. If the physician believes that the restriction needs to continue, the order must be renewed with additional justification at that time as documented by the physician. An individual cannot be restricted from communicating with the Abuse Hotline or their attorney.

III. Treatment

Individuals have the right to access services for emergency medical conditions. This right is afforded to all individuals requesting emergency medical examination or treatment regardless of whether they are in a designated receiving facility or state mental health treatment facility when the request is made. Physical conditions, as well as mental health conditions, can be designated as an emergency medical condition. Most individuals receiving inpatient mental health services can be identified as experiencing an emergency mental health condition, particularly at the time of admission.

Federal regulation prohibits a hospital from delaying or denying treatment due to an individual's inability to pay once it is determined an emergency medical condition may exist. According to the Emergency Medical Treatment and Labor Act (EMTALA), individuals experiencing an emergency condition who are unable to pay must be provided the same services as those that are able to pay for services. Financial considerations must not delay, deny, significantly diminish, or alter examination or stabilizing treatment. An individual who experiences an emergency medical condition must be provided with appropriate examination and stabilization services if the current facility has the capacity and capability to provide those services. If the facility does not have the capacity or capability, they must to locate another facility that can provide services and arrange for an appropriate transfer.

More information on EMTALA may be found in chapter 13 and the online course *Emergency Medical Treatment: Florida's Baker Act and Marchman Act*.

A. Consent to Treatment

ch. 65E-5.170, F.A.C.	• Right to Express and Informed Consent
ch. 59A-3.254(4), F.A.C.	• Patient Rights and Care

Individuals who are competent to consent to treatment and in need of acute or ongoing mental health services are encouraged to consent to and receive services voluntarily whenever possible. This includes providing consent when applying for services; participating in the development of their own treatment and discharge plans; and, determining when they want to change their level of care or conclude treatment.

An individual receiving involuntary examination can maintain his or her right to consent to or deny treatment in most circumstances. An involuntary examination does not override the right to consent or deny treatment – only a substitute decision-maker, emergency treatment, or court order can do that. Treatment cannot be forced unless an individual is an active and significant physical threat to themselves or others or a court has intervened. If the individual is unable to provide express and informed consent due to either being incompetent or incapacitated, a substitute decision-maker may be appointed to make specific types of decisions for the individual. When an individual has a substitute decision- maker for their medical needs, the individual cannot make decisions about their own treatment however, they can be provided with an explanation of the treatment they will receive in easy-to-understand terms and language.

B. Treatment and Planning

Treatment planning must occur with the individual receiving services, their substitute decision-maker if applicable, and members of the treatment team. Treatment planning should be individualized and include goals, objectives, and interventions that effectively address the identified issues and promote recovery. The treatment planning process must be transparent and respectful regarding the choices of the individual receiving services.

Each treatment plan is based on the unique strengths and vulnerabilities of the individual as well as the individual's progress and needs. Individuals in a designated receiving facility or state mental health treatment facility are required to receive services outlined in their treatment plan with consideration given to all of the following domains.

- Medical
- Vocational
- Social
- Educational
- Rehabilitative Services

Services must be administered skillfully, safely, and humanely by qualified staff.

The initial treatment plan must be completed within five (5) days of admission and prior to the individual's discharge. Treatment team meetings occur based on the level of care and expected length of stay. In a receiving facility, this often means that the treatment team meets weekly to review the appropriateness of the individual's goals and the current progress towards those goals. Individuals who remain in a receiving or treatment facility must have their treatment plan updated at least once every 30 days. The treatment plan must be updated a least once every 60 days for individuals who are held in a facility for longer than 24 months.

Treatment team meetings are designed to review the individual's needs and goals and identify if any modifications need to be made based on the individual's progress in treatment, severity of symptoms, and any new symptoms or diagnoses that should be addressed. Routine monitoring of progress towards treatment and recovery goals is made, along with appropriate modifications to the treatment plan, as treatment progresses. The individual's progress, or lack thereof, should be documented both in the progress notes as well as their treatment plan.

If the individual is discharged prior to the initial scheduled treatment team meeting, his or her case may not be reviewed with the treatment team. In those instances, the individual may only be invited to collaborate on the development of their treatment plan, and upon discharge, their treatment plan may be resolved without ever discussing it with the entire treatment team in a formal setting.

Treatment planning includes both the treatment structure for active treatment and planning for subsequent treatment upon discharge. Community agencies are expected to work together to increase awareness of needed services, avoid any gaps in services, and provide a smooth transition into the next level of care in the behavioral health system. Crucial to the quality provision of treatment is the identification and analysis of the elements that will be necessary to determine when the individual is ready to be transitioned to the next level of care.

This transition from one provider to another or one level of care to another within the same provider, typically referred to as discharge planning, begins at admission and, like the treatment plan, continuously adapts to the individual's transforming needs. Many outpatient services are arranged prior to discharge from the designated receiving facility or state mental health treatment facility. It is the responsibility of the treatment team to identify and arrange services for the individual while in the facility and help facilitate the initiation or continuation of outpatient services following discharge. More information on discharge planning is discussed in chapter 11.

IV. Access to Clinical Records

s. 394.4615, F.S.	• Clinical Records; Confidentiality
ch. 65E-5.250, F.A.C.	• Clinical Records; Confidentiality

Individuals receiving services in a designated receiving facility, or a state mental health treatment facility have the right to access their clinical record. A physician, however, may write an order to temporarily restrict the individual's access to specific information in their clinical record by documenting that such information would be detrimental to the individual's well-being. This restriction order is valid for up to seven (7) days and must provide justification as to why the individual is restricted from viewing their information. The physician must review the restriction and document the reason to continue the order to restrict access to clinical records every seven (7) days thereafter.

V. Exercise and Fresh Air Rights

ch. 65E-5.150, F.A.C.	• Individual Dignity
ch. 65E-5.350(h), F.A.C.	• Eligibility Criteria and Procedures for Designation

Individuals admitted to a federally supported behavioral health program, such as a designated receiving facility that receives Medicare payments or uses federal block grant funds issued by the Department, are allowed the opportunity to exercise and access an outdoor, fresh air area on a daily or near daily basis. These activities can be separate or combined, but both must be accessible to everyone. A physician must write an order and provide justification if an individual is restricted from exercise or fresh air activity based upon risk factors.

VI. Right to Release

s. 394.4625, F.S.	• Voluntary Admissions
s. 394.459(8), F.S.	• Rights of Patients
ch. 65E-5.220, F.A.C.	• Right to Habeas Corpus
Form CF-MH 3036	• Notice of Right to Petition for Habeas Corpus/Grievance
Form CF-MH 3038	• Notice of Release or Discharge
Form CF-MH 3090	• Petition for Writ of Habeas Corpus or for Redress of Grievances
Form CF-MH 3051a	• Notice of Right of Person on Voluntary Status to Request Discharge From a Receiving Facility
Form CF-MH 3051b	• Notice of Right of Person on Voluntary Status to Request Discharge From a Treatment Facility

Individuals must be provided with information regarding their right to request discharge upon admission. This notice must be provided at least once every six (6) months for the duration of the admission.

Individuals have the right to request discharge at any time.

An individual on voluntary status may request discharge orally or in writing at any time following admission to the facility. Form CF- MH 3051a: Notice of Right of Person on Voluntary Status to Request Discharge from a Receiving Facility can be used for this request. Once the request is made, the individual must be discharged within 24 hours unless the individual withdraws their request for discharge or is transferred to involuntary status. A state mental health treatment facility may extend the 24-hour discharge period for adequate discharge planning, but the period must not exceed three (3) days, excluding weekends or holidays.

If a discharge request is communicated to a staff member other than a physician or clinical psychologist, a notification must be made to one of these professionals as soon as possible and no later than 12 hours after the request has been made. Once the professional has been notified of the request for discharge, the professional must examine the individual and determine whether involuntary criteria is met. If involuntary criteria are met, the individual must be transferred to involuntary status unless the request for discharge is rescinded.

An individual under involuntary status may also request discharge by completing a writ of habeas corpus. This may be completed by the individual receiving services or by someone else on their behalf. The facility must file this request with the local circuit court by the next court working day.

VII. Representatives and Substitute Decision-Makers

A. Representatives

Individuals in a designated receiving facility or state mental health treatment facility on involuntary status have the right to a representative. This representative may be selected by the individual themselves if competent to provide express and informed consent or through an advance directive. A representative is identified for the individual if he or she is not competent and does not have an advance directive or is competent and refuses to identify anyone.

The individual's representative must receive the same information a competent individual would receive including

- Prompt notification of the individual's admission, all proceedings, and any restriction of rights.
- A copy of the inventory of personal effects.

The representative must have immediate access to the individual receiving services and is authorized to file a petition for a writ of habeas corpus or right to release on the individual's behalf.

Depending on how the individual's representative is appointed and if authority is granted by the court, the representative may or may not be able to make treatment decisions, access or release information in the individual's clinical record, or request the transfer of the individual to another facility.

B. Advance Directives

ch. 59A-3.254(4)(b), F.A.C. • Patient Rights - Advance Directives and Health Care Surrogates

Individuals in a designated receiving facility or state mental health treatment facility have the right to have their existing advance directives honored and develop new advance directives while receiving services. Familiarity with an individual's advance directives is important in identifying future decisions made for that individual. Advance directives must be completed when an individual is competent to provide express and informed consent. These directives will then be employed when an individual becomes incapacitated or incompetent. Advance directives are commonly used to make medical or behavioral health decisions but are also used in financial decision-making.

C. Legal Representation

Individuals who are examined or treated under involuntary status have the right to be represented by an attorney. The public defender will provide representation to individuals receiving involuntary services unless the individual declines representation or has a private attorney.

More information on substitute decision-makers is found in chapter five (5) and the online course entitled *Guardian Advocate and the Baker Act*.

VIII. Other Individual Rights

s. 394.459(7), F.S.	• Rights of Patients
ch. 65E-5.210, F.A.C.	• Right to Vote in Public Elections

A. Education

Minors have a right to access educational services. Inpatient and residential facilities have an obligation to ensure minors have access to educational services during their admission. Designated receiving facilities serving minors must work with the local educational system and or the local educational multiagency network for students with a serious emotional disturbance. More information about educating minors in a designated receiving facility is found in chapter 12.

B. Voting in Public Elections

Individuals are guaranteed the right to register and to vote in any election for which they are qualified to vote if they can do so within the appropriate time frames. Florida offers a vote-by-mail ballot no-excuse absentee voting. To participate the individual will need to know weeks in advance that they will be in the facility at the time of election. Additional information about how to register for vote-by-mail is available at the Florida Division of Elections.

C. Firearms

18 U.S.C. 922(g)(4)	• Unlawful Acts
s. 394.463, F.S.	• Involuntary Examination
s. 790.06, F.S.	• License to Carry Concealed Weapon or Firearm
s. 790.064, F.S.	• Firearm Possession and Firearm Ownership Disability
s. 790.065, F.S.	• Sale and Delivery of Firearms
s. 790.401, F.S.	• Risk Protection Orders

State and federal law can restrict individuals from purchasing firearms if they are deemed to be an imminent risk of harming oneself or others. A physician may petition the court to restrict an individual's access to firearms by requesting a firearm disability be ordered. A petition for firearm disability may be submitted to the clerk of court if all the following apply:

- The individual poses an imminent danger to self or others.
- A physician identifies that the individual meets criteria for involuntary inpatient placement or involuntary outpatient services, even if the individual transfers from involuntary to voluntary status prior to a petition being filed with the court.
- The individual's records are ordered by the court to be submitted to the Department of Law Enforcement and maintained in a database of individuals who are prohibited from firearm purchase.

Individuals who transfer from involuntary to voluntary status must receive a written notice that acknowledges their rights to purchase firearms may become restricted. This notice must include a statement that the individual acknowledges a petition may be filed with the court to prohibit the future purchase of firearms or the ability to obtain or maintain a concealed carry license.

Any certification of a firearm disability must be filed with the local clerk of court. If an individual receives the certification of firearm disability, the information must be entered into the Mental Competency (MECOM) database and the National Instant Criminal Background Check System (NICS). The individual may later petition the court for a relief of firearm disability. A petition for firearm disability may not be filed for individuals who meet any of the following criteria.

- Receive services in a designated receiving facility or state mental health treatment facility exclusively on voluntary status.
- Receive services due to self-neglect.
- Are discharged within the initial 72-hour examination period due to not meeting the criteria for involuntary services.
- Are first taken to a medical hospital and, before going to a receiving facility, are either discharged or transferred to voluntary status.
- Are not considered an imminent risk.

There are also circumstances when current firearms may be seized by law enforcement. When a law enforcement officer initiates an involuntary examination or takes an individual into custody for transport they may seize and hold an individual's firearms if the individual poses a credible threat of violence towards themself or others. This surrender may be voluntary, or the officer may petition the court for a risk protection order. When voluntarily surrendered, the items must be available for return no more than 24 hours after the individual can document that he or she no longer poses a credible physical threat to self or others. In addition, the individual must already be discharged from inpatient or involuntary outpatient services. The return of items seized through a risk protection order are subject to the terms of the court order.

IX. Grievances

42 C.F.R. 51.25	• Grievance Procedure
s. 381.026, F.S.	• Florida Patient's Bill of Rights and Responsibilities
ch. 65E-5.180, F.A.C.	• Right to Quality Treatment
ch. 65E-5.352, F.A.C.	• Procedures for Complaints and Investigations
ch. 65E-5.400, F.A.C.	• Baker Act Funded Services Standards
ch. 59A-3.254(4)3(c), F.A.C.	• Patient Rights and Care

There are federal regulations regarding the safety of individuals receiving services. Health care professionals and organizations are provided with the opportunity to anonymously submit information to one of the authorized Patient Safety Organizations for the examination and evaluation of events concerning the safety of individuals receiving services. The law focuses on quality assurance, quality improvement, the reduction of medical errors, and the overall need for incident reporting.

Designated receiving facilities must follow state and federal laws that address grievance procedures as well as the reporting of potential abuse. Facilities must develop policies and procedures to comply with those guidelines. state mental health treatment facilities must also follow the Department's Operating Procedures. Designated receiving facilities and state mental health treatment facilities typically have forms to complete for individuals to document a grievance. They must, however, accept any submission of a grievance when the individual requests to have it regarded as a formal grievance. This includes a handwritten note on a piece of paper or a verbal complaint.

A grievance can be filed directly by the individual receiving services or by a third party on the individual's behalf. There are several ways a grievance can be filed in designated receiving or state mental health treatment facilities. For example, an internal grievance may be filed with the facility where the individual is receiving services if they believe that their rights are being violated. Grievances typically focus on the violation, or perceived violation, of an individual's rights. While an abuse complaint could be filed as a grievance, abuse is a serious offense that is singled out from the grievance process with separate policies and procedures.

ch. 65E-5.220, F.A.C. • Right to Habeas Corpus

An individual on involuntary status must be notified of their right to file a writ of habeas corpus (CF-MH 3036) with the circuit court. A writ of habeas corpus (CF-MH 3090) is a formal request for the court to review the individual's case to determine if they are being detained without just cause. If there are concurrent concerns about other rights that might be violated or withheld from the individual, the court will also hear those concerns.

Individuals on voluntary status must be notified of their right to request release if they believe they are being held improperly in a designated receiving facility through form (CF-MH 3051a) or state mental health treatment facility through form (CF-MH 3051b). A right to release request can be filed by an individual under voluntary status in a designated receiving facility after requesting discharge. The right to discharge is identified by law and the individual may file a grievance if the request is not properly acted upon.

While an individual has the right to sign themselves into a facility, they cannot sign themselves out without the authorization of a physician or administrator.

The Americans with Disabilities Act provides protections for individuals to have physical access to structures and services despite their disability. It is the right of individuals in inpatient and residential facilities to contact Disability Rights Florida if they think they are being discriminated against due to a disability. Disability Rights Florida conducts investigations into complaints of abuse, neglect, and rights violations. Priority is given to individuals with a temporary or permanent mental health disability who are currently receiving services in institutions including inpatient and residential treatment settings. Some services are provided by Disability Rights Florida to those living independently as resources allow.

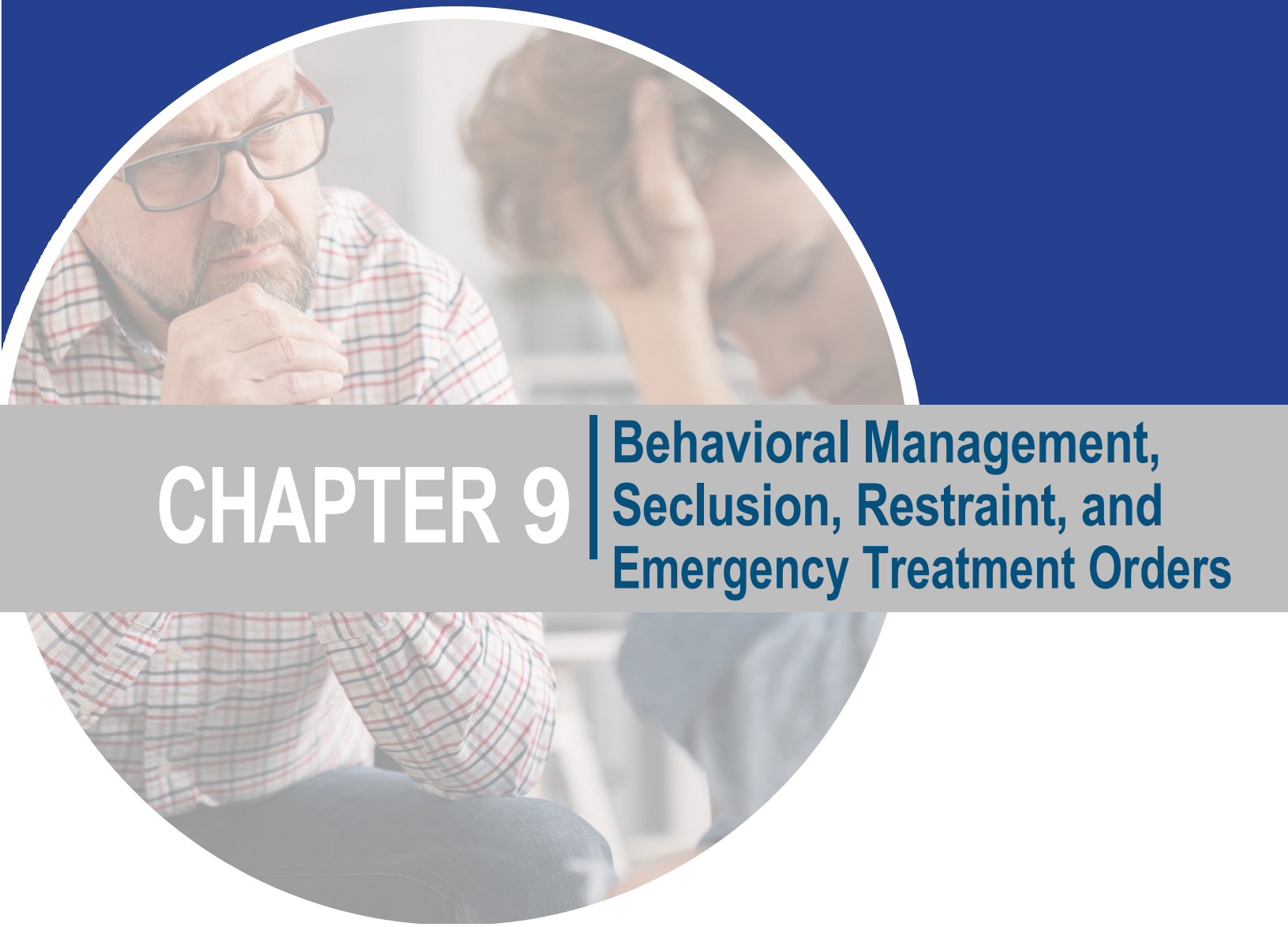
The Florida Abuse Hotline (800-962-2873) can be called if it is believed that an individual receiving services in a designated receiving facility or state mental health treatment facility, and it is suspected they are experiencing abuse or neglect. The Florida Abuse Hotline is the centralized reporting center for abuse and neglect of children and vulnerable adults. Adults receiving services in a designated receiving facility and state mental health treatment facility are considered vulnerable adults; therefore, abuse and neglect reports are handled by the Department's Abuse Hotline. As a result, rules for mandated reporting of suspected abuse apply. More information about abuse reporting can be found in chapter 13.

X. Violation of Rights

s. 394.4593, F.S. • Sexual Misconduct Prohibited; Reporting Required; Penalties

Staff members who violate an individual's rights or abuse the privileges of their position can be held liable for damages to the full extent of the law.

Any staff who engage in sexual activity with an individual receiving services in a designated receiving facility or state mental health treatment facility can be charged with a felony, even if the individual receiving services consented. Failure to report any sexual activity within a designated receiving facility or state mental health treatment facility is a misdemeanor offense.



CHAPTER 9 | Behavioral Management, Seclusion, Restraint, and Emergency Treatment Orders

I. General Management of the Treatment Environment and Behavioral Management Programs

II. Alternatives to Behavioral Management Programs

III. Following the Release of Seclusion and Restraint

I. General Management of the Treatment Environment and Behavioral Management Programs

Individuals receiving mental health services must receive treatment in the least restrictive environment that can adequately meet their needs and provide the appropriate level of safety. An individual may need to be in a secure inpatient or residential facility to ensure safety. When receiving services in a designated receiving facility or state mental health treatment facility, individuals are granted many rights, including the freedom of movement within the facility.

Individuals receiving services must be allowed to enter common areas unless a restriction is necessary to maintain safety through employing a form of seclusion or restraint. While seclusion or restraint is sometimes necessary to preserve safety and security, this chapter will discuss: (1) techniques to help avoid seclusion and restraint practices; and (2) guidelines to follow when seclusion or restraint is applied.

- Seclusion is considered the act of restricting an individual's freedom of movement within the facility by confining the individual to a specific area.
- Restraint is the restriction of movement of an individual's own body and includes the administration of physical techniques, mechanical devices, or psychotropic medications to assist in the restraint.

Seclusion and restraint provide external measures to help control an individual's behavior and maintain safety. If it can be documented that the act of seclusion or restraint is the least restrictive alternative to protect the physical well-being of the individual or those around them, seclusion or restraint can be implemented despite the individual's right to freedom of movement. Staff working in a behavioral health care setting must be trained before actively engaging in seclusion or restraint techniques specific to the age group they are working with. This training must include information on deploying techniques for both de-escalation as well as those for restraint.

Many designated receiving facilities in Florida strive to never physically restrain the individuals they serve. They believe that the potential for causing additional trauma and the risk of injury to the individual served and the staff working in the facility to too great and poses a liability. They also believe that when individuals served are treated appropriately, negative behavior is addressed as soon as it is detected and staff intervene properly, physical restraint can be completely avoided.

s. 394.459(2)(e), F.S.	• Rights of Patients
ch. 65E-5.1601, F.A.C.	• General Management of the Treatment Environment
ch. 65E-5.1602, F.A.C.	• Individual Behavioral Management Programs
ch. 65E-5.180(7), F.A.C.	• Right to Quality Treatment - Seclusion and Restraint

Individuals should be in an environment that includes them in the treatment process while promoting recovery. Every individual must have a treatment plan that will help identify their reason for treatment, goals of treatment, and desired outcomes of proposed interventions. A representative from each specialty that is responsible for delivering services to the individual, as well as the individual receiving services, should sign the treatment plan. Unless otherwise documented, the physician's signature indicates that there are no medical contraindications with the treatment plan while the individual's signature implies agreement with the proposed treatment methods. A treatment plan must be completed within five (5) days of admission, even if the length of stay is less than five (5) days.

A. Trauma-Responsive

ch. 65E-5.180(7), F.A.C. • Right to Quality Treatment - Seclusion and Restraint

The need to address trauma is viewed as an important component of effective behavioral health service delivery. In receiving facilities or treatment facilities, the use of seclusion and restraint strategies may generate negative feelings and re-traumatize people who already have had significant trauma in their lives. It is critical that these facilities adopt a trauma-responsive approach wherein the facility applies the principles of trauma-informed care to all areas of functioning and integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly.

Trauma is then seen as the expectation, not the exception. Even if an individual's traumatic experiences are unknown to staff, events and behaviors that are triggering and calming can still be identified. This approach can guide staff in how to tailor interactions, so individuals experience the least number of triggering events possible.

The ongoing effects of trauma can impact many aspects of treatment. The treatment team should be aware of traumatic events in the individual's past when planning and delivering the individual's treatment. Staff should also be trained on how interactions and the environment may trigger the recollection and re-experiencing of these events.

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.[1] A significant number of individuals who experience behavioral health conditions have a history of trauma even if it is not revealed to treatment staff.[2]

B. Behavioral Management Practices

s. 394.457(5)(b), F.S. • Operations and Administration

ch. 65E-5.180(7), F.A.C. • Right to Quality Treatment - Seclusion and Restraint

Behavioral management practices are an inherent element within the culture of the treatment environment. There are several elements that should be considered when implementing behavioral management techniques. This includes identifying all the following information.

- Other conditions or diagnoses that may contribute to specific behaviors or exclude certain interventions.
- Situations and stimuli that are precursors to an individual displaying certain desired or undesired behaviors.
- The specific behavior the intervention is targeting.
- The desired outcome of the intervention.
- How long to use behavioral management techniques before discontinuing the intervention.
- Whether a different intervention should be used.
- The changed behavior that identifies that the intervention was successful.

All individuals receiving services in a designated receiving facility or state mental health treatment facility are required to have a safety plan (CF-MH 3124) completed as soon as possible following admission. The safety plan should identify service methods and environments the individual finds either soothing or agitating, particularly when not feeling well. For example, some people may react adversely to being touched when they are upset, while others may find it comforting.

When specific interventions are identified that help prevent anxiety, agitation, or escalation of disruptive behaviors, this information should be included in both the individual's treatment and safety plans. Both the treatment and the safety plan are expected to be updated each time an incident of seclusion or restraint occurs with careful documentation about the circumstances surrounding the escalating behaviors. This includes identifying potential triggers as well as the individual's reactions to successful and unsuccessful interventions to de-escalate the situation. Collecting and analyzing this information can be very valuable to the individual's treatment and well-being.

Seclusion and restraint documentation must be included in the individual's clinical record, except for the incident report which is separate and is not filed in the clinical record.

C. De-Escalation Techniques

s. 394.453(2), F.S.	• Legislative Intent
s. 394.457(5)(b), F.S.	• Operations and Administration
ch. 65E-5.1703, F.A.C.	• Emergency Treatment Orders
ch. 65E-5.180(7), F.A.C.	• Right to Quality Treatment - Seclusion and Restraint
ch. 65E-5.330, F.A.C.	• Training

Individuals receiving specialized care, such as inpatient psychiatric services and residents of long-term care facilities, often have many triggers that evoke emotional and behavioral outbursts. Stimuli in the normal physical environment, such as routine noises or movements, can make the individual feel uncomfortable, disoriented or threatened.

Current methods of intervening with agitated individuals emphasize a non-coercive approach. This involves verbally engaging the individual to establish a collaborative relationship and then using verbal de-escalation techniques to reduce the agitated state. There are four main objectives when working with an individual who is agitated or disruptive:

1. ensure the safety of the individual, staff, and others in the area;
2. help the individual manage emotions and distress and maintain or regain control of his or her feelings and behavior;
3. avoid the use of restraint when at all possible; and
4. avoid coercive interventions that escalate agitation. Only after de-escalation interventions are unsuccessful should seclusion or restraint be applied.

De-escalation techniques are used to lessen quickly intensifying or out of control emotions and behaviors to improve physical and emotional safety. Specific techniques, such as redirection, can be used to divert the individual from the current agitator and place the focus and attention elsewhere. This might be by changing the topic of conversation or adding a positive stimulus. The individual might need to be removed from the current environment, such as suggesting they move to a different room or a quiet area, or the environment may need to be altered by doing something like playing music. A list of de-escalation techniques is found in Appendix J. Seclusion and Restraint.

Specific de-escalation strategies that the individual has identified as effective can be found on his or her safety plan. Safety plans should be easily accessible to staff directly engaged with individuals so that they can use this information to identify environmental triggers and address even mild signs of anxiety or changes in typical behavior and reference safety plans to learn what individuals find calming. De-escalating behavior early, before it becomes more serious, is more likely to be effective.

1. Best Practices Tool

s. 394.457(5)(b), F.S. • Operations and Administration

Individuals experiencing mental health symptoms may become more sensitive and reactive to their environment. The Florida Health Care Association has developed a Best Practice Tool for behavior management that is consistent with Florida law. This tool was created through the Quality First Credentialing Program with the intent of educating nursing staff on alternative and effective interventions for individuals displaying aggression and other disruptive behaviors.

The best practices tool was initially developed for long-term care facilities and recommends that residents are kept in their current environment if it is safe to do so. Individuals who are experiencing mental health symptoms and cognitive impairments often have difficulty with change and find comfort in their regular environment.

It is also important for long-term care facilities to reduce the risk of transfer trauma which frequently occurs with residents when they are transferred from one environment to another. Transfer trauma can have significant effects including emotional and behavioral consequences such as heightened depression, anxiety, and resistance. For these reasons, it is especially important for residential facilities to have the capability to provide behavioral management for their residents under most circumstances. Removing these individuals from their familiar environment, though sometimes necessary to provide safety measures due to physical, emotional, or behavioral symptoms, should be a last resort.

This best practice tool is not limited to long-term care environments and can be used with different populations and in a variety of settings to assist with the de-escalation of volatile emotional or behavioral situations. It provides detailed suggestions on how to redirect and manage potentially adverse and detrimental behaviors without the use of seclusion or restraint. Some suggestions include assessing for and addressing the following situations.

- Identify behaviors that indicate that the individual is becoming agitated or restless.
- Use a multidisciplinary staff approach to help identify physical and emotional triggers and potential techniques to calm reactive behaviors.
- Awareness of stimuli that might improve or worsen the situation based on prior interactions with the individual such as touch, sound, and amount of personal space.
- Identify soothing behaviors and stimuli such as providing a snack, music, or recreational activity.
- Rule out physical and medical problems such as infections, pain, and metabolic causes.
- Maintain a calm tone of voice, active listening techniques, and non-threatening posture during the interaction.
- Use verbal redirection to keep the individual and others safe.
- Take the individual to a quiet part of the facility.
- Increase supervision while decreasing stimuli.
- Establish and maintain a routine, including familiarity with those who provide assistance such as facility staff and caregivers.

It is important to remember that individuals who are actively struggling with mental health symptoms, particularly those who have additional difficulty processing information, may not have the ability to engage in cognitive processes such as rationalizing or analyzing a situation. This may occur in someone who also struggles with a neurocognitive or neurodevelopmental disorder such as dementia or autism. As a result, some of the effective de-escalation techniques, as well as the seclusion and restraint guidelines, differ for these populations. Coping skills are often diminished and other non-traditional intervention methods may be necessary. More information regarding considerations for individuals with co-occurring conditions such as dementia and autism is found in chapter 12.

Seclusion and restraint are only used when it is the least restrictive alternative to increase safety and security when an individual exhibits behavior that directly place the physical welfare of themselves or others in danger.

2. One-to-One (1:1) Supervision

An order for one-to-one (1:1) supervision provides additional protection for the individual's safety and may or may not include an additional order for seclusion or restraint. When one-to-one supervision is used it means:

(1) that a single staff member is responsible for watching that individual within close proximity until the order is completed; and,
(2) it may occur within or outside of a secluded area.

One-to-one supervision is often ordered when an individual is assessed as experiencing a higher than usual risk for falling or engaging in self-harming behaviors with the inability to contract for safety. These staff members, often referred to as sitters, may be regular employees of the facility or contracted through another company. An individual may have an additional order for seclusion and be confined to their room or may only have an order for one-to-one supervision and be allowed in common areas with the continuous presence of a sitter. If the sitter needs to interrupt the supervision for any reason, another staff member must already be present to take over the supervision responsibilities. An individual on one-to-one supervision must always be monitored by a staff member including when using the restroom and shower allowing for as much privacy as possible and during shift turnover.

II. Alternatives To Behavioral Management Programs

s. 394.457(5)(b), F.S. • Operations and Administration

Using verbal de-escalation is ideal and often effective; however, sometimes these techniques are not adequate to maintain safety. The right to freedom of movement can be temporarily suspended and overridden by a physician's order. This may be necessary when de-escalation techniques are not effective, and the individual presents an active and imminent physical threat. In these emergency situations, seclusion or restraint should be considered on a case-by-case basis to determine if restricting an individual's movement is the least restrictive alternative to preserving safety and security in the facility.

An individual who requires seclusion or restraint may display a combination of both verbal and non-verbally threatening behaviors; however, verbal aggressiveness is typically not enough to initiate seclusion or restraint. Staff may be able to identify if an individual is escalating, attempt de-escalation and take other precautions, such as referencing the individual's safety plan to learn what helps them feel calm. This may include providing the physician with a preliminary report of the behavior and clearing the area of other individuals and staff members. To employ seclusion or restraint measures, the threat must be identified by current behaviors, not just verbal threats, that pose a safety threat.

There is often a need for seclusion or restraint when an individual is displaying increasingly threatening behaviors. Seclusion or restraint can be ordered by a physician based on staff reports of significant behavioral warning signs of an imminent physical threat. The physician must order the least restrictive form of seclusion or restraint that is believed to be effective.

A. Guidelines for Seclusion and Restraint

s. 394.457(5)(b), F.S. • Operations and Administration

ch. 65E-5.180(7), F.A.C. • Right to Quality Treatment - Seclusion and Restraint

State and federal laws regulate the use of seclusion and restraint. These policies are monitored and enforced by AHCA and the Centers for Medicare and Medicaid Services (CMS). Each designated receiving and state mental health treatment facility must have explicit seclusion and restraint policies and procedures that minimally include all the following elements:

- Safety measures to ensure safe seclusion and restraint practices are used to protect the individual in crisis, bystanders, and staff engaging in the techniques.
- Limitations on the amount and duration seclusion or restraint is used.
- Procedures for how to proceed before, during, and after an act of seclusion or restraint event occurs.
- Annual training for staff on seclusion and restraint practices, including de-escalation.
- Established practices for data collection, documentation, and reporting.

Designated receiving facilities and state mental health treatment facilities also have their own policies and procedures in areas such as facility oversight, documentation, staffing, and time frames.

Never use seclusion or restraint as a form of punishment
or for the compensation or convenience of staff.

Seclusion may occur in any area of a facility and often includes separating the individual from the general population. Staff may use seclusion when an individual requires monitoring due to behaviors that are a danger to the individual's or others safety. Seclusion also confines the individual to a specific area. The individual is still free to move about the specified area during seclusion, but they are not able to move beyond the perimeter. The staff member assigned to observe the individual is responsible for continuously watching the individual and ensuring that the individual does not engage in any dangerous behaviors or leave the specified area. If either of these occur, the staff member should alert other staff members. It is preferable to assign a staff member who has an established rapport with the individual and make sure that they are knowledgeable about the individual's safety plan.

Restraint is the act of restricting an individual's ability to engage in freedom of movement. A restraint may be physical, mechanical, or chemical.

- A physical restraint uses physical techniques such as a physical hold.
- A mechanical restraint uses physical devices such as four-point soft restraints on the wrists and ankles.
- A chemical restraint uses psychotropic medication to restrict an individual's verbal or physical behavior via an emergency treatment order.

Seclusion and restraint may only be used to contain an individual who is actively behaving in a manner that poses an imminent physical threat to themself or others and cannot be de-escalated or redirected with other less restrictive techniques. This means that seclusion or restraint cannot be automatically ordered for an individual who has a history of poor response to de-escalation techniques until all other less restrictive alternatives are considered. Orders can be obtained from a physician, Advanced Practice Registered Nurse (APRN), or physician assistant when it is determined that seclusion or restraint is necessary. Telephone orders may be dictated to a registered nurse who has physically evaluated the individual and has been trained in seclusion and restraint. If not ordered by the individual's attending physician, the attending physician must be notified as soon as possible after the order is given.

Seclusion and restraint orders must include a time limit so that an individual is not left in a state of seclusion or restraint any longer than necessary. The maximum time limits for seclusion and restraint orders are as follows:

- Adults (Age 18+) 4 Hours
- Minors (Ages 9-17) 2 Hours
- Minors (Ages 8 years and under) 1 Hour

If the individual is in continued need of seclusion or restraint, a new order must be written before time expires on the current order. Once the individual is no longer an imminent danger and the need for seclusion or restraint has passed, the individual should be released even if the time limit in the order has not expired.

Once a seclusion or restraint order is initiated, there are additional time frames that must be followed. The individual's safety and well-being must be checked, including the monitoring of their vital signs (such as pulse and respiratory rate), checking for signs of injury, and skin integrity.

Seclusion- Ages 13 and over	Observation by trained staff at least once every 15 minutes and at least one observation per hour must be performed by a nurse.
Seclusion- Ages 12 and under	Direct and continuous observation by trained staff for the first hour. If seclusion continues past one (1) hour, observation must continue once every 15 minutes.
Restraint	Any individual placed in restraints must be assessed by a nurse no longer than 15 minutes after initiation of the restraints and at least every half hour thereafter.

The order must be renewed to continue the seclusion or restraint if the individual's behavior still warrants seclusion or

restraint. As soon as possible, an adult who is restrained should also be placed in a private area to preserve individual dignity, safety, and privacy. Minors under the age of 18 may not be restrained while placed in seclusion.

A physician's order is required for seclusion and mechanical or chemical restraint. Physical restraint may occur without a physician's order and may only be initiated by a staff member who is trained in seclusion and restraint. This must be reported to the physician as soon as possible. A registered nurse or highest-level staff member, as specified by written facility policy, who is immediately available and who is trained in seclusion and restraint procedures may initiate seclusion or physical restraint in an emergency when danger to oneself or others is imminent. This training includes de- escalation techniques, knowledge of CPR and first aid, and how to assess the individual's physical state through a visual assessment and the monitoring of vital signs.

Increased safety can be achieved when all individuals who are not actively involved in the seclusion or restraint incident are clear of the area. While some staff may stand at the perimeter to assist if needed and to keep other individuals clear of the area, all staff do not need to be present. Too much staff presence may cause the individual to feel threatened and react to defend themselves or can make the space too crowded and reduce the staff available to respond to the needs of other individuals receiving services. Some facilities may have crisis intervention teams that identify which staff will respond in the event of a crisis for each shift.

Seclusion and restraint must be applied in the safest and most humane manner. Important factors such as physical condition, medical problems, current medications, diagnoses, and specific age should be considered when determining the type and duration of the seclusion or restraint. Other factors include:

- The individual must be appropriately clothed for the environment.
- Staff must ensure that the positioning of the individual is accommodated for physical disability, medical condition, or age.
- The individual must be provided reasonable opportunities to toilet and drink upon request.
- At least once every two (2) hours the individual must be provided opportunity for range of motion.
- Individuals must be searched for potential contraband at the time of, or immediately following, the application of seclusion or restraint.
- Individuals must not have their hands restrained behind their back unless necessary for safety and only for the duration that an imminent threat of harm is present.
- The use of walking restraints (shackles) is prohibited unless an individual is transported off the unit and under the direct supervision of trained staff who maintain continuous visual contact within close proximity to the individual.

Individuals should not be restrained in a face down (prone) position. The use of restraint in the prone position may obstruct the ability to breath and cause dangerous respiratory conditions. If this position is necessary to obtain control of the individual, they must be repositioned for safety and comfort as soon as possible. Individuals are not allowed to have anything placed over their face due to respiratory concerns. Staff may wear protective gear for airborne precautions, but the individual cannot have a mask.

The individual must immediately be made aware of:

(1) the behavior that led to the seclusion or restraint; and,

(2) the behavior expected of them before seclusion or restraint can be discontinuation.

This information must also be documented in the clinical record. Parents of minors must be notified within 24 hours that these methods were used, but every effort should be made to notify them as soon as possible.

Observations must be documented with the name of the staff member providing the observation along with the date and time the observation occurred. The seclusion or restraint must be discontinued if there is concern at any time that the individual is experiencing an emergency medical condition.

In addition to routine observations, a physician, APRN, physician assistant, or registered nurse who is trained in seclusion and restraint must perform a physical examination of the individual within one (1) hour of the initiation of seclusion or restraint. This examination must include all the following elements:

- A face-to-face assessment reviewing the individual's current physical, emotional, and behavioral condition.
- A review of the clinical record for any diagnoses, medical problems, or physical conditions that may contribute to the initiation, discontinuation, or interfere with the safe use of seclusion or restraint.
- A review of the individual's current medications, including any medication interactions or potential contributing factors with consideration to any changes that need to be made to the medication regimen.
- A review of the individual's physical position during a restraint and if any modifications need to be made to the

position that the individual is being held.

Verbal orders for seclusion or restraint must be signed by the ordering physician within 24 hours. This signed order must accompany additional documentation in the clinical record, so it addresses all of the following:

- The behavior that necessitated the seclusion or restraint.
- The reason that less restrictive alternatives were not appropriate.
- The name and title of the staff member who initiated the procedure.
- The date and time the seclusion or restraint was initiated.The behaviors required to discontinue the technique.
- The individual's response to the intervention.
- The rationale for any continuation of orders.
- The date and time of discontinuation.

When the examination is completed by a registered nurse, the attending physician must be notified of the findings as soon as possible after the assessment is completed. Seclusion or restraint must be discontinued if it is determined that the risk associated with the seclusion or restraint is higher than the risk of the behavior displayed prior to the initiation.

If seclusion or restraint continues for 24 hours, the reviewing physician, psychiatric nurse, APRN, or physician assistant must assess the individual in person to continue the practice.

Phone orders are no longer sufficient.

There is specific documentation that must be completed after a seclusion or restraint is administered. This documentation typically requires the completion of several different forms. A designated receiving facility or state mental health treatment facility may want to collect all the required documentation that needs to be completed after a seclusion or restraint event and place them in pre-made packets so staff can easily access them.

1. Oversight Committees

ch. 65E-5.180(7), F.A.C. • Right to Quality Treatment - Seclusion and Restraint

Each facility using seclusion and restraint must establish an oversight committee. This committee must minimally consist of all the following persons.

- The facility administrator or their designee
- A medical staff member
- A quality assurance staff member
- A peer specialist or advocate, when available

The oversight committee is tasked with reviewing each incident of seclusion and restraint in a timely manner. They must analyze the event and identify if the least restrictive alternative was applied. The committee must also look for emerging patterns of use to decrease the utilization of seclusion and restraint. Patterns may emerge with specific individuals receiving services, the person ordering the seclusion or restraint, or a broad trend throughout the facility.

2. Conditions of Participation

42 C.F.R. 482.13 • Conditions of Participation for Hospitals

In addition to state laws, hospitals that accept Medicare or Medicaid payments must follow the federal guidelines outlined in the Conditions of Participation (CoPs). The CoPs identify several individual rights that must be observed including rights regarding confidentiality, personal representatives, advance directives, and seclusion and restraint.

The CoPs require that, when seclusion or restraint is used, the individual's treatment plan is modified to reflect the circumstances under which the practice was used and other interventions and techniques that may lead to more favorable future outcomes. The CoPs largely reflect state laws which are identified throughout this chapter. For example, seclusion and restraint techniques must be employed on a case-by-case basis. It is not acceptable to use as needed orders (referred to as PRN) or standing orders for the implementation of seclusion or restraint.

3. Accrediting Organizations

The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities (CARF) both provide accreditation status to many health care organizations and have standards for how seclusion and restraint is to be administered. They largely focus on using de-escalation and other techniques in lieu of using seclusion or restraint practices. These organizations take the position that seclusion and restraint interventions are only used when necessary for the safety of the individual and others in the immediate environment. Organizations that receive accreditation from the Joint Commission or CARF must follow their seclusion and restraint practices.

B. Emergency Treatment Orders

s. 394.459(4)(c), F.S.	• Rights of Patients
ch. 65E-5.150(1), F.A.C.	• Person's Right to Individual Dignity
ch. 65E-5.1703, F.A.C.	• Emergency Treatment Orders
ch. 59A-3.254(4)(h), F.A.C.	• Right to Be Free of Restraints

Emergency treatment order (ETO) means a written emergency order for psychotropic medication or a written order for seclusion or restraint. If a medication is prescribed as part of an assessment and plan of care, whether on a routine or as needed basis, it is a treatment. If the medication is prescribed as a response to an individual's harmful behaviors or unmanageable symptoms, it is a chemical restraint. Emergency treatment orders are considered a form of chemical restraint since a single dose or combination of psychotropic medications is administered to the individual to immediately restrict his or her freedom of movement. The intent of the ETO is to inhibit the dangerous or erratic behaviors that are being exhibited. An ETO should be ordered when: de-escalation techniques are ineffective and consent for the administration of psychotropic medications is declined; or, when obtaining consent may further endanger the individual or others. It is the only time a medication can be administered without the express and informed consent of the individual or his or her substitute decision-maker. If an individual has a substitute decision-maker, they must be notified as soon as possible after the administration of the ETO.

Individuals do not have the right to refuse treatment when being administered as an ETO. Staff may use additional restraint practices to administer the ETO, if necessary. The reason for an ETO must be documented in the physician's order and the progress notes. This documentation must include identification of the imminent risk and why less restrictive alternatives were insufficient. Emergency treatment orders must be ordered by a physician and are typically administered in the form of an injection. Like seclusion and restraint orders, an ETO order must be considered on a case-by-case basis and cannot be written as a PRN or standing order.

Seclusion or restraint is prohibited as a form of punishment, supervision, or a staffing solution. This includes the administration of psychotropic medication. Medication should only be used as a supplement to treatment and, in rare cases, when necessary to improve the immediate physical safety of the individual and those around them. This means that seclusion or restraint, including an ETO, should not be used as the sole or primary method of treatment, punishment, correction, or supervision.

The physician must review the circumstances leading to the ETO and determine if there are any metabolic or biological factors that could be influencing the behavior. This might include ordering laboratory tests, reviewing medication levels, metabolic panels, and medication interactions and side effects. If a second ETO is dispensed to the same individual within a seven (7) day period, a petition for a guardian advocate must be submitted to the court within one (1) court working day.

III. Following the Release of Seclusion or Restraint

s. 394.457(5)(b), F.S. • Operations and Administration

ch. 65E-5.180(7), F.A.C. • Right to Quality Treatment - Seclusion and Restraint

Immediately following the individual's release from seclusion or restraint, the individual's physical condition must be assessed and documented. This physical assessment must be conducted by either the treating physician or, if allowed by the facility, may be delegated to a staff member trained in seclusion and restraint. If the assessment is delegated the staff member must either be an Advanced Practice Registered Nurse (APRN), Registered Nurse (RN), or physician assistant.

The incident must also be reviewed by staff with the individual including identifying the behaviors that prompted and discontinued the order. This conversation should occur as soon as possible but no longer than 24 hours after the discontinuation. A staff member should seek to understand what caused the individual to experience a worsening of symptoms and how the emotions and behaviors were defused. The identification of any triggering events or stimuli, as well as those that defused the situation and led to discontinuation must be documented in the clinical record, including updating the treatment and safety plans (CF-MH 3124). Any coping skills that helped lead to the discontinuation of the current event should also be reviewed and documented.

The individual's treatment team must meet within two (2) working days to discuss and review any modifications that need to be made to the individual's treatment plan. The incident should be reviewed in the context of the individual's personal history and current diagnosis to determine if the following criteria apply:

- Any patterns of similar behaviors.
- If additional services are necessary to either:
  - Prevent future incidents or
  - Address the effects of the recent incident of seclusion or restraint.

Facility staff involved with the event must meet with management to review the event including the:

- Circumstance leading to the order for seclusion or restraint
- Effectiveness of the interventions; compliance with hospital policies and legal procedures
- Value and risk of utilizing less restrictive alternatives such as de-escalation or other behavioral management techniques.

The facility's oversight committee for seclusion and restraint events must review the findings. Any identification of trends in triggering stimuli or helpful interventions should be documented and added to the individual's treatment and safety plans.

A. Reporting

ch. 65E-5.180(7), F.A.C. • Right to Quality Treatment - Seclusion and Restraint

Occurrences of seclusion and restraint must be reported to the Department monthly. This reporting shall be done electronically using the Department's web-based application either directly via the data input screens or indirectly via the File Transfer Protocol batch process. The required reporting elements are:

- Provider tax identification number
- Individual's social security number
- Individual's facility identification number
- Date and time of initiation
- Discipline of the person ordering the seclusion or restraint
- Discipline of the person implementing the seclusion or restraint
- Reason order was initiated
- Type of seclusion or restraint used
- If there were any significant injuries experienced during the event
- Date and time of discontinuation

1. Sentinel Events

If an individual dies during or shortly after a seclusion or restraint event, that occurrence must be reported to the Department's Office of Substance Abuse and Mental Health. For those facilities that are subject to the federal Conditions of Participation, a report must also be made to the Centers for Medicare and Medicaid (CMS). These reports must be made by the end of the next working day. This includes a death that occurs under any of the following circumstances:

- During seclusion or restraint.
- Within 24 hours of the discontinuation of a seclusion or restraint event.
- Within one (1) week following the seclusion or restraint event when it is reasonable to believe that the seclusion or restraint contributed to the individual's death.

Deaths must be reported to CMS by completing a Report of a Hospital Death Associated with Restraint or Seclusion (CMS-10455). You must also email FL_DeathReports@cms.hhs.gov or fax 443-380-5912. Reports to the Department can be mailed to:

Attention: SAMH Director

Florida Department of Children and Families

Office of Substance Abuse and Mental Health

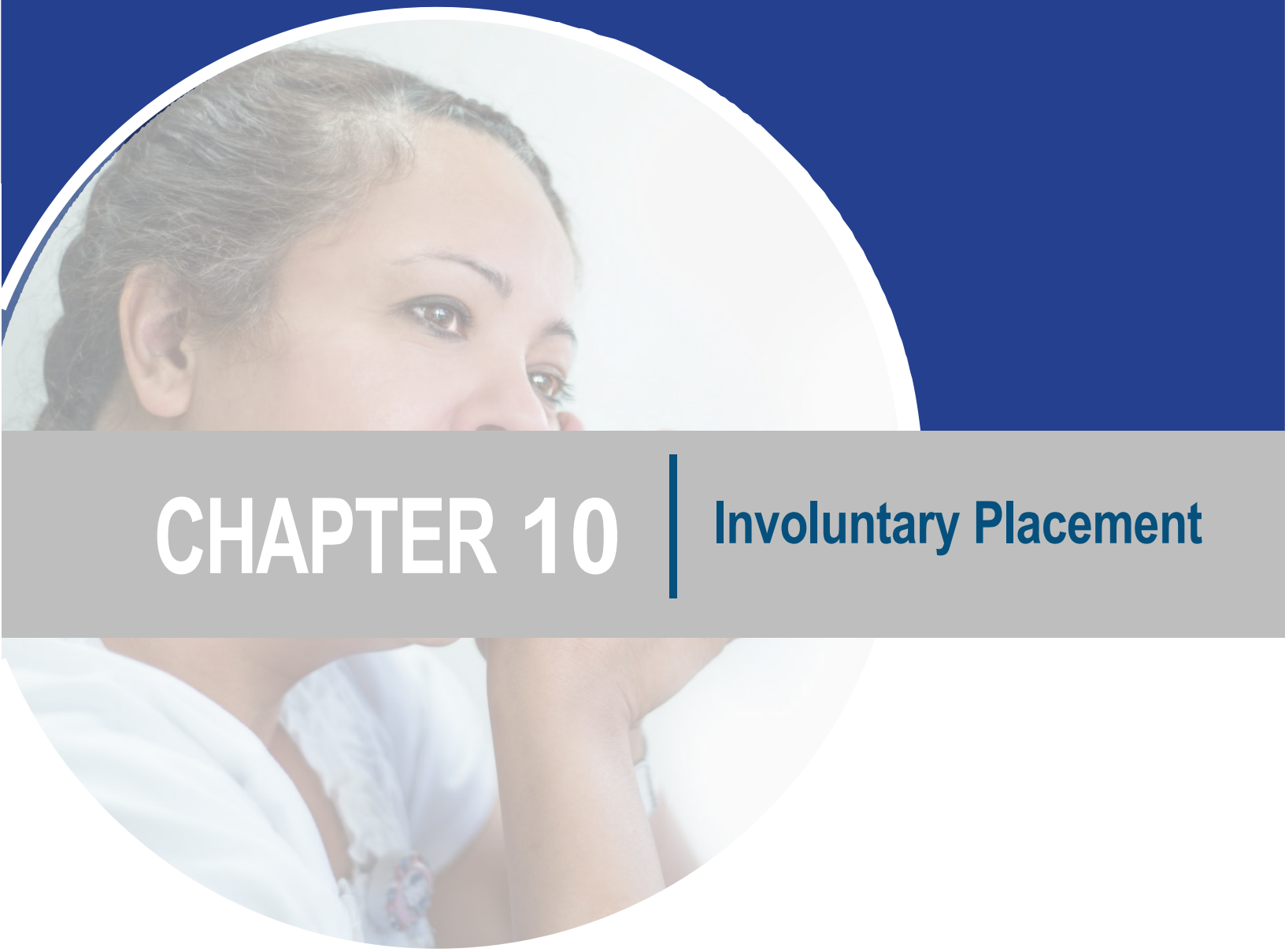
2415 N. Monroe Street, Suite 400 Tallahassee, FL 32303

1. Substance Abuse and Mental Health Services Administration (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

2. Missouri Institute of Mental HealthealHealthHealth. *MIMH Fact Sheet: Trauma Among People with Mental Illness, Substance Use Disorders and/or Developmental Disabilities*. (2004). Retrieved from https://dmh.mo.gov/docs/mentalillness/traumafactsheet2004.pdf.

3. Richmond, J. S., Berlin, J. S., Fishkind, A. B. (et al.) (2012). *Verbal de-escalation of the agitated patient: Consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup*. Western Journal of Emergency Medicine, 13(1), 11-16.

4. Crisis Prevention Institute. *How to Reduce Transfer Trauma for a Person with Dementia* (2015). Retrieved from https://www.crisisprevention.com/ Blog/November-2010/A-Real-Issue-for-Many-Individuals-With-Dementia.



CHAPTER 10 | Involuntary Placement

I. Requirements for Involuntary Placement

I. Requirements for Involuntary Placement

Individuals may only be held in a designated receiving facility for an involuntary examination during the initial 72-hour examination period. When the individual continues to meet the criteria after the 72-hour examination period and is unable or unwilling to transfer to voluntary status, involuntary placement allows a facility to hold an individual for continued stabilization.

A. Involuntary Inpatient Placement

s. 394.467, F.S.	• Involuntary Inpatient Placement
ch. 65E-5.290, F.A.C.	• Involuntary Inpatient Placement

A Petition for Involuntary Inpatient Placement (CF-MH 3032) must be filed with the court to continue to provide services in a designated receiving facility past the initial examination period. This petition must be filed if the individual meets the criteria for involuntary inpatient placement or involuntary outpatient services. The court will then hold a hearing to determine if the individual meets criteria for involuntary placement.

1. Criteria

The criteria for involuntary inpatient placement requires clear and convincing evidence that, because of a mental health condition, the individual meets all of the following conditions.

- Is unable or unwilling to provide express and informed consent for voluntary services.
- Is unable to reasonably meet their needs, including maintaining safety for the individual and the community, in a less restrictive environment because the individual either:
  - Is unable or unwilling to engage in self-care activities that pose a significant threat to the individual's physical well-being that cannot be managed by current resources and supports.
  - Poses a significant threat to themself or others as evidenced by recent behavior that cannot be reasonably managed at a lower level of care.

The individual may meet criteria as the result of an act of aggression or risk-taking behaviors or due to psychosis, depression, or other symptoms of a mental health condition that impair the individual's ability to adequately care for themselves. To meet the criteria for inpatient involuntary placement, these behaviors or symptoms must continue to be evident during the 72-hour involuntary evaluation period.

2. Petition Requirements

A Petition for Involuntary Inpatient Placement (CF-MH 3032) may be filed if the individual continues to meet criteria for involuntary services past the initial 72-hour involuntary examination period and is either unwilling or unable to provide express and informed consent for voluntary services. Once the petition is filed, the designated receiving facility may continue to hold the individual in the facility until either the individual no longer meets criteria for involuntary inpatient placement, the court orders a transfer to a state mental health treatment facility, or the court releases the individual from the designated receiving facility.

The petition is filed with the circuit court by the facility administrator and must include supporting evidence from the first and second opinions. These opinions are typically completed by two psychiatrists or a psychiatrist and a clinical psychologist and must be provided after personally assessing the individual within the initial examination period.

The facility administrator may petition the court for the appointment of a guardian advocate for individuals who have been deemed incompetent to consent to treatment by a psychiatrist and do not already have a substitute decision-maker. If the 72-hour involuntary examination period ends on a weekend or holiday, the petition may be filed with the court on the next working day if all other requirements have been met within the initial 72-hour period. If the petition is not filed with the court within the required timeframe and the individual is either unable or unwilling to sign in voluntarily, the individual must be released from the facility. There may be several continuances filed with the court before a determination is made in the case.

3. Notifications

When a court hearing is scheduled, notifications are made to all persons who have been identified as having a vested interest in the outcome of the hearing such as substitute decision-makers and attorneys. These notifications include all the following information:

- Notice of the filing of petition.
- The address of the circuit court where the petition was filed.
- Notice that the public defender's office was contacted.
- Notice that the individual, their guardian, representative, or the facility administrator can request a change of venue if it is in the best interest of the individual.
- Notification that an independent expert examination can be requested.
- Date, time, and location of hearing.
- Name of each person expected to testify including each examining expert More information about notifications is found in Appendix K.

4. Legal Representation

A public defender must be appointed within one (1) court working day from when a petition for involuntary inpatient placement or involuntary outpatient services was filed unless the individual secures their own private attorney. The public defender must be notified immediately of their appointment. The appointed public defender or private attorney must have access to the individual and their clinical record, and they are entitled to at least one (1) continuance by filing a notice to the court requesting a hearing for the continuance of involuntary placement (CF-MH 3113). The facility is represented by a state attorney.

5. Court Hearings

A court hearing must be held within five (5) court working days of the filing of the petition in the county where the individual is currently being held unless a continuance is requested and approved by the court. The court hearing for involuntary inpatient placement is like any other court hearing where testimony is provided under oath in a recorded session. It may be presided over by a judge or a magistrate. The individual may request an independent expert examination. At least one of the two professionals that offered supporting documentation for the filing of the petition by providing either the first or second opinion must be available at the initial court hearing to provide testimony as to why the individual should continue to receive services involuntarily. If a Transfer Evaluation (CF-MH 3089) has been completed, the person who completed the transfer evaluation or a knowledgeable colleague from the same organization, must be present at the hearing and available to testify.

The individual must be able to attend the hearing in a safe, secure environment. This often means that the hearing will be held at the facility where the individual is receiving services. While the individual is typically at the hearing, their attendance may be waived. The court may waive the presence of the individual at all or a portion of the hearing if it is in the individual's best interest and the individual's attorney does not object. An individual who attends the hearing has the option to decline to testify.

The court will consider the individual's competence in determining their own need for treatment, as well as their ability to provide express and informed consent. If the court determines that the individual is incompetent to consent to treatment, a guardian advocate must be appointed (CF-MH 3107). For more information on guardian advocates and the court system, please see the online course *Guardian Advocate and the Baker Act*.

6. Court Determination

At the conclusion of the court hearing, whether this is the initial hearing or a court continuance, the court must do one of the following actions:

- Grant a continuance; or
- Order the individual to initial or continued involuntary inpatient placement or involuntary outpatient services; or
- Release the individual from the facility.

For the court to determine that the individual should continue to receive services involuntarily, the court must be presented with clear and convincing evidence that the individual continues to meet criteria for involuntary placement and that less restrictive alternatives that would sufficiently provide a reasonable degree of safety are not available.

Individuals who are found to meet the criteria for involuntary inpatient placement (CF-MH 3008) may be held in a designated receiving facility for up to 90 days or a state mental health treatment facility for up to six (6) months. The court may order that the individual remain at the current receiving facility where they will continue to receive services for the duration of their involuntary placement without transferring to a treatment facility. Once the individual no longer meets criteria for involuntary inpatient placement, even if the court order has not expired, the individual must be transferred to voluntary status or released from the facility. If the individual does not meet criteria for involuntary inpatient placement but meets criteria for involuntary outpatient or substance use services, the more appropriate alternative may be ordered by the court.

The court may order an individual to be transferred to a state mental health treatment facility, often referred to as a state hospital. The individual will remain at the current receiving facility for continued services until the treatment facility has the capacity to accept. The receiving facility must forward all relevant documentation to the treatment facility where the individual has been ordered. Relevant documentation includes, but is not limited to, all of the following:

- The psychiatric evaluation.
- Assessments performed by a clinical psychologist or clinical social worker.
- Advance directives.
- State Mental Health Facilities Admission form (CF-MH 7000).
- Physician to Physician Transfer form (CF-MH 7002).

If the individual no longer meets criteria for involuntary placement prior to being transferred to the treatment facility, the individual may be released from the receiving facility with appropriate plans for continued community-based services. The request for transfer is cancelled and the individual, guardian, guardian advocate, representative, initiating professional, and circuit court must be notified of this change (CF-MH 3033).

7. Continued Involuntary Inpatient Placement

s. 394.467(7), F.S.	• Procedure for Continued Involuntary Inpatient Placement
ch. 65E-5.290(4), F.A.C.	• Involuntary Inpatient Placement
ch. 65E-5.300(5), F.A.C.	• Continued Involuntary Placement at Treatment Facilities

If an individual is currently ordered to involuntary inpatient placement and continues to meet the criteria, the administrator of the designated receiving facility or state mental health treatment facility is required to file for a continuance (CF-MH 3035) to extend the individual's involuntary services at the facility prior to the expiration of the court order.

This petition to file for a continuance must be accompanied by a statement from a physician or clinical psychologist that is treating the individual offering justification for the request. The statement should include all the following elements:

- A brief description of the individual's progress, or lack of progress, in involuntary treatment since ordered.
- How continued treatment is expected to benefit the individual.
- What future treatment will consist of.
- Reasonable outcomes if the individual is released from the facility.

This continuance must also be filed for minors about to turn 18 or an individual with active criminal charges whose charges are about to expire.

A hearing for involuntary inpatient placement that is held while the individual is at the receiving facility occurs in the judicial system. A hearing for continued involuntary inpatient placement for an individual who is receiving services in a treatment facility occurs in the administrative system.

Many of the other procedures (e.g., court filings, time frames) for initial and continued involuntary placement are identical. In addition, no single court order can exceed a six (6) month period. If the individual continues to meet criteria for involuntary inpatient placement, another continuance must be filed with the court in the same manner the initial continuance was filed.

An Order for Continued Involuntary Inpatient Placement (CF-MH 3031) must be signed by the administrative law judge to continue involuntary inpatient placement. If the administrative law judge finds that an individual who had previously been adjudicated incompetent to consent to treatment is now competent to consent to treatment, the administrative law judge must recommend to the original ordering court that competence is restored and that the guardian advocate is dismissed (CF-MH 3116).

A. Involuntary Outpatient Services

s. 394.4655, F.S.	• Involuntary Outpatient Services
ch. 65E-5.285, F.A.C.	• Involuntary Outpatient Placement

It is important for individuals with mental health conditions to receive treatment. Mental health treatment results in benefits to the individual and society. Treatment is especially important for individuals who have recently been released from an inpatient facility. The treatment team will make recommendations regarding the type of services that are needed for individuals who step down into a lower level of care following hospitalization. This might include a partial hospitalization program, an intensive outpatient program, individual therapy, case management, medication management, or a combination of services. While these referrals are normally provided on a voluntary basis, there are some instances when an individual may be ordered by the court to follow up with involuntary outpatient services.

Sometimes an individual returns quickly to a designated receiving facility for re-admission following a recent discharge. In the medical field, this is often referred to as a rapid readmission. An individual may need to be quickly readmitted because the same support that was available to them in the inpatient environment is not available or the individual is not participating in the recommended follow up outpatient services identified on the discharge plan. When the same individual has several rapid readmissions due to not participating in outpatient services, the facility may petition the court to order involuntary outpatient services for that individual.

Involuntary outpatient services provide two primary benefits. They deliver services in a less restrictive environment than inpatient treatment and they increase the likelihood that the individual will access and receive services. These services provide structure and support needed to help avoid another admission.

An adult may be ordered for involuntary outpatient services upon a finding of the court, by clear and convincing evidence, that all the following apply:

- The symptoms are based on a mental health condition.
- The individual does not meet criteria for inpatient or residential services.
- It has been clinically determined that the individual has a low likelihood of surviving safely within the community without additional supervision.
- The individual has a history of poor compliance or noncompliance with past mental health treatment and is unlikely to voluntarily engage in treatment.
- All less restrictive alternatives have been considered and deemed inappropriate or unavailable.
- It is believed that the individual will benefit from proposed services.
- In the past 36 months the individual was either:
  - Admitted to a receiving facility, treatment facility, or received services in a forensic or correctional facility at least twice or
  - Exhibited at least one instance of engaging in serious violent behaviors towards self or others.

More information is found in Appendix L.

If the individual does not actively meet the criteria for involuntary examination or involuntary placement but continues to experience chronic and acute symptoms that are not improving or quickly reoccur, the individual may be ordered to involuntary outpatient services.

1. Petition Requirements

A petition for involuntary outpatient services is completed by the administrator of the designated receiving facility or state mental health treatment facility. Like a petition for involuntary inpatient placement, a petition for involuntary outpatient services must be based on two professional opinions, typically two psychiatrists, who have personally evaluated the individual within the past 72 hours. The second opinion must be a face-to-face examination that may be conducted in person or by electronic means. There must be a documented history of the individual not engaging in recommended services. It must also be believed that, without services or supervision, the individual will not be able to safely survive in the community. This is often preceded by the individual having recent hospitalizations, not participating in voluntary services, and a frequent reoccurrence of symptoms to a critical level warranting hospitalization when not receiving services.

Before a petition can be filed with the court, there must be an existing provider with appropriate services that has the ability and willingness to accommodate the individual. An initial treatment plan must be developed with the individual

and the proposed treatment provider. The petition must then be completed by the administrator of a receiving facility or treatment facility and be accompanied by a copy of the proposed treatment plan. For a receiving facility, the petition must be filed in the county where the facility is located; for a treatment facility, the petition must be filed in the county where the individual will reside upon discharge.

If the petition for involuntary outpatient services is filed by a treatment facility, the petition must be accompanied by the State Mental Health Facility Discharge Form (CF-MH 7001). If the individual is still being held in a receiving facility at the time of the hearing, the court may order the individual's release from the receiving facility either with or without involuntary outpatient services ordered.

2. Court Hearings

Court proceedings for involuntary outpatient services are very similar to the court proceedings for initial and continued involuntary inpatient placement; only the differences will be highlighted here.

Pending a hearing for involuntary outpatient services an individual may be held at a designated receiving facility or be released from the facility while awaiting the hearing. A hearing must be held within five (5) days filing a petition for involuntary outpatient services.

Like other involuntary services under the Baker Act, the determination for involuntary outpatient services must be based on mental health symptoms and behaviors. Information in the clinical record may be provided to determine the need for involuntary outpatient services to the individual's attorney, the state attorney, the court, and the proposed treatment provider.

3. Treatment Plans

The court must be made aware of any material modifications that are made to a court-approved treatment plan for involuntary outpatient services. Material modifications are revisions that significantly change the content of the treatment plan. Court approval must be acquired before any significant modifications are made to a court approved treatment plan if the individual and the service provider disagree on the proposed modifications (CF-MH 3160). If both the provider and the individual agree on the changes, the court must only be notified of these changes with an updated treatment plan for their records. This also pertains to circumstances in which an individual no longer meets criteria for involuntary outpatient services or the individual requests a new service provider.

Hospitalization does not void the court order for involuntary outpatient services. Following hospitalization, it is the responsibility of the service provider to determine if modifications must be made to the individual's treatment plan to increase engagement and effectiveness of services.

4. Promoting Compliance

The provider must attempt to promote compliance when an individual is ordered to involuntary outpatient services and does not follow through with court-ordered services. An individual may need additional structure and support to promote compliance when all the following apply:

- In the clinical judgement of a physician, the individual has not followed through to meet the terms of involuntary outpatient services.
- The provider has documented efforts attempting to engage the individual in services.
- The individual meets the criteria for an involuntary examination.

Initiating an Involuntary Examination

An involuntary examination should be initiated when involuntary outpatient services are no longer sufficient to keep the individual safe. This can be initiated with a Certificate of a Qualified Professional (CF-MH 3052b). The court may also be involved. The individual may be ordered to an involuntary examination at a hearing for involuntary outpatient services. This may occur if the court determines inpatient services are more appropriate.

In the event an individual is admitted to a designated receiving facility, all the regular procedures for an involuntary examination must occur. If it is determined that the individual does not meet the criteria for involuntary inpatient placement, the individual must be discharged from the facility or may sign in voluntarily if able and willing to provide express and informed consent for services.

5. Continued Involuntary Outpatient Services

s. 394.4655(8), F.S.	• Procedure for Continued Involuntary Outpatient Services
ch. 65E-5.285(4), F.A.C.	• Continued Involuntary Outpatient Placement

Prior to the expiration of the court order, the provider's administrator is required to file a petition for a continuance with the clerk of the circuit court (CF-MH 3180) if the individual continues to meet the criteria for involuntary outpatient services. This petition must be filed with the same information and in the same manner as the initial petition for involuntary outpatient services.

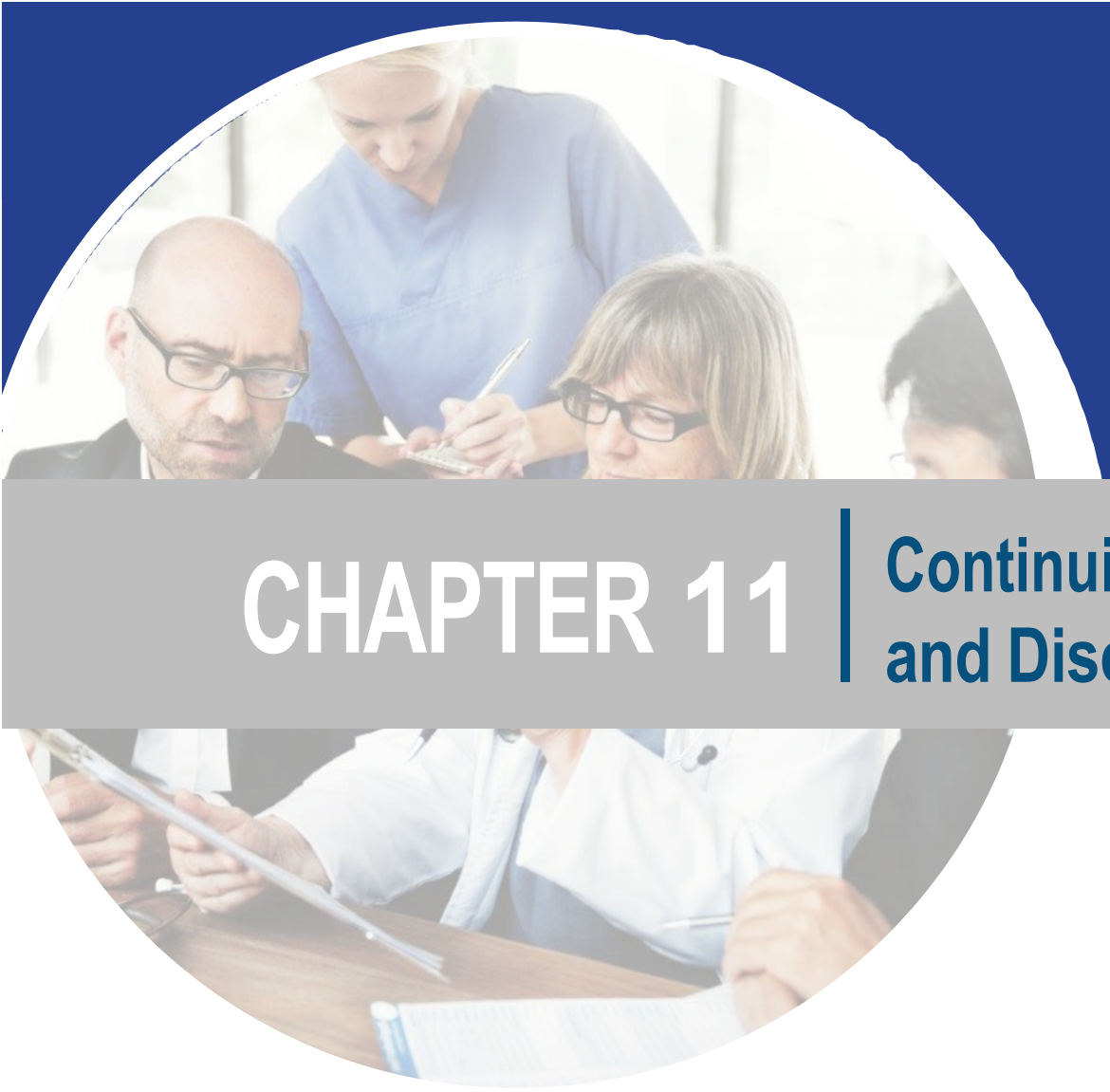
Unlike hearings for continued involuntary inpatient placement, hearings for continued involuntary outpatient services will remain in the judicial system. Hearings for continued involuntary outpatient services are very similar to other involuntary Baker Act hearings. For example, the individual will be represented by a public defender unless otherwise represented by a private attorney and will be appointed a guardian advocate if the court determines the individual is incompetent to provide express and informed consent for treatment. The court hearing may be waived (CF-MH 3185) if the individual and their attorney agree to participate in involuntary outpatient services. The court may make one of the following determinations:

1. Extend involuntary outpatient services (CF-MH 3155).
2. Release the individual from involuntary services.
3. Find the individual eligible for voluntary status.

6. Discharge

A petition for discontinuation of involuntary outpatient services (CF-MH 3170) may be filed by the individual receiving services or by another person on the individual's behalf. An individual may also be discharged from involuntary outpatient services by the provider's administrator once the individual no longer meets criteria for involuntary outpatient services. Notification must be provided to the court (CF-MH 3038) with additional notifications distributed by the provider's administrator to involved parties. This includes the person or court initiating the involuntary outpatient services, the individual served, their substitute decision-maker if any, and the individual's attorney. For those who can provide express and informed consent, this may include transferring the individual to voluntary status and continuing services on a voluntary basis.

More information on notifications is found in Appendix K.



CHAPTER 11 | Continuity of Care and Discharge

I. Continuity of Care

42 C.F.R. 482.43	• Condition of Participation: Discharge Planning
ch. 65E-5.130, F.A.C.	• Continuity of Care Management System
ch. 65E-5.1303(2)(e), F.A.C.	• Discharge from Receiving and Treatment Facilities
ch. 59A-3.254(2), F.A.C.	• Coordination of Care

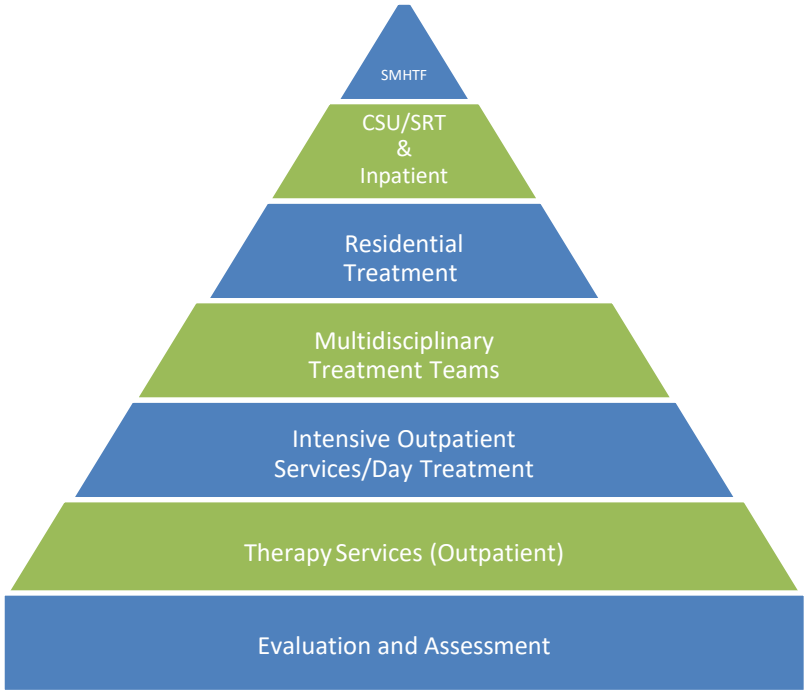
Continuity of care is a prerequisite for the provision of high-quality care to meet the need of individuals transitioning from acute care to community-based care. Poorly managed care transitions from acute care like inpatient treatment to less intensive levels of care like outpatient therapy, particularly for individuals who have complex needs or are at high-risk for a recurrence of symptoms, can negatively affect an individual's health and well-being. This may lead to continued use of acute crisis services, avoidable re-hospitalization, or re-arrest. Being discharged from an inpatient setting after and involuntary examination indicated that a crisis event has been stabilized, the individual is out of danger, but it does not mean the condition is cured and symptoms will never reoccur. Mental health conditions can be long lasting like many other chronic health conditions and need ongoing treatment to manage symptoms.

Continuity of care may be viewed from the perspective of either the individual receiving services or the service provider. For service providers, continuity of care is the sharing, coordination, and integration of health care information among different providers to support the individual's care across multiple points in time and multiple care settings. Continuity in the 'experience of care' relates to an individual's satisfaction with the interpersonal aspects of care, ease of use of integrated services, having choice and flexibility, and the effectiveness of coordination of their care.[1,2]

Continuity in the delivery of care incorporates important aspects of services such as 'care coordination' and 'case management.' Care coordination connects systems including behavioral health, primary care, peer and natural supports, housing, education, vocation, and the justice systems. It is time-limited, with a heavy concentration on educating and empowering the individual served and provides a single point contact until an individual is adequately connected to care that meets their needs.[3] Although many of the functions of care coordination mirror that of case management, they are distinct interventions. Care coordination serves to assist individuals who are not yet effectively connected with the services and supports they need to transition successfully from higher levels of care to effective community-based care. Case management is a service component within the overarching behavioral health system of care that is used most often provided to manage the care of persons with ongoing mental health conditions.

A. Levels of Care, Service Providers, and Support Services

Behavioral health services can be categorized into 'levels of care', based on their purpose and intensity level. These services range from highly specialized inpatient services to less intensive levels of care, such as outpatient therapy. Individuals can move through various levels of care based on their assessed needs and acuity



Florida has a person-centered, coordinated, and recovery-oriented network of community-based services and supports. This network builds on th strengths and resiliency of individuals, families, and communities to improve the health, wellnes and quality of life for those with mental health conditions. Providers offer services spanning a variety of interventions from acute care to multidisciplinary treatment teams through providers such as hospitals, community mental health centers, specialty treatment centers, licensed private practitioners, primary care offices, and schools.

Within this system is an array of services listed below.

- Prevention and wellness services
- Engagement services
- Outpatient treatment
- Residential treatment (short and long-term)
- Medication-Assisted Treatment
- Community supports and recovery services
- Intensive support services
- Other living supports
- Acute intensive treatment services

- Adult Mental Health

- Children's Mental Health

Today, primary and mental health care providers often work together to assess and treat individuals in their care. This approach reflects a decade of effort in these service delivery systems to deliver 'integrated care' that blends the lines between traditional services. Integrated care encompasses a broad spectrum of health service interventions intended to blend primary care services with mental health services. This integration, as well as the blending of primary and preventive medicine into traditional mental health settings, represents a more holistic approach. In addition, the integrated care approach helps to normalize and de-stigmatize treatment for both mental health and substance use conditions.[4]

Transitions between levels of care or service components can be disruptive. This includes transitions between home, hospital, residential care settings, and consultations with different providers in outpatient facilities. Transitions from designated receiving facilities or state mental health treatment facilities can be confusing and complex. Individuals may be discharged with a new diagnosis, a new treatment, or a new medication regimen to help them better manage their condition. In addition, older adults with complex health issues are most likely to undergo multiple transitions of care.

Transitions are best facilitated through a referral process known as a 'warm hand-off' in which the current care provider introduces an individual receiving services to their new health care practitioner. The warm hand-off process helps to facilitate trust between the individual and the new practitioner. Examples of warm hand-offs include assisting the individual in making the initial call to the referral facility, staying with the individual when the initial appointment is made and walking the individual over to the new provider. Ideally, during a warm hand-off, the new service provider establishes rapport with the individual, delivers brief supportive counseling or a brief intervention, and educates the individual about what to expect and answers any questions they have.[5]

It is also important for the individual to experience a warm hand-off during the referral process when leaving a designated receiving facility or state mental health treatment facility. The warm hand-off may occur during discharge or during admission, particularly if the individual is assessed voluntarily and does not meet the criteria for inpatient services.

It is important to use a combination of professional, community, and personal resources to assist the individual in attaining and maintaining stability.

B. Case Management

ch. 65E-5.130, F.A.C. • Continuity of Care Management System

Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the individual's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.[6] Case managers serve important functions in several areas including the following:

- Establishing rapport and an effective working alliance with the individual.
- Creating a welcoming atmosphere for interviewing and service delivery.
- Motivating and engaging the individual in identified service needs.

Case management services emphasize the use of community resources to help individuals meet their needs. Intervention is viewed in terms of facilitation and connecting individuals to agencies, social service organizations, governmental entities, educational institutions, community organizations, and key people that can support them. These services and linkages are intended to reduce frequency and severity of symptoms. Services are geared to assist individuals with improving stability through securing basic human needs such as food, housing, utilities, and health care.

If an individual has a mental health case manager funded by the Department, such as through the Florida Assertive Community Treatment (FACT) Team, that case manager must visit the individual no later than two (2) days following admission to a receiving facility. Case managers are also expected to assist facility staff in discharge planning.

C. Peer-Based Recovery Support Services

Peer-based recovery support is the process in which persons with similar lived experience of a behavioral health condition give and receive nonprofessional, non-clinical assistance to achieve long-term recovery. Peer-based recovery support services complement clinical supports by providing strategies for self-empowerment.[7] Peer support provides another level of acceptance, understanding, and validation beyond the traditional therapeutic relationship. In sharing their lived experience and practical guidance, peer support workers help individuals develop their own goals and take concrete steps towards building fulfilling, self-determined lives for themselves. Often, those who provide peer-based recovery support have gained certification as a Recovery Peer Specialist. These persons bring their lived experience of recovery, along with training and supervision, to assist others in initiating and maintaining recovery.

Peer-based recovery support services are available in both formal and informal settings. These services may be offered before an individual enters treatment or while they are waiting for a service opening. During a formal treatment program, peer recovery support services give the individual a connection to community. After treatment,

such services help individuals manage their recovery by developing recovery skills and accessing ongoing recovery support resources. The individual is further supported with opportunities to enrich his or her endeavors in recovery support settings.

Peer-based support services also may serve as a pathway to recovery by individuals who choose not to enter the formal treatment system.

D. Interpersonal Support

In addition to utilizing community, professional, and peer resources, individuals often can gain encouragement and assistance from their existing support system including family, friends, neighbors, coworkers, and a church community. A strong, healthy interpersonal support system can be an integral part of an individual's well-being providing benefits that may reduce emotional challenges like depression and anxiety as well as behavioral difficulties like substance use and conduct disorders.[8]

II. Discharge Planning

ch. 65E-5.100(4), F.A.C.	• Definitions - Discharge Plan
ch. 65E-5.1303, F.A.C.	• Discharge from Receiving and Treatment Facilities

Discharge planning is an extension of an individual's treatment plan that occurs when the individual discontinues services with a provider or transitions from one provider to another. Discharge planning is an important element of an individual's treatment and is identified in state and federal laws as well as best practice guidelines. Discharge planning helps ensure that individuals continue to receive appropriate services at the next level of care to promote recovery and prevent a worsening or recurrence of symptoms. This involves identification of the individual's current resources and anticipation of their needs following discharge. Discharge planning should include the identification of current and prospective providers and community services that continue to deliver needed assistance and support following discharge from the current provider.

Discharge planning is an important part of today's 'recovery model.' The current perspective on recovery centers on making long-term recovery the expected outcome for individuals with mental health conditions. Such an approach emphasizes resilience and control over one's challenging issues and life. Treatment, ancillary services, and supports are geared to improve the way in which mental health conditions are managed, focusing on the long-term well-being of the individual and the provision of strong recovery supports.

Florida grants individuals receiving mental health services the right to participate in discharge planning. Discharge planning begins when an individual starts receiving services and continues throughout the course of treatment. Discharge planning requirements exist for general health care services as well as specific mental health standards. Individuals who receive services are strongly encouraged to actively participate in all aspects of care planning to identify needs and preferences and make informed decisions about services and supports. This supports recovery and ensures that the services will meet the needs of the individual.

Individuals should be asked where they want to receive services upon discharge. Individuals who were receiving services from another service provider prior to admission can be referred to that provider for continuity if the individual agrees. The facility needs to identify another provider that can accommodate the individual's needs if the individual does not request a specific provider or requests only providers that are currently unable or unwilling to provide services.

> Recovery management involves a time-sustained and focused collaboration between individuals and traditional and non-traditional service providers. Individuals and providers work together toward the goal of stabilizing, and then actively managing the ebb and flow of behavioral health conditions, until remission and recovery has been achieved, or until they can be effectively managed by the individual and his or her family. [9]

Discharge planning, when conducted properly, can improve outcomes and reduce the likelihood that there will be a recurrence of symptoms that can lead to readmission.[10] Specific factors must be evaluated and documented when planning discharge from a designated receiving facility and state mental health treatment facility. Providers should offer referrals that anticipate the individual's needs at discharge even if an individual refuses to participate in discharge planning. Best practice states to the extent possible the individual should have a follow up appointment within seven

days of discharge when ongoing mental health services are recommended after discharge.

Potential barriers to a successful discharge may occur in several areas:

- **Transportation**:
  - Does the individual have Medicaid? Medicaid will cover transportation to medical and behavioral health appointments as well as transporting the individual home when they are discharged from a facility.
  - How will the individual get home following discharge?
  - How will the individual access future appointments?

If housing is needed, the individual should be provided with information on community housing resources. Each Managing Entity has a housing coordinator that can provide information about housing resources in their community.

- **Living conditions:**
  - Does the individual have a place to live?
  - Is the physical and emotional home environment safe?
  - Are the living conditions stable?
- **Aftercare follow-up appointments:**
  - Does the individual have a scheduled follow-up appointment within seven (7) days of discharge?
  - Has the individual been provided with a prescription for psychotropic medication to last until their scheduled aftercare appointment? Providers should be aware of individual's ability to access to services and medication.
  - Individuals should be given information verbally and in writing about appointments the facility has made at the time of discharge, including referrals or other appointments (primary care, medical and dental) and educational and community resources.
  - Does the individual need more than routine follow-up. For example, has the individual had several admissions over a short period of time, lack natural supports or have more serious symptoms? Should the provider consider a referral to care coordination, CAT program or FACT team? Is the Agency for Persons with Disabilities (APD) program involved?
- **Education and Community Resources:**
  - Has the individual been provided with verbal and written information, in a language and terms they can understand, regarding the symptoms of their diagnosis and effects of prescribed medications?
  - Has the individual been provided with Mobile Response Team (MRT) resources?
  - Has the individual been provided with information on community resources, including peer support groups, which would assist them in their recovery process?

The clinical record must contain documentation about potential barriers to discharge and how these will be addressed. For example, individuals who cannot access safe and appropriate housing face a significant barrier to recovery.[11] An individual who does not have a place to live or does not feel safe returning to their current living situation should be assisted in accessing local housing resources and connected with care coordination services when appropriate.

Many receiving facilities employ care coordinators to improve discharge planning and engage individuals who are not connected to services or do use the community-based services available to them. While independent housing may not always be obtainable, it is a viable option for many. Housing should be safe, affordable, and meet the individual's physical and emotional needs while providing the appropriate level of autonomy.[12]

Housing options may include natural resources, such as receiving assistance from the individual's family members and friends. It may also be appropriate to apply for services from a local provider offering supervised or supportive housing. This includes options such as a licensed Assisted Living Facility, an Adult Family Care Home, or the FACT team. Other resources include connecting individuals to PATH (Projects for Assistance in Transition from Homelessness) projects (if coverage area allows), utilizing or connecting to SOAR (SSI/SSDI, Outreach, Access, and Recovery) programs to assist individual's with applying for benefits, and utilizing Peer Specialists to promote engagement, warm hand-offs and assist with regular contact in the community. Each of these options provides different types of assistance and autonomy depending on the individual's needs. Individuals should be encouraged to identify the types of assistance they prefer to preserve individual dignity while providing safe and secure options that can help reduce a recurrence of symptoms.[13]

III. Discharge Requirements

Once an individual is admitted to a designated receiving facility, Florida laws outline formal discharge procedures that must be followed before releasing or transferring the individual from the facility.

An individual who is admitted for services cannot decide to discontinue services without being formally released from the facility, even if the individual was admitted under voluntary status. A physician or administrator must approve release from the facility.

s. 394.463(2)(f), F.S.	• Involuntary Examination
s. 394.468, F.S.	• Admission and Discharge Procedures

An individual receiving services under involuntary status cannot be transferred to voluntary status or released by a designated receiving facility (CF-MH 3111) without authorized and documented approval. Unless administrative or by order of the court, discharge must occur with the approval of a psychiatrist, clinical psychologist, or psychiatric nurse.

A facility must discharge an individual who meets any of the following conditions:

- The individual has sufficiently improved. Based on the premise of an individual receiving services in the least restrictive environment, the improvement justifies that retention in the facility is no longer clinically appropriate. An individual may be discharged to the care of a residential or community facility or an outpatient service.
- The individual has been admitted to a facility under voluntary status and refuses or revokes consent to treatment. Within 24 hours after such refusal or revocation, the individual must be discharged unless transferred to involuntary status or the refusal or revocation is freely and voluntarily rescinded.
- The individual requests discharge and does not meet criteria for involuntary services. The individual, a loved one, or an attorney of the individual receiving services may request discharge either orally or in writing at any time following admission to the facility. Oral requests, like written requests, must immediately be entered into the individual's clinical record.

Facilities licensed as hospitals have additional requirements that must be followed. Florida law requires hospitals to develop and implement discharge planning policies and procedures. These policies and procedures must address all of the following elements:

- Identification of individuals who could use assistance with discharge planning and resources.
- Timely and appropriate initiation of discharge planning procedures for those who have been identified as being able to benefit from discharge planning activities.
- Identify the roles and responsibilities of each treatment team member including physicians, therapists, the individual receiving services and their collateral support system.
- Assessment of discharge needs and documentation of treatment planning process.

42 C.F.R. 482.43	• Condition of Participation: Discharge Planning
s. 395.3025(4), F.S.	• Patient and Personnel Records

Federal regulation also requires discharge planning as a condition of participation for hospitals receiving Medicare funds. Federal mandates largely mirror state legislation. However, some additional federal requirements are that:

- Individuals who are likely to need long-term care services in the near future, including home health care, are provided with a list of those services that accept Medicare (when applicable).
- The individual and family are notified that they have the right to choose their provider. Individuals are typically provided with at least three options for services when available.

All facilities providing mental health services, including those licensed as a hospital, have federal and state legal requirements for discharge planning. To fulfill these requirements facilities often speak with the individual shortly after the initiation of services. This includes identifying discharge needs and collaborating with the individual about referrals. It is important to begin this process early, even if it appears that the individual will not be discharged for several days.

Discharge needs must continuously be reassessed throughout the treatment process, so the most appropriate and comprehensive referrals are made at discharge. Providers may request consent to release information to the referral source so that information can be shared upon discharge. While best practice recommends obtaining a release of information, some information can be disclosed to another provider for continuity of care purposes without consent. These exceptions will be further discussed in chapter 14.

Individuals may benefit from additional care coordination strategies to assist with specific discharge activities and referrals. Care coordination can increase the communication between providers and engage the individual in the discharge planning process. If an individual declines to engage in the discharge planning process, the use of care coordination strategies can still be employed. For example, peer services can be used to help the individual develop skills and confidence to assert their service preferences and ensure that their needs are being met during the transition in care.

Individuals who choose to not be involved with their discharge planning can be provided with a referral to all the services and supports that are recommended by the treatment team to maximize the possibility that they will seek services after discharge. Individuals may change their mind later and need information about what services are available and how to access them.

IV. Right to Discharge

s. 394.4625, F.S. • Transferring Between Voluntary and Involuntary Status

Individuals are expected to be examined and treated in the least restrictive environment including when they meet both of the following criteria:

- The individual is transferred to voluntary status because they no longer meet criteria for involuntary examination and are able and willing to provide express and informed consent.
- The individual is discharged because inpatient services are no longer appropriate, and the individual's needs can be sufficiently met at a lower level of care.

Discharge typically occurs following the stabilization of the acute symptoms that were present upon admission. Individuals in a designated receiving facility or state mental health treatment facility have a right to request discharge, regardless of whether they are under voluntary or involuntary legal status. This request can be made verbally or in writing at any time by the individual receiving services or by someone else on the individual's behalf such as a relative, friend, substitute decision-maker, or personal attorney.

When an individual who is under voluntary status refuses to consent or revokes consent for treatment, it is treated like a request for discharge.

There may be instances in which an individual requests discharge from a staff member who is not qualified to authorize a discharge. This information must be shared with one of the professionals who is qualified to approve the discharge. The notification must be made as soon as possible and no longer than 12 hours after the request is made.

The case is reviewed by the facility, typically the attending psychiatrist, to determine if the individual should be

released. Within 24 hours of the individual's request to be discharged, a determination must be made by taking one of the following actions:

- The individual may rescind the request and continue voluntary services.
- The facility may determine that the individual must continue services under involuntary status.
- The facility may release the individual from the facility with recommended follow up appointments.

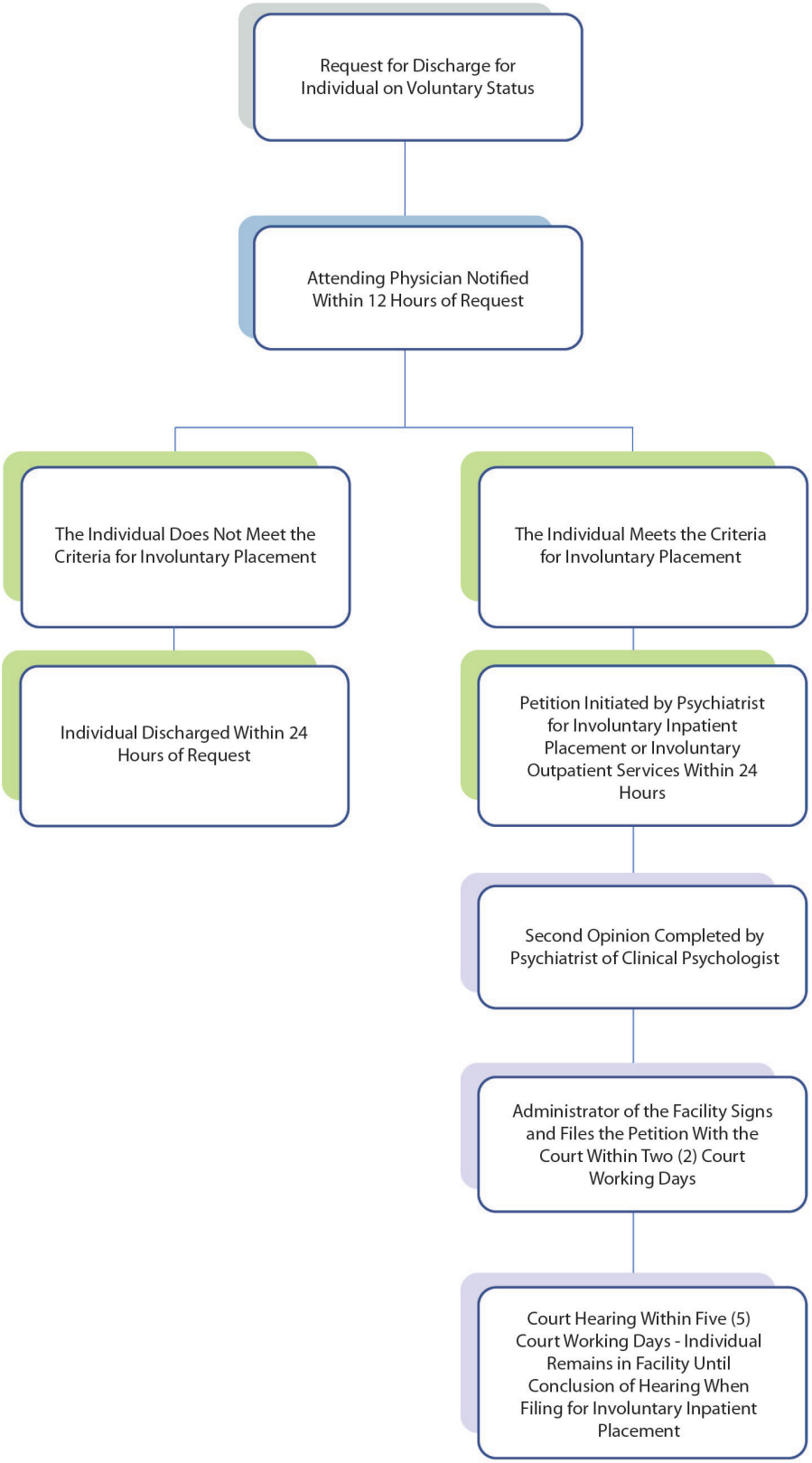
The timeframes for discharge are different for a state mental health treatment facility than they are for a receiving facility when an individual is discharged due to a request made through a right to release or writ of habeas corpus. In these instances, the treatment facility has up to three (3) working days to release an individual to complete an adequate discharge plan.

A. Discharge of Individuals on Voluntary Status

s. 394.4625(2), F.S.	• Discharge of Voluntary Patients
ch. 65E-5.1303, F.A.C.	• Discharge from Receiving and Treatment Facilities

An individual on voluntary status may request discharge orally or in writing at any time following admission to the facility. Form CF- MH 3051a: Notice of Right of Person on Voluntary Status to Request Discharge from a Receiving Facility can be used for this request. If the individual is currently receiving services under voluntary status and it is determined that the individual meets criteria for involuntary placement, the individual must be transferred to involuntary status within 24 hours of the request for discharge. The administrator of the facility must file a petition for involuntary inpatient placement (CF-MH 3032) or involuntary outpatient services (CF-MH 3130) with the court within two (2) court working days after the request for discharge or treatment refusal occurs. The individual must be discharged if the petition is not filed within the specified time frame, or the individual does not meet criteria for involuntary inpatient placement or involuntary outpatient services. The following flowchart provides a visual representation of this process.

Individual's Request for Discharge While on Voluntary Status



B. Discharge of Individuals on Involuntary Status

s. 394.469, F.S.	• Discharge of Involuntary Patients
ch. 65E-5.320, F.A.C.	• Discharging of Persons on Involuntary Status

An individual on involuntary status may be discharged at any time he or she no longer meets the criteria for involuntary placement. The administrator of the facility must complete one of the following actions:

1. Discharge the individual, unless he or she is under criminal charges, in which case the individual must be transferred to the custody of the appropriate law enforcement officer;
2. Transfer the individual to voluntary status on his or her own authority or at the individual's request, unless the individual is under criminal charge or adjudicated incapacitated; or
3. Place an improved individual, except an individual on a criminal charge, on convalescent status in the care of a community facility.

If an individual is discharged by the court, the facility must discharge the individual, even if facility staff, such as a psychiatrist or administrator, believes that the individual still meets criteria for involuntary services. The individual must leave facility grounds for the discharge to be considered complete.

V. Notice of Discharge or Release from a Facility

s. 394.4599, F.S.	• Notice
s. 394.463(3), F.S.	• Notice of Release
s. 394.469(2), F.S.	• Discharge of Involuntary Patients - Notice

A notice of release or discharge (CF-MH 3038) must be provided to individuals released from a designated receiving facility or state mental health treatment facility for discharge or transfer. Copies of this notification are provided to all the following parties.

- The individual
- The individual's guardian, guardian advocate, or representative
- The professional or court that initiated an involuntary examination
- The individual's attorney

Per CMS guidelines, a Medicare recipient can appeal the decision for discharge if they do not feel ready for discharge.

Any discharge instructions provided to the individual or their representative must also be sent to the provider that is responsible for delivering continuing care services following discharge.

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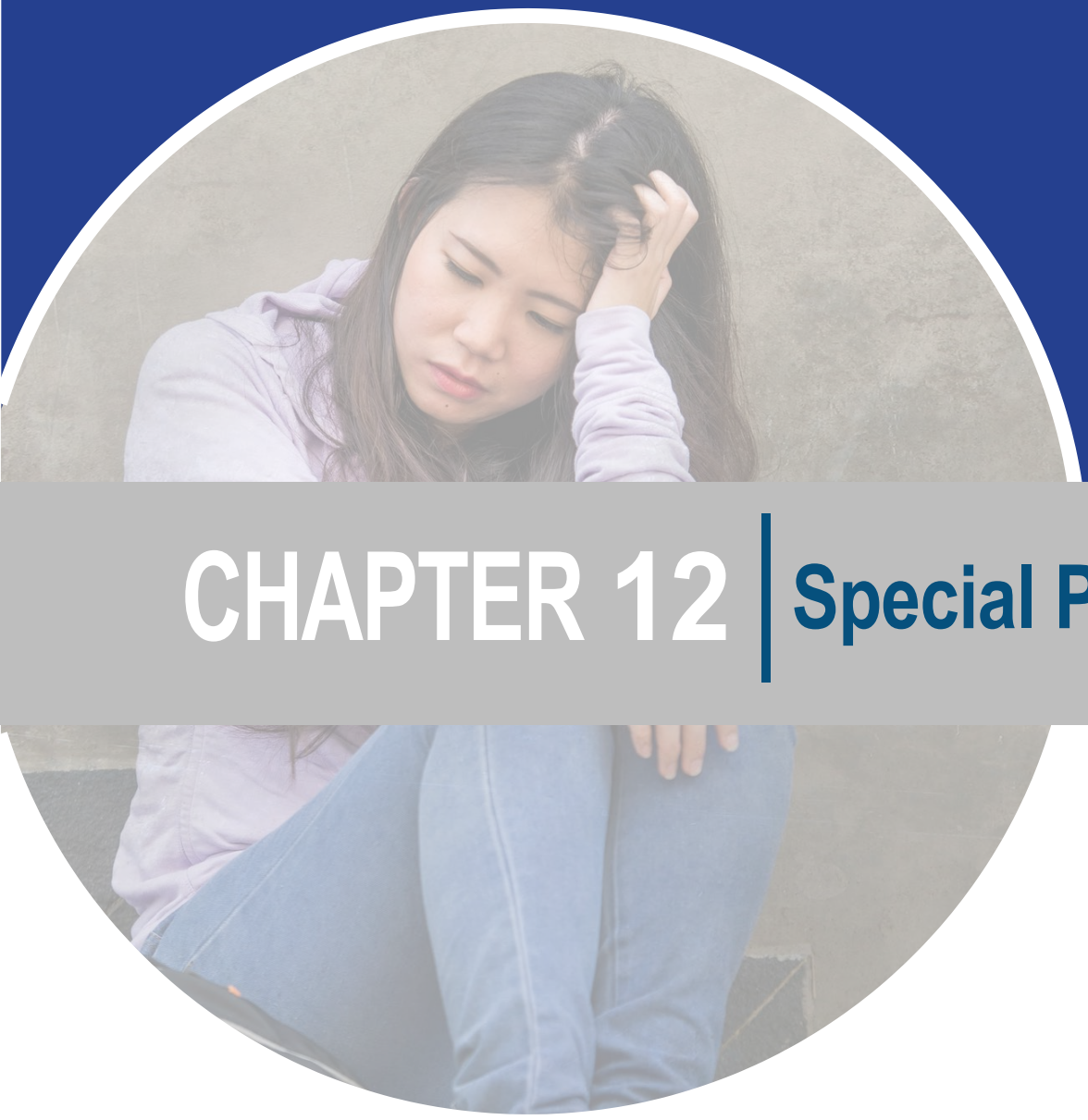

CHAPTER 12 | Special Populations

I. Overview

II. Minors

III. Vulnerable Adults

IV. Substitute Decision-Makers and Advance Directives

V. Veterans

I. Overview

The Baker Act contains specific criteria and procedures related to special populations: minors, individuals who reside in a long-term care facility, veterans, and individuals who are in the custody of the Department of Corrections. These individuals often have different needs based on additional complications and barriers. One of the legal requirements of providing mental health services in a designated receiving facility or state mental health treatment facility is to ensure that the services are individually tailored and age appropriate.

This chapter reviews specific Baker Act provisions for minors and vulnerable adults. Unless otherwise indicated, minors and vulnerable adults referenced in this chapter are subject to the same laws and procedures as identified in the rest of this guide.

Training courses related to the Baker Act and these special populations are located on the Florida Alcohol and Drug Abuse Association (FADAA) Learning Management System for Behavioral Health at www.FloridaLearner.org.

II. Minors

s. 394.455(29), F.S.	• Minors - Definition
ch. 743, F.S.	• Disability of Nonage of Minors Removed

A minor, per the Baker Act, is defined as an individual who is 17 years of age or younger and who has not had the disability of nonage removed. The disability of nonage means that minors cannot make certain decisions based solely on their age and minors must have a parent or guardian's permission make certain legal decisions. For more information about minors who are married, unmarried pregnant, or emancipated please refer to chapter 743, Florida Statutes.

For purposes of this guide:

- The term "minor" will be used to identify individuals under the age of 18 who have not had the disability of nonage removed.
- This chapter will use the term "parent" to refer to an individual's current legal guardian, including a birth parent, adoptive parent, or other individual who has legal custody as recognized by the court as the person who has legal authority to make decisions on behalf of the minor. This may include a family member who has power of attorney or guardianship. Authority may also be granted to an organization, such as the Department or the Department of Juvenile Justice (DJJ), who currently has custody of the minor.

If a minor has had the disability of nonage removed, they will be treated like an adult in regard to legal status (voluntariness and competence), but will go to a designated receiving facility that provides services to their age group.

Minors are considered vulnerable based on developmental status (the continuing growth and development of the brain) and lack of independence (dependence on others to meet their basic needs). The way mental health care is delivered, and the protections afforded to minors, is dependent upon both of the following factors:[1]

- If the services are being provided voluntarily or involuntarily
- Which level of care (an inpatient or outpatient setting) services are delivered in

A. Involuntary Examination for Minors

Although the criteria to initiate an involuntary examination are the same, many of the policies and procedures for delivering services in a designated receiving facility are different for minors than they are for adults. Once an involuntary examination is initiated, there are different timeframes for providing services and notifications. Minors are not automatically considered competent to provide express and informed consent for admission or treatment in a designated receiving facility. Please refer to Appendix K. Notifications for more information about notifications and minors.

B. Voluntary Admission for Minors

s. 394.4625(1), F.S.	• Authority to Receive Patients
s. 744.102, F.S.	• Guardianship Definitions
s. 39.01, F.S.	• Definitions for Proceedings Relating to Children

Three conditions must be met for a minor to qualify for voluntary admission to a designated receiving facility.

- The minor must voluntarily assent to receive services.
- The facility must conduct a clinical review to verify the minor's voluntariness and ability to provide assent.
- The minor's parent must consent to the voluntary admission.

More information regarding guardianship and proceedings relating to children are found in chapter 744 and chapter 39, Florida Statutes. Please refer to the online course entitled Minors and the Baker Act for additional information on services provided to minors in the Baker Act and other mental health facilities.

C. Treatment for Minors

s. 394.491, F.S.	• Guiding Principles for the Child and Adolescent Mental Health
s. 394.495, F.S.	• Child and Adolescent Mental Health Systems of Care

Mental health services have essentially the same purpose for minors as they do for adults – to use existing strengths and supports to positively impact the issues that affect the minor's overall well-being. Minors, like adults, must receive services in the most appropriate and least restrictive environment building on existing strengths and meeting the unique needs of the individual.

Initial screening, diagnosis, and evaluation for services for minors are similar to those for adults; however, there are some differences. For assessments, a professional must include specific elements for minors including both of the following.

- Intellectual ability and academic performance
- Behavioral and emotional management and expression

Additional individual rights need to be considered when delivering services to minors.

- Minors right to consent
- Treatment planning
- Behavioral management with minors
- Minors right to education
- Minors in crisis stabilization units
- Minors in residential treatment centers
- Minors in the custody of the Department
- Minors with cri minal charges

• Other Persons Who May Consent to Treatment of

1. Consent for Treatment

s. 394.4784, F.S.	• Minors; Access to Outpatient Crisis Intervention Services
s. 743.064, F.S.	• Emergency Medical Care of Minors Without Parental Consent
s. 743.0645, F.S.	• Other Persons Who May Consent to Treatment of a Minor

Minors have restrictions on what they can authorize without a parent, including consenting to most medical and mental health services. In most cases, the minor and their parent must provide express and informed consent. Efforts made to locate and engage the minor's parent must be documented in the clinical record. When a minor is **not** in the custody of the Department or DJJ and their parent cannot be reached, these persons may be contacted to provide consent, in the following order.

- A person with power of attorney
- Stepparent
- Grandparent
- Adult sibling
- Adult aunt or uncle

These persons can only provide consent for general medical treatment which does not include extraordinary treatment. Extraordinary treatment includes the authorization of psychotropic medication, surgery, and anesthesia.

While minors need the co-signature of a parent to sign in voluntarily to a designated receiving facility, some other types of services can be accessed by a minor without parental consent. A minor age 13 years or older who experiences an emotional crisis has the right to request, consent to, and receive mental health diagnostic and evaluative services provided by a licensed mental health professional. This includes outpatient diagnostic, evaluation services, crisis intervention, therapy, and counseling. A minor may engage in up to two visits during anyone (1) week period. Services do not include the ability to consent to medication.

Parents cannot be held liable for payment of such crisis services accessed by a minor except for those services in which the parent participates. Licensed mental health professionals are not required to provide services without parental consent. The only exception is when the professional is working in a hospital and a minor accesses service for an emergency medical condition.

Minors are expected to have specialized services that are separate from adults while receiving mental health inpatient services in a designated receiving facility or mental health treatment in a residential setting. There are certain exceptions including allowing:

- A minor under the age of 14 to share common areas with adults under the direct supervision of staff.A minor 14 years or older to share both common areas and a room with an adult if it is deemed appropriate by a physician as a safety precaution. This placement must be reviewed daily by the minor's attending physician, designee, or on-call physician for the duration the minor resides on the adult unit.
- Services must be age-appropriate which may require adaptations in programming including educational programming, a different therapeutic approach, different behavioral interventions, and suitable unit activities.

When parental rights are intact, it is best practice to involve them in the examination to best understand the situation that led to the examination, any relevant history of mental health and substance use issues and treatment, and the decision-making process to decide what services are recommended. If a court orders involuntary services, the court may also order the involvement of the minor's parent in treatment.

Minors cannot be court ordered to a state mental health treatment facility. Minors who are ordered to an involuntary inpatient placement must continue receiving treatment services in a designated receiving facility. The administrator of the receiving facility must file a petition with the administrative law judge for minors nearing the age of 18 who are in an involuntary inpatient placement for continued involuntary inpatient placement (CF-MH 3035).

The minor's parent must be notified to provide consent for treatment, if a minor experiences a serious illness, bodily injury, or serious psychiatric episode. If treatment must be provided prior to receiving consent for the safety of the minor or those around them, notification of services rendered and consent for any additional treatment must be obtained as soon as possible. More information regarding emergency medical treatment is found in chapter 11, in the federal legislation the Emergency Medical Treatment and Labor Act (EMTALA), and in the online course entitled Emergency Medical Treatment: Florida's Baker Act and Marchman Act.

1. Treatment Planning

s. 394.496, F.S.	• Service Planning

Treatment planning with minors must meet the same requirements of treatment planning for adults and should include the minor's parent or guardian. The treatment plan must address a minor's basic medical, emotional, social, and educational needs.

2. Behavioral Management with Minors

ch. 65E-9.013, F.A.C.	• Restraint, Seclusion, and Time Out

Minors often experience rapid physical, emotional, and social changes. These changes may create stress for them and their support system. Minors are still learning how to interact with others and express and manage emotions.

Life changes and stressors experienced by minors with mental health concerns may result in acts of impulsive and risky behaviors.[2] It is estimated that by age 16, two out of three minors have experienced at least one traumatic event.[3] When left unaddressed, traumatic events can eventually result in unfavorable emotional, social, and behavioral outcomes including increased instances of mental health symptoms and the engagement in unsafe behaviors.[4] Individuals who have experienced trauma can find it more difficult to manage emotions leading to undesirable outcomes including increased aggression.[5]

When aggression is exhibited, providers should make every effort to de-escalate the situation prior to the administration of seclusion or restraint. This is especially true for minors since the use of seclusion or restraint has a potential to create a more intense adverse reaction.[6]

There are several approaches that help prevent the use of seclusion or restraint. Trauma-informed care is one important approach. Trauma-informed care increases awareness of the impact of trauma and integrates techniques to address trauma and decrease re-traumatization through policies, procedures, and everyday practices. This involves staff education about the effects of trauma, how to address it, and how to employ alternative interventions to seclusion and restraint. Alternative interventions that have been found to be effective in helping decrease the use of seclusion or restraint include teaching staff de-escalation techniques and providing a debriefing after an event that required de-escalation, seclusion, or restraint. It is also important to involve minors and family members in the treatment and safety planning process.

The integration of physical outlets through exercise and recreational activities into treatment schedules is also helpful.[7]

Safety planning is an effective tool that is used to help identify internal and external resources that can be used to help calm an individual who is having difficulty managing their emotions. Safety plan tools may include a variety of coping skills, such as calming activities, as well as identified triggers of anxiety and signs of agitation. All individuals who are admitted to a designated receiving facility must have a personal safety plan (CF-MH 3124) completed upon admission and updated after each incident of seclusion or restraint.

It is important to be familiar with protocols for using seclusion and restraint with minors. Many facilities and organizations have separate policies and procedures that take into consideration specific circumstances and subsequent consequences of seclusion and restraint with minors. Staff working with youth in a mental health care setting must be trained before actively engaging in seclusion or restraint techniques for minors. There are guidelines for applying, documenting, monitoring, and reviewing the use of seclusion or restraint practices. It is important to consider that the body of a minor is still physically maturing, emotional and intellectual growth is developing, a physical restraint should always be a last resort only when all other options have been unsuccessful. More information on regulations for seclusion and restraint with minors is found in chapter nine (9).

3. Minors in the Custody of the Department

s. 39.407, F.S.	• Medical, Psychiatric and Psychological Examination & Treatment
ch. 65C-35, F.A.C.	• Psychotropic Medication for Children in Out of Home Care

It is estimated that approximately 15 percent of minors in the U.S. have a mental health condition.[8] This rate is even higher for minors who are removed from their home by the Department.[9] Mental health conditions often present themselves as crises leading to over 34,000 involuntary examinations initiated for minors in Florida during the 2021-2022 fiscal year.[10]

The Department's goal is to prevent the separation of families and, when separation is necessary through an out of home placement, to work towards the goal of reunification.[11] Parents often retain their parental rights even when the minor is removed from the home with temporary custody granted to another caregiver. Parental rights are not terminated until permanent custody is granted to the Department or another caregiver through a court order.

When temporary custody is in effect, it is important to keep the parents, as well as the current caregivers, involved as much as possible. This includes inviting parents and caregivers to medical and behavioral health appointments and seeking their opinion for treatment objectives and services. Parents and caregivers can be invited to attend treatment

team meetings to discuss the course of treatment, be given the opportunity to provide information and ask questions. This can occur over the phone or another virtual meeting option if the parents do not have transportation or are working. The team should refer parents to outpatient services or support groups to promote a healthy family environment in anticipation of the minor returning home upon discharge.

Parents have the right to decline or consent to the administration of psychotropic medication on behalf of their child unless parental rights have been terminated or a court order has overridden their wishes.

There are times when the best interest of the minor outweighs parental wishes. The Department may file a motion to request the court to order medical or behavioral examination or treatment if a parent declines or rescinds consent to necessary treatment. Parental consent or a court order is not necessary when the minor is experiencing an emergency medical condition, the examination or treatment is directly related to suspected abuse, neglect, or abandonment by the person providing consent, or parental rights have been terminated.

A court may order several evaluations by qualified professionals including evaluations to determine whether to initiate an involuntary examination. The Department or Community-Based Care organizations are responsible to provide the licensed professional with all the available medical information that is relevant to that evaluation.

There are specific procedures with regards to the administration of psychotropic medication when a minor is removed from the home. The administration of medication may begin prior to a court hearing when initiated in a hospital, crisis stabilization unit, or inpatient psychiatric program. If psychotropic medication continues to be administered for three days, a motion for a court order must be filed for continued authorization. When petitioning the court for an order for the administration of psychotropic medication, the following information must accompany the motion:

- The age of the minor.
- The specific medication and dosage to be prescribed.
- The reason for the medication including the diagnosed condition and symptoms it will target.
- The potential benefits, risks, and side effects of proposed and alternative medications including potential drug interactions, contraindications, and the results of abruptly stopping the medication (this must also be explained to the caregiver and the minor the medication is intended for).
- A physician statement regarding the review and appropriateness of the medication and how treatment will be monitored.
- How current medications will replace or supplement any current treatments.
- Any alternative and additional treatments or services that the physician recommends such as counseling or case management.

4. Minors Right to Education

s. 394.459(3)(a), F.S.	• Rights of Patients
s. 394.495, F.S.	• Child and Adolescent Mental Health Systems of Care
ch. 2018-3	• Public Safety

Collaboration with schools is essential. Schools have an important function in initiating services for those students who demonstrate a need for inpatient or outpatient mental health services. Over 20% of involuntary examinations initiated on minors have occurred in the school setting.[12] In 2018, Florida enacted chapter 2018-3, Laws of Florida, with the passing of Senate Bill 7026. Better known as the Marjory Stoneman Douglas High School Public Safety Act, these laws put additional safeguards in place to increase public safety in the community with a particular focus on schools.

The local education system is expected to collaborate with other agencies to provide education, as well as mental health treatment and support, to students who are already involved in daytime mental health programs such as inpatient, residential, or partial hospitalization programs. This is particularly true for those students who have been challenged academically due to a mental health condition. Florida currently refers to this population as a student with an emotional or behavioral disability.

Mental health conditions, particularly untreated conditions, may impact how students perform both socially and academically.[13] Poor academic performance may jeopardize future social, emotional, physical, and economic functioning.[14, 15] Chapter 2018-3, Laws of Florida, identified the use of community action treatment teams to assist with providing community-based behavioral health services to students with serious behavioral health conditions who are identified as high risk for an out-of-home placement. This includes students who have had at least two behavioral health hospitalizations, significant involvement with law enforcement, or are struggling academically or behaviorally in school.

5. Protected Health Information and Schools

Due to the prevalence of mental health conditions in students, it is important that there are policies and procedures in place to help students feel comfortable sharing information with school personnel.

Information that is held in a student's school record is governed by the Family Educational Rights and Privacy Act (FERPA) and the Protection of Pupil Rights Amendment (PPRA). FERPA supersedes HIPAA regarding the authority governing a student's health records. The PPRA, also has authority that surpasses that of HIPAA in many educational environments. These regulations govern how information in a student's file is protected and released. While these practices are very similar to HIPAA, there are some exceptions, particularly when releasing information for audits or to accrediting organizations, upon student transfers to another school, research, and certain emergency situations. A comparison of HIPAA, FERPA, and PPRA is located in Appendix M. Confidentiality in Schools.

6. Elopement of a Minor

A minor's parent must be notified if a minor elopes from a designated receiving facility. This notification must occur as soon as possible and be documented in the clinical record.

III. Vulnerable Adults

s. 415.102(28), F.S.	• Vulnerable Adult

Vulnerable adults are individuals over the age of eighteen whose ability to fulfill day-to-day activities or basic needs is significantly compromised due to a mental, emotional, cognitive, developmental, or physical disability or dysfunction. Vulnerable adults are classified many ways and often meet one of the following conditions:

- Recipients of inpatient psychiatric services
- Older adults, often defined as over the age of 60 or 65
- Residents of long-term care facilities
- Living with a developmental disability
- Living with a neurocognitive disorder such as dementia
- Under the supervision of a substitute decision-maker who is making most of their daily decisions

Vulnerable adults, like minors, have additional legal protections beyond those afforded to most adults. This includes the right for others to make a report on their behalf and have it investigated if there is reason to believe that the individual is experiencing abuse, neglect, or exploitation. Vulnerable adults may also have a temporary or permanent substitute decision-maker such as a guardian, guardian advocate, or health care proxy who is identified in an advance directive or appointed by a court. Many of the concerns and techniques that apply to older adults also apply to other populations of vulnerable adults such as those who have cognitive impairments from a moderate or severe

neurodevelopmental disorder.

A. Older Adults

There are few regulations intended for older adults as it relates to the Baker Act. For example, there are no designated receiving facilities deemed exclusive for older adults. Some psychiatric facilities, however, do have special units and programs designed for the needs of older adults with trained staff and tailored treatment interventions and activities. This section addresses the special regulations and considerations that apply to the Baker Act and service provision to older adults, particularly those residing in long-term care facilities.

1. Transfer Trauma

Older adults, and particularly those adults who require assistance with activities of daily living, may require additional support when changing environments and routines. Temporary or permanent relocation of their residence can be difficult for them. Often referred to as relocation stress, transfer trauma is a significant challenge for some older adults. It can cause negative emotional responses, acting out behaviors, and physical problems such as increased falls.[16] As a result, it is vital that staff at a long-term care facility make every effort to provide on-site psychiatric and behavioral interventions, including ensuring that staff are properly trained to verbally de-escalate agitated individuals, that would prevent a transfer to a different facility.

2. Behavioral Management with Vulnerable Adults

Many older adults often have behaviors that may mimic a mental health condition and, when a co-occurring mental health condition is present, the management of behaviors may become even more complex. For these reasons, de-escalation techniques may need to be applied with these individuals differently than they are with other populations. In addition, if de-escalation techniques are not effective, the application of seclusion or restraint must be carefully considered. For example, when considering an emergency treatment order there are many psychotropic medications that are contraindicated for older adults, particularly those with a diagnosis of dementia. There are detailed regulations on how antipsychotic medications are to be used with individuals who have a diagnosis of dementia. In addition, the frailty of an older adult should also be considered when employing physical holds and restraints. More information on de-escalation techniques are found in chapter nine (9).

3. Residents of Long-Term Care Facilities

s. 394.4625, F.S.	• Voluntary Admissions
s. 394.463, F.S.	• Involuntary Examination
ch. 65E-5.180, F.A.C.	• Right to Quality Treatment

Individuals residing in long-term care facilities such as assisted living facilities, nursing homes, and group homes are considered incompetent to provide express and informed consent unless proven otherwise. Cognitive impairment can interfere with an individual's decision-making ability and often necessitates assistance for completion of activities of daily living. These individuals often receive assistance with tasks such as meal preparation, dressing, bathing, and medication administration. This includes individuals who meet one of the following criteria:

- They are residents of nursing homes and at least 60 years of age.
- They are diagnosed with dementia, at least 60 years of age, and receiving services at a nursing home, assisted living facility, adult day care center, or adult family care home.
- They have their medical decisions made by a health care surrogate or proxy.

A resident of a long-term care facility may be admitted to a designated receiving facility or state mental health treatment facility when they experience symptoms of a mental health condition that cannot be managed in the long-term care facility. It must be believed that the receiving facility or treatment facility can provide services that will benefit the individual. Long-term care facilities should be able to manage most of the symptoms experienced by residents; however, some residents will need medical or psychiatric hospitalization.

The individual must meet both of the following criteria for involuntary admission:

- The concerning symptoms are directly related to a mental health condition.
- There is a reasonable belief that the individual will benefit from treatment.

These are important elements to consider since older adults may experience symptoms that mimic a mental health condition believed to be the result of a neurocognitive disorder such as dementia. Many can benefit from medication management and being on a secure unit with 24/7 staff. This can often be provided just as effectively at the individual's current long-term care facility as it would in a psychiatric facility while maintaining continuity of care. For example, an older adult with dementia and a co-occurring mental health condition may benefit from a medication adjustment without removing the resident from the facility. In addition, individuals with neurocognitive disorders such as dementia are not normally expected to benefit from other services typically provided in a designated receiving facility. Traditional group therapy, for example, is largely ineffective with this population due to the learning and communication barriers inherent in the cognitive decline associated with dementia.

There may be some instances, however, when the individual meets the involuntary criteria and the staff of the long-term care facility cannot safely manage the individual's symptoms. This may occur when the older adult becomes extremely aggressive towards self or others and all other interventions have been unsuccessful.

s. 394.4625, F.S.	• Voluntary Admissions
ch. 65E-5.280(6), F.A.C.	• Involuntary Examination

A resident of a long-term care facility cannot be transferred to a designated receiving facility for examination or admission without first having an involuntary examination initiated or being deemed competent to provide express and informed consent through an independent expert examination. It is best practice for a qualified professional on-site to initiate the involuntary examination. Law enforcement is used to initiate the involuntary examination in the most imminently dangerous situations. In most instances, law enforcement will only be called for transportation after an involuntary examination is initiated by a qualified professional. Law enforcement will assess the situation and, when indicated, may cosign the individual to medical transport. It is the responsibility of the long-term care facility to ensure that appropriate notice of transfer is provided to the facility receiving the individual.

If a long-term care facility sends an individual to a designated receiving facility without the proper paperwork, the designated receiving facility must report the sending facility to AHCA by certified mail by the next working day.

The resident is expected to return to the long-term care facility after discharge from the designated receiving facility or state mental health treatment facility. If the long-term care facility is concerned about their ability to meet the ongoing needs of their resident, the facility must evaluate the resident prior to discharge before making a determination on whether they will accept the resident back.

Additional information on transportation procedures for individuals on involuntary status is found in chapter seven (7), module two of the online course Law Enforcement and the Baker Act, and the transportation FAQs.

4. Independent Expert Examination

s. 394.4625(1)(b), F.S.	• Authority to Receive Patients
s. 394.467(6)(a)2, F.S.	• Involuntary Inpatient Placement
s. 400.0255, F.S.	• Resident Transfer or Discharge
Form CF-MH 3022	• Application for Appointment of Independent Expert Examiner

Residents of long-term care facilities must be assessed and determined competent before being voluntarily admitted to a designated receiving facility. An independent expert examination (CF-MH 3022) is used to determine whether an individual residing in a long-term care facility is competent to provide express and informed consent (CF-MH 3099). This examination may be completed by any of the following three types of professionals:

- A clinical staff member of a mental health overlay program
- A clinical staff member of a mobile crisis response team
- A licensed professional qualified to initiate an involuntary examination who is employed by a publicly funded community mental health center

If a qualified professional is unavailable to perform the independent expert examination within two (2) hours of the request, a licensed professional qualified to initiate an involuntary examination who is not employed by a publicly funded community mental health center may conduct the examination if there is no conflict of interest. A conflict of interest includes working for the sending facility, destination facility or the professional having financial interest in the final determination.

For further information regarding older adults in Baker Act and other mental health facilities, please visit the online course entitled Long-Term Care and the Baker Act.

IV. Substitute Decision-Makers and Advance Directives

ch. 65E-5.170, F.A.C.	• Right to Express and Informed Consent
ch. 65E-5.230, F.A.C.	• Guardian Advocate
ch. 65E-5.2301, F.A.C.	• Health Care Surrogate or Proxy
s. 394.4598, F.S.	• Guardian Advocate

When providing medical and behavioral health care services, hospitals are responsible for following written advance directives as well as notifying and consulting with substitute decision-makers. Hospitals cannot always be aware of advance directives and substitute decision-makers, but an effort must be made to ask about the presence of these factors and follow legal protocols once it is apparent that the individual has one of these elements in place.

V. Veterans

s. 394.4672, F.S.	• Procedure for Placement of Veteran with Federal Agency
ch. 296, F.S.	• Veteran's Nursing Homes
s. 744.602, F.S.	• Veteran's Guardianship Law
s. 744.637, F.S.	• Certified Copies of Public Records

Individuals who are active service members or Veterans of the military may have an increased rate of mental health conditions such as PTSD, depression, anxiety, and an increased risk for suicide-related thoughts, behaviors, and deaths. [17,18] The incidence of military related suicides has risen 26 percent from 2001 to 2019.[19] This translates to a suicide rate among Veterans that is approximately one and a half times higher than the general population.[20] Suicide risk is a particular, heightened concern for individual's serving during times of war. Approximately 20 percent of deaths of active-duty personnel during the Iraq and Afghanistan wars are attributed to suicide regardless of whether the individual was deployed.[21] In fact, those who were not deployed had a 20 percent higher instance of suicide than those who were deployed.[22]

Florida houses more than nine percent of the nation's 16.5 million Veterans. As a result of their increased suicide risk and the high population of Veterans in Florida, many Veterans and active service members may access voluntary or involuntary services under the Baker Act. It is important for providers, service members, Veterans, and family members to be aware of the programs and policies of the Department of Veteran's Affairs (VA). The VA has several programs in place to address the mental health of service members and Veterans which include measures to reduce the suicide rate.[23]

Through house bill 8247, the Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020 (Veterans COMPACT Act of 2020) was signed into law in December of 2020. The Veterans COMPACT Act of 2020 requires the VA to fund or reimburse Veterans seeking suicide crisis services, including applicable transportation costs and follow up care, at either a VA or non-VA facility. Veterans are eligible to receive funded or reimbursed services for up to 30 days of inpatient care and 90 days of outpatient care. [24]

To be eligible for other benefits and programs through the VA, an individual typically can no longer be serving on active duty. However, there are several factors that determine a veteran's eligibility and level of benefits based on factors such as level of disability, length of service, and type of discharge. The local VA can be contacted to determine eligibility for benefits and inquire about current programs. The following information and referral and crisis lines are available for additional assistance:

Florida Department of Veteran's Affairs (FDVA)	805-487-1533
Florida Veteran's Support Line	844-MyFLVet (844-693-5838)
TTY Number	800-799-4889
VA Benefits	800-827-1000
VA Caregiver Support	855-260-3274
VA Homeless Programs	877-4AID-VET (877-424-3838)
VA Women Veterans Call Center	855-VA-WOMEN (855-829-6636)
Vet Centers	800-905-4675
Veteran's Crisis Line	Dial 988, then press 1

For more information regarding mental health benefits available to active service members and veterans, please refer to the VA's Guide to VA Mental Health Services for Veterans and Families, Emergency Care in Non-VA Facilities, and suicide prevention webpage, https://www.mentalhealth.va.gov/suicide_prevention/index.asp. To find local resources for Veterans, visit, https://www.veteranscrisisline.net/find-resources/local-resources/

A. Veterans with Criminal Charges

s. 394.47891, F.S.	• Military Veterans and Servicemembers Court Programs
s. 948.16(2)(a), F.S.	• Misdemeanor Pretrial Intervention and Mental Health Court
s. 948.21(2), F.S.	• Conditions of Probation or Community Control
s. 948.06(2)(j), F.S.	• Violation of Probation or Community Control

Active service members and Veterans who are charged with a misdemeanor and who experience symptoms of a behavioral health condition related to their military service may be able to access specialized programs. This includes programs focusing on substance use and misuse, traumatic brain injury, and mental health conditions. These individuals may qualify to have their criminal case diverted from the typical court proceedings into a misdemeanor pretrial veterans' treatment intervention program if they also meet all the following conditions:

- The individual's involvement is based on a non-violent felony conviction which occurred after June 30, 2016.
- The individual is willing to participate in mental health treatment.
- The individual agrees to be compliant with prescribed psychotropic medication.

A Veteran or active service member who is on probation or another form of community control may also be required to participate in a treatment program that is able to effectively address the individual's mental health condition, traumatic brain injury or substance use.

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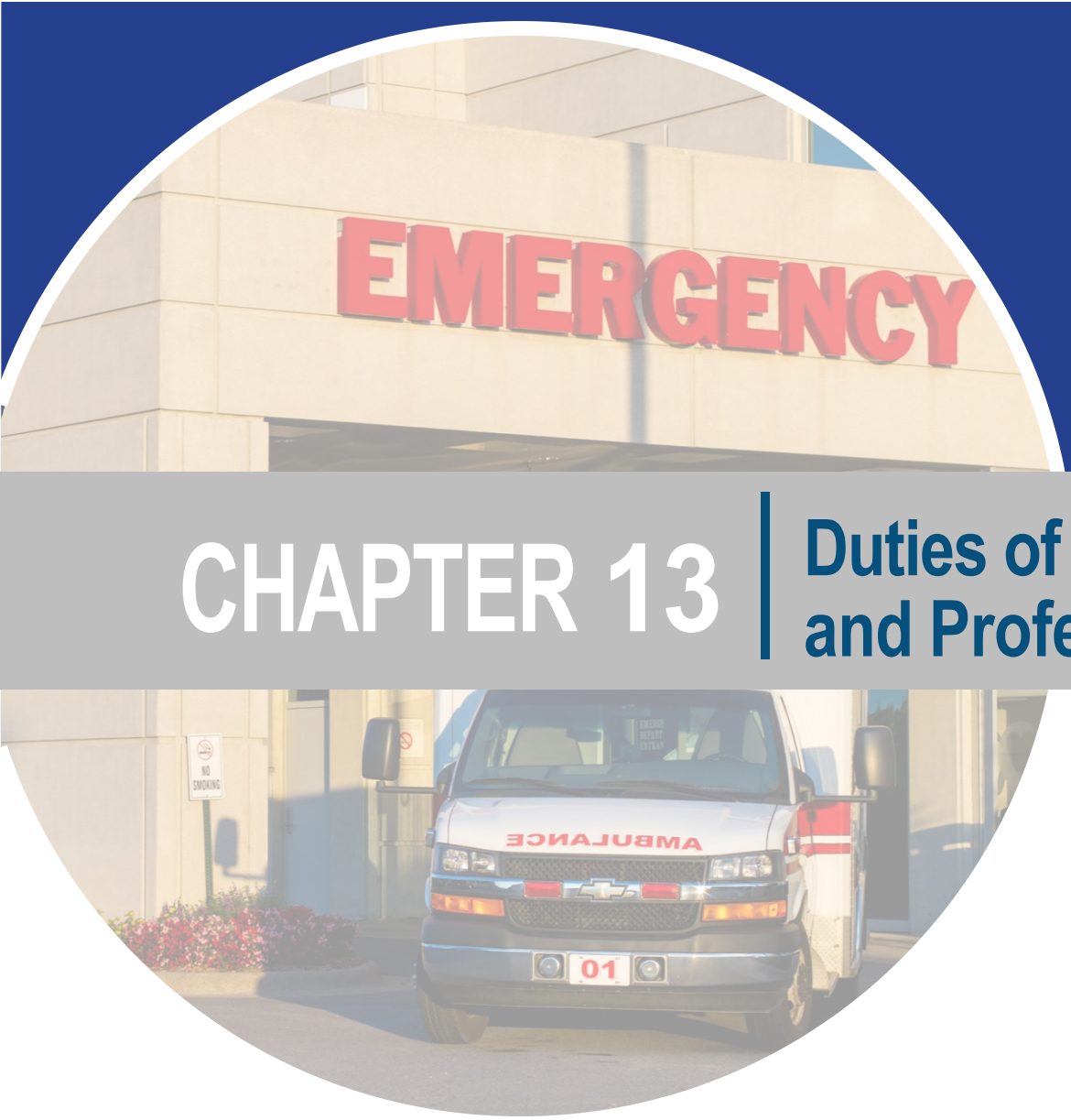


CHAPTER 13 | Duties of Facilities and Professionals

I. Overview

Staff working at designated receiving facilities and state mental health treatment facilities have responsibilities such as maintaining a safe and secure environment, filing court documents, providing notifications, and making abuse reports within specific time frames. Staff must also identify emergency medical conditions, respect individual rights, and understand the requirements of express and informed consent. This chapter will review many laws that staff must follow.

II. Designated Receiving Facilities

s. 394.462, F.S.	• Transportation
ch. 65E-5.260, F.A.C.	• Transportation

Designated receiving facilities must accept all individuals properly transported under involuntary status even if the facility does not accept the individual's insurance, is at capacity or does not have the capability to provide the necessary care.

The designated receiving facility, for example, may not have the capability to serve a specific population, address an emergency medical condition or a staff member may suspect an individual is experiencing a physical condition that needs further examination or treatment in a medical hospital. If it is believed that an individual needs to be transferred to a medical hospital, a staff physician must be alerted to determine whether to transfer that individual to a local emergency room for medical clearance. An individual who has been admitted to a designated receiving facility and transferred to a local emergency department for medical clearance should only be discharged from the designated receiving facility if one of the following conditions apply:

- The emergency department admits the individual.
- The individual is on voluntary status and declines to return to the sending facility for continued services.

If a law enforcement officer transports an individual to a receiving facility, but it is determined that the individual needs an immediate transfer due to capacity or capability, the facility must call to arrange medical transport. The law enforcement officer does not have a responsibility to provide the additional transport even if they are still on scene when the determination for a transfer is made. For example, if a law enforcement officer delivers a minor to a facility that is only licensed for adults, the facility must accept the minor from the officer, provide an initial assessment, find an appropriate accepting facility, and arrange a subsequent transfer. If the individual is experiencing an emergency medical condition or requires immediate care that is beyond the facility's capability, then the facility must call a medical transport service (often 9-1-1) to transfer the individual to a medical emergency department.

This is also true if the facility does not have a bed available to admit a person, also referred to as capacity. For example, if a law enforcement officer delivers an individual to a facility that is full or does not have a bed available for admission, the facility must accept the individual from the officer, provide an initial assessment to determine if the criteria are met and the individual needs to be admitted to a receiving facility. If the individual does meet the criteria and needs to be admitted but there is not a bed available, the facility must find an appropriate accepting facility and arrange a subsequent transfer.

Facilities should not request law enforcement conduct facility to facility transfers unless specified in the county's transportation plan. In addition, law enforcement is not required to remain on the premises for an extended period or required to return to a facility for security purposes. However, law enforcement may remain present while awaiting security or additional staff members who can provide further assistance and support to secure a safe environment.

Once an individual arrives at a designated receiving facility, either under voluntary or involuntary status, and is deemed appropriate for admission, there are specific requirements that staff must complete. More information on admission requirements is found in Appendix N. Admission Checklists.

III. Licensure Requirements

s. 394.4572, F.S.	• Screening of Mental Health Personnel
ch. 65E-5.351, F.A.C.	• Minimum Standards for Designated Receiving Facilities

Designated receiving facilities have requirements in to attain and maintain licensure. This includes provisions such as fully sustaining all reception, screening, and inpatient services 24/7 and having policies and procedures to ensure that all legal requirements under the Baker Act are met. In addition, most personnel working in a designated receiving facility or state mental health treatment facility must undergo a Level 2 background check.

IV. Facility Administrators

Petitions for involuntary inpatient placement, involuntary outpatient services, appointment of guardian advocates, and a transfer to a treatment facility must be filed with the court by the facility administrator or their designee. Facility administrators may also perform an administrative discharge. An administrative discharge may occur if the individual has been admitted to a medical hospital or when an individual on voluntary status elopes from the facility but does not meet the criteria for involuntary examination. Some of the other responsibilities of facility administrators include the following:

- Requesting an individual be transferred to another facility.
- Authorizing certain emergency medical treatment when permission from the individual or their substitute decision-maker cannot be immediately obtained.
- Requesting the court review decisions made by a guardian advocate.
- Authorizing a search for an individual who elopes from the facility.

A more extensive list of responsibilities is found in Appendix O. Responsibilities of Facility Administrators.

V. Abuse Reports

s. 39.201, F.S.	• Mandatory Reports of Child Abuse or Neglect
s. 39.202, F.S.	• Confidentiality of Reports in Cases of Child Abuse
s. 415.1034, F.S.	• Mandatory Reports of Abuse of Vulnerable Adults
s. 415.107, F.S.	• Confidentiality of Reports and Records

Per Florida Statute, any person who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible is a mandatory reporter. In a designated receiving facility or state mental health treatment facility, all staff are required to report the suspected abuse, neglect, and exploitation of a minor (child) or vulnerable adult. This includes hospital staff and professionals such as physicians, nurses, and social workers. A person can face legal charges if it is determined that he or she had enough evidence to make a report of potential abuse or neglect and did not report it. If the person who failed to report the incident is also a licensed or certified professional, they may face additional sanctions. A list of professionals whose professional code of ethics requires the reporting of suspected abuse, neglect, or exploitation of a minor or vulnerable adult can be found in Appendix P. Mandated Reporters.

A. Abuse Reports: How and Where

Florida law requires reporting to the Florida Abuse Hotline when someone suspects that abuse, neglect, abandonment, or exploitation has occurred against a minor or vulnerable adult.

The abuse hotline accepts reports 24 hours per day, seven (7) days per week. Reports can be made by phone, fax, or online and can be made in any of the following ways.

Reporting Method	Contact Information
Toll-Free Abuse Hotline	800-96-ABUSE (1-800-962-2873) **Press 1** to report suspected abuse, neglect or abandonment of a child **Press 2** to report suspected abuse, neglect or exploitation of the elderly or a vulnerable adult **Press 3** to verify the identity of a child protective investigator who recently visited you **Press 4** for information/referrals to other services in your local area.
Reporting Concerns for Child Victims Online Form	https://reportabuse.dcf.state.fl.us/Child/ChildForm.aspx
Reporting Concerns for Vulnerable Adult Victims Online Form	https://reportabuse.dcf.state.fl.us/Adult/AdultForm.aspx
Florida Relay TTY for Deaf English Spanish and Creole	711 or 800-955-8771 800-453-5145
Fax	800-914-0004

Staff who work in designated receiving facilities and Baker Act treatment facilities should be familiar with their facility's policies and procedures. All facility staff are mandated to report suspected abuse; However, some facilities require specific individuals, such as the Director of Nursing or other administrator, to make this report.

VI. Accommodations

Facilities must provide individuals with reasonable accommodations for conditions and circumstances that, if untreated, would substantially limit one or more major life activities. Reasonable accommodations may be required for individuals who use an assistive device, have a physical, cognitive, or emotional disability, or experience a language barrier. The accommodation must ensure the individual can access and benefit from available services and programs. Facilities have policies to protect the safety of all individuals within the facility and often prohibit items that could potentially be used as a weapon. This could include assistive devices such as canes and crutches or the use of a walker during admission.

In addition, facilities must ensure that any verbal or written information provided to an individual is accessible in the language and terminology the individual understands, this includes the use of an interpreter for examination and treatment.

VII. Hospitals

s. 394.459, F.S.	• Rights of Patients
s. 395.003, F.S.	• Licensure; Denial, Suspension, and Revocation
ch. 65E-5.140, F.A.C.	• Rights of Persons

Hospitals provide services such as observation, evaluation, diagnosis, and treatment. Facilities that are licensed as hospitals under chapter 395, Florida Statutes and provide services to individuals under the Baker Act must meet specific regulations and comply with the Baker Act's standards of care, individual rights, and procedures for examination and placement. These regulations apply regardless of whether services are being provided to an individual on voluntary or involuntary status. They also apply to medical hospitals that provide services to individuals receiving involuntary services under the Baker Act, even if the medical hospital is not a designated receiving facility. For example, a facility must maintain specific standards relating to scheduled activities and interventions for behavior management. More information on the rights of individuals receiving services under the Baker Act is found in chapter eight (8).

A. Conditions of Participation

Hospitals that accept Medicare or Medicaid payments must abide by the federal Conditions of Participation (CoPs). There are several different categories covered under the CoPs; however, the ones most relevant to Baker Act facilities are those that address individual rights. CoPs identify several rights that must be afforded to individuals receiving services including confidentiality, personal representatives, advance directives, and seclusion and restraint.

1. Emergency Services and EMTALA

42 U.S.C. 1395dd	• Examination and Treatment for Emergency Conditions
s. 395.1041, F.S.	• Access to Emergency Services and Care
s. 401.445, F.S.	• Emergency Examination and Treatment of Incapacitated Persons

Florida and federal laws have protections for providing for the examination, treatment, and transfer of individuals experiencing an emergency medical condition. An emergency medical condition occurs when an individual is experiencing a condition that could reasonably lead to serious jeopardy, impairment or dysfunction of the individual's body or health, including psychiatric conditions. Hospitals have a responsibility to examine, and either stabilize or transfer, all individuals who meet one of the following conditions:

- The individual comes to the hospital and a request for examination for an emergency medical condition is made.
- The individual is identified as experiencing an emergency medical condition by a paramedic, emergency medical technician, or staff at a medical or psychiatric facility such as a medical hospital or designated receiving facility.

Individuals who meet criteria for an involuntary examination also meet criteria for an emergency medical condition.

The Emergency Medical Treatment and Labor Act (EMTALA) guarantees that individuals reporting an emergency medical condition will receive hospital services based on their chief complaint without regard to ability to pay. It guarantees that all individuals who present to an emergency department, including a psychiatric hospital that accepts emergency voluntary admissions, will receive a screening. This screening must not be influenced by the individual's ability to pay or history with the facility, including multiple admissions or a recent discharge.

EMTALA requires all hospitals to comply with the same standards and regulations for a psychiatric condition as they do for a medical condition. Crisis stabilization units and other facilities not licensed as hospitals do not have to comply with federal EMTALA regulations or Florida's hospital regulations. Crisis stabilization units have their own set of administrative rules.

Once an individual is identified as requiring services for a potential emergency medical condition, the hospital must fulfill one of the following outcomes:

- The individual is found to not have an emergency medical condition and is released.
- The individual's emergency medical condition is stabilized, and the individual is released.
- The individual is transferred to an inpatient unit within the hospital.
- The individual is transferred to a more specialized hospital or facility that is better equipped to treat the emergency medical condition.

a. Consent to Treatment

EMTALA guarantees individuals will receive an examination and treatment until their emergency medical condition stabilizes. Hospitals should make attempts to obtain consent for treatment from the individual or their substitute decision-maker. Individuals or their substitute decision-maker may decline treatment services during an emergency medical condition.

An involuntary examination under the Baker Act cannot be initiated for the primary or sole purpose of providing treatment or medical testing.

Examination and treatment can be provided even if the individual is unable to consent to treatment or if obtaining the individual's consent would be detrimental to their well-being if unreasonable force is not used. Obtaining consent may be detrimental when the nature of the situation is too emergent to reasonably ask for consent or the individual is unable to communicate. For example, if an individual is bleeding profusely or is unresponsive due to a suspected heart attack, it is not practical to first seek consent before providing examination or treatment. This is also true if the individual is unable to provide express and informed consent while experiencing an emergency medical condition due to current intoxication or acute mental health symptoms. Under these circumstances there can be a presumption of consent when it is believed that under normal circumstances an individual would consent to the treatment.

Without expressed consent, the emergency examination and treatment must only go to the extent that an emergency condition is examined and, if necessary, treated to the point of stabilization. Any further examination or treatment is not allowed without obtaining express and informed consent or a court order.

Life saving measures, such as CPR, are used for those individuals without a do not resuscitate order (DNR). If life saving measures were provided because the medical staff was unaware that the individual had an active DNR they cannot be held liable.

b. Financial Considerations

Governed by the CMS, EMTALA requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay. Financial information can be collected if it doesn't interfere with or delay the natural progression of services that would be provided to an individual if finances were no consideration. This means that an individual presenting with an emergency medical condition cannot be denied triage or needed medical services based on any financial criteria and the collection of financial information cannot interfere with or delay examination or treatment. For example, an individual cannot be told they have to wait to be triaged until they provide financial paperwork; however, they can be asked to complete financial paperwork following the triage process or be asked to provide financial information along with demographic and medical information that is part of the triage process.

Hospitals cannot require the guarantee of payment if an individual is experiencing an emergency medical condition, including requiring pre-authorization from an insurance company to complete an admission. This is inclusive of individuals who require a transfer to another hospital due to the receiving hospital's capability or capacity. Financial status can be considered when determining the overall cost of care for an individual. While transfers are often

discouraged unless it is to a higher or more specialized level of care, it is allowed in situations where a public designated receiving facility can accept an individual from a private designated receiving facility and significantly reduce the individual's financial burden.

An individual who is experiencing an emergency medical condition and meets criteria for an involuntary examination can have payment information explained and verified but it cannot deter admission. This occurs regardless of whether they are being admitted under voluntary or involuntary status.

> The collection of financial information or determination of financial status may not, in any way, delay, suspend, or deny an individual's examination of an emergency medical condition and, if needed, the treatment necessary to stabilize that condition.

Once the emergency medical condition is stabilized, transfer decisions that route the individual to the most appropriate facility for their funding source is allowed. If all other transfer requirements are met, initial referrals can be made to the facility that accepts the individual's insurance, is in-network, or provides the most accommodations for uninsured or underinsured individuals.

c. Medical Clearance

A medical hospital must provide a statement of medical clearance before an individual under involuntary status can be transferred to a designated receiving facility. If medical clearance is not provided, the medical hospital must continue to treat that individual until the medical condition stabilizes within the designated receiving facility's capability.

For more information on emergency medical conditions and EMTALA, please refer to the online course *Emergency Medical Treatment: Florida's Baker Act and Marchman Act* and the *Baker Act Frequently Asked Questions for the Topic of Emergency Medical Conditions, EMTALA (Emergency Medical Treatment and Labor Act) and Hospital Transfers*.

VIII. Rights and Responsibilities of Professionals

s. 394.460, F.S.	• Rights of Professionals
s. 456.059, F.S.	• Communications Confidential; Exceptions

Professionals who serve individuals with behavioral health symptoms, particularly those who work in a designated receiving facility or state mental health treatment facility, must comply with federal and state laws, agency policies and procedures, and a professional code of ethics. Additionally, the Baker Act law requires professionals to provide adequate protections to individuals and those in the community.

Professionals who perform duties within their scope of practice and act in good faith are immune from civil and criminal liability. For example, a professional or an administrator of a designated receiving facility who breaches confidentiality in a duty to warn case cannot be held liable when the report is made in good faith.

A. Good Faith

s. 394.459(10), F.S.	• Rights of Patients: Liability for Violations

'Good faith' occurs when someone engages in actions without any form of malice or deceit. Professionals who act in good faith are immune from civil and criminal liability if they remain in compliance with the law based on the information they have at the time. This includes a professional's actions in connection with the admission, diagnosis, treatment, transfer, or discharge of an individual. For example, a professional who initiates an involuntary examination based on the belief that the individual is an imminent danger due to a suicide attempt would be acting in good faith. If the individual is immediately released because the designated receiving facility determines the criteria for an involuntary examination are not met, because the examination further finds that the person does not have active suicidal thoughts, no plan to harm themselves again, contracts for safety by agreeing to contact their outpatient therapist if they experience any suicidal thoughts, and has good family support, the professional cannot be held liable for initiating the involuntary examination.

Persons who do not act in good faith, however, may be held liable for their actions, particularly if negligence occurs. This might include a qualified professional or law enforcement officer who initiates an involuntary examination when they do not believe that the individual meets the criteria. For example, an individual who refuses medical treatment and whose decision is not related to symptoms of a mental health condition is not considered a danger to themselves under the Baker Act. A court order would need to be obtained to order medical treatment. Someone who intentionally used their power to initiate an involuntary examination to avoid going through the court is not acting in good faith.

B. Firearm Prohibitions and Reporting to the Mental Competency (MECOM) Database

Clerks of Court are required to report all individuals who are involuntarily placed in a mental health facility to the Mental Competency (MECOM) database within 30 days after the Order for Involuntary Placement has been signed by the court.

Individuals, including minors, may also be reported to MECOM if a physician files a petition for involuntary placement after finding that the individual posed an *active and imminent danger to themselves or others* and meets at least one of the following criteria.

- The individual acknowledged in writing, at the time of voluntary admission, that the physician may restrict their right to bear arms, and meet either of the following conditions:
  - A petition for involuntary inpatient placement or involuntary outpatient service would have been filed if voluntary consent had not been obtained
  - A petition for involuntary inpatient placement or involuntary outpatient services was filed the individual but voluntarily agreed to services prior to a hearing with the court

Once the petition for a firearms restriction is filed, it is reviewed in court. The court can then order the individual be reported to MECOM. Individuals reported to MECOM are prohibited from purchasing firearms or obtaining a concealed carry permit. There are no provisions made for current firearms that the individual has licensed and in their possession. The MECOM database only restricts future purchases and permits. Individuals may petition the court later to overturn the firearms restriction.

IX. The Clinical Record and Documentation

ch. 59A-3.254, F.A.C.	• Patient Rights and Care
ch. 65E-5.160(j), F.A.C.	• Right to Treatment
ch. 65E-5.180, F.A.C.	• Right to Quality Treatment

Facilities must keep updated demographic and clinical records for each individual served. The clinical record is an important collection of documents that provides both a history and roadmap of an individual's services with a provider. Clinical records contain documents that protect both the individual receiving services as well as the provider. It offers providers an effective way to convey their interactions and intentions to other members of the treatment team ranging from why the individual sought treatment to what goals need to be met to discontinue treatment. It documents many important aspects of the communication between the individual and the clinical and medical staff including results of assessments, recommendations, treatment goals, and measures for identifying whether there is progress towards the identified goals or the need for a change during treatment.

Documentation must be legible, up to date, and readily available to all staff.

The clinical record should serve as a foundation and blueprint for current and future services. Any information pertinent to service provision, including evaluation, treatment, and discharge, must be maintained in this record. There are numerous documents essential to the clinical record including assessments, Baker Act forms, treatment plans, progress notes, and consents. These should be organized in the clinical record in a uniform order that is consistent throughout the organization. For a list of documents commonly found in the clinical record please refer to Appendix P. Documents in the Clinical Record.

X. Safety Precautions

Facilities have a responsibility to keep individuals safe. While psychiatric hospitals and CSUs are designed for psychiatric emergencies, medical hospitals are not. There are several precautions that medical hospitals can take to help ensure the safety and security of the individual and those around them. The hospital can employ any of the following techniques:

- Have the individual take off their shoes and remove the shoes from the room; provide socks or slippers for them to wear instead.
- Move the individual into a room that is furthest from exit doors that lead outdoors or to another part of the hospital.
- Move the individual into a room near the nurse's station.
- Employ a trained 'sitter' or use video monitoring to watch the individual for concerning behaviors.

If a 'sitter' is being used to confine an individual to a room, that technique would be considered seclusion and all seclusion measures would need to be implemented.

Designated receiving and treatment facilities must develop policies and procedures that address the following:

- Which personal effects will be removed from individuals for reasons of personal or unit safety
- How they will be safely retained by the facility
- How and when they will be returned to the individual or other authorized individual

The policies and procedures must specify how contraband and other personal effects determined to be detrimental to the individual are addressed if not returned to the individual. An inventory of these items (CF-MH 3043) must be witnessed by two staff and by the individual, if able, at the time of admission, at any time the inventory is changed, and at the time the personal effects are returned to the individual or transferred to another facility.

A. Elopement

s. 394.467(8), F.S.	• Involuntary Inpatient Placement
s. 394.463(2), F.S.	• Involuntary Examination
ch. 65E-5.280(4), F.A.C.	• Involuntary Examination

Facilities have a responsibility to keep individuals safe and secure. This includes preventing elopements to the best of their ability.

The facility administrator may determine whether to pursue an individual who has eloped from the facility who was admitted under involuntary status or met the criteria for an involuntary examination. Facilities will often seek the assistance of law enforcement in returning the individual to the facility for individuals who still meet criteria for an involuntary examination or involuntary placement regardless of whether they are voluntary or involuntary at the time of elopement.

If the individual who eloped is currently under voluntary status but meets criteria for an involuntary examination, a qualified professional who has observed the individual within the last 48 hours must initiate a Certificate of Professional Initiating an Involuntary Examination (CF-MH 3052b). This certificate must be completed prior to calling law enforcement for assistance in locating the individual following an elopement. If the individual is currently held under voluntary status and does not appear to meet criteria for an involuntary examination, law enforcement should not be notified. Below is a chart that outlines when law enforcement should be notified of an elopement.

Should You Notify Law Enforcement of an Elopement?	Yes	No	Additional Actions
Individual is voluntary and only meets criteria for voluntary services.		✓	No action required.
Individual is voluntary and meets criteria for an involuntary examination.	✓		An involuntary examination is initiated by a qualified professional and provided to law enforcement. Individual is located and delivered to the nearest designated receiving facility.
Individual has had an involuntary examination initiated and is within the initial 72-hour examination period. Individual meets criteria for involuntary placement but petition has not yet been filed with the court.	✓		Initiating paperwork is provided to law enforcement. Individual is located and delivered to the nearest designated receiving facility.
Individual is currently under petition for involuntary placement.	✓		Copy of the petition is provided to law enforcement who are to locate and deliver the individual back to the original facility where the petition was filed.
Individual is currently court ordered to involuntary placement.	✓		The administrator of the facility authorizes a search for the individual. When the assistance of law enforcement is requested, a copy of the order is provided. Law enforcement is to locate and deliver the individual back to the facility where the individual is currently fulfilling the order for placement.

If the individual who is currently under involuntary status is still in the initial 72-hour examination period and a petition for involuntary placement has not been filed with the court, law enforcement may stop at the facility to obtain the original documentation that was used to initiate the involuntary examination. Once the individual is located, law enforcement may return the individual to the facility where the individual eloped or may take the individual to the nearest designated receiving facility.

The individual may then be transferred back to the original facility where the elopement occurred or may stay at the current facility that received the individual from law enforcement. If a petition was already filed with the court or the individual was already under an order for involuntary placement, the officer is to receive a copy of the initiating paperwork to return the individual to the original facility. If the elopement occurs from a medical hospital's emergency department, the individual should be returned to the emergency department to complete appropriate transfer procedures per EMTALA, even if the individual has already been medically cleared.

XI. Transfers to Designated Receiving Facilities

Ch. 394.463, F.S. • Involuntary Examination

Individuals who are at a medical hospital and have an involuntary examination initiated will be referred to a designated receiving facility for further services. Once an individual is medically cleared, a medical hospital has two (2) hours to request a transfer and 12 hours to complete the transfer. A second statement of medical clearance is required if the transfer is not completed in that time frame.

EMTALA requires that the individual is stable and medically cleared for transfer at the time of transfer. A new statement of medical clearance may be required when there is a long duration of time that lapses from the time of medical clearance to the time of transfer. This ensures that the individual's condition has not changed, and that individual remains medically clear.

A designated receiving facility can request certain lab results and tests to ensure that they have the capability to care for the individual. All the required lab results needed to make a determination about whether the designated receiving facility has the capability to meet the individual's medical needs should be requested at one time to prevent any delay in the potential transfer. A designated receiving facility cannot have a general policy to require certain lab results prior to accepting an individual. For example, a designated receiving facility cannot have a certain blood alcohol level that they refuse to accept for individuals. Instead, they must discuss with the nurse or doctor at the hospital the individual's behaviors, demeanor, gait, speech, and other elements to determine if the individual needs further medical care or monitoring that is beyond the capability of a psychiatric facility. If the receiving facility is concerned about their ability to provide adequate medical care, they can deny the transfer with justification.

XII. Warrants and Subpoenas

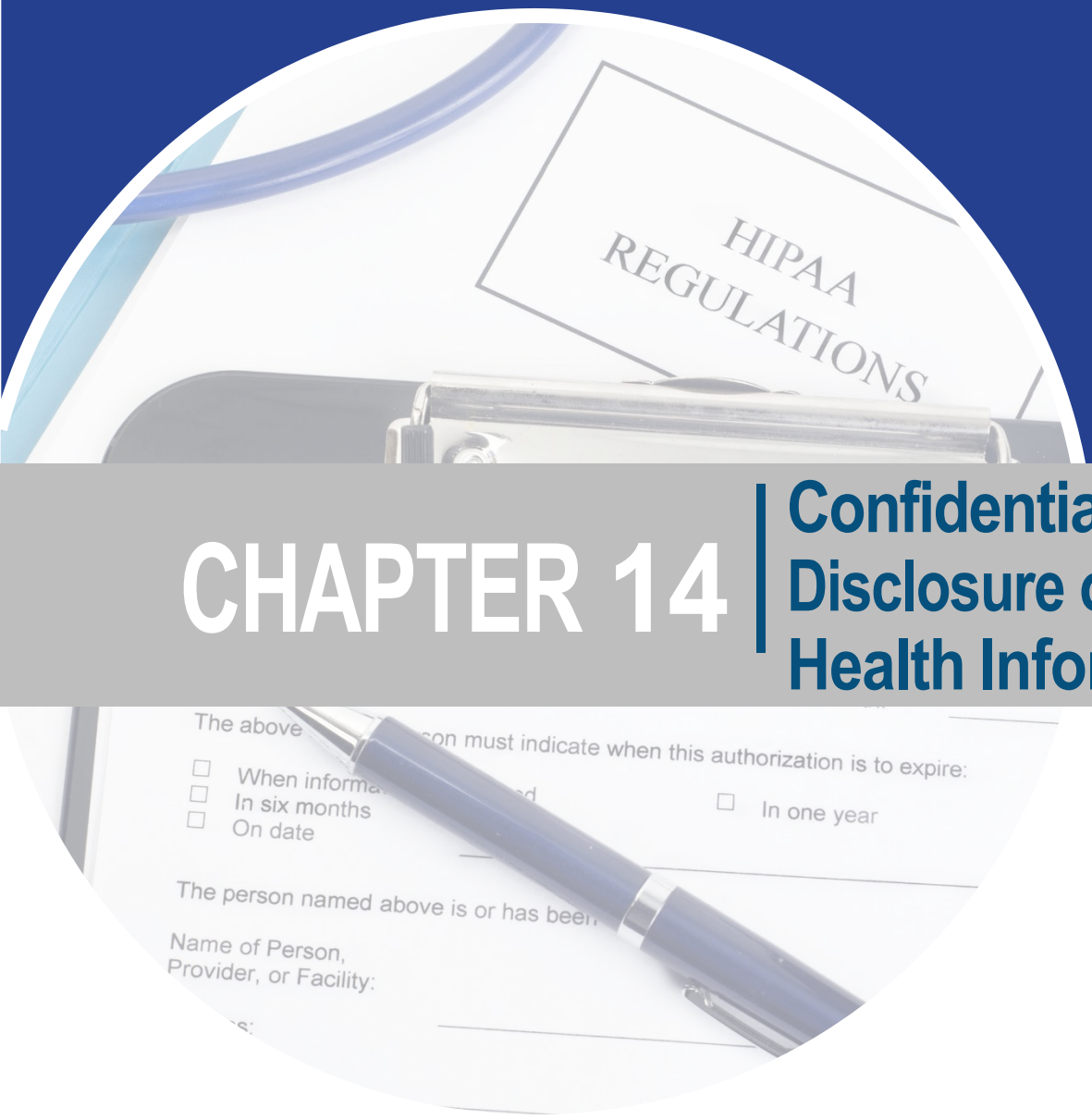
Occasionally, law enforcement will be provided with an arrest warrant for an individual who is currently receiving treatment at a designated receiving facility or state mental health treatment facility. If a law enforcement officer arrives at a facility with an arrest warrant, it is the responsibility of the staff to allow the officer to search the unit. Per HIPAA's privacy laws, however, staff are not allowed to assist the officer in the search. This means that staff cannot inform officers whether that individual is currently receiving treatment or assist them in identifying the individual unless the officer has a court order authorizing these actions.

If an officer arrives at a facility with a subpoena, neither staff nor individuals receiving services are allowed to accept the subpoena. The officer should instead be directed to senior management, preferably the Chief Administrative Officer of the designated receiving facility.

XIII. Weapons

s. 394.458(1)(a)3, F.S. • Introduction or Removal of Certain Articles Unlawful

Weapons, including those being carried by law enforcement officers, are prohibited in hospitals providing mental health services unless specifically authorized by the facility's administrator. If the hospital does not authorize weapons within the facility, it is recommended that officers leave weapons in their vehicle or have a lock box set up where weapons can be temporarily held. Facilities policies and procedures should address when law enforcement officers are permitted to carry a weapon inside the facility. For example, the policy when law enforcement officers transporting an individual for evaluation versus the policy when law enforcement officers are called to assist with a security issue.

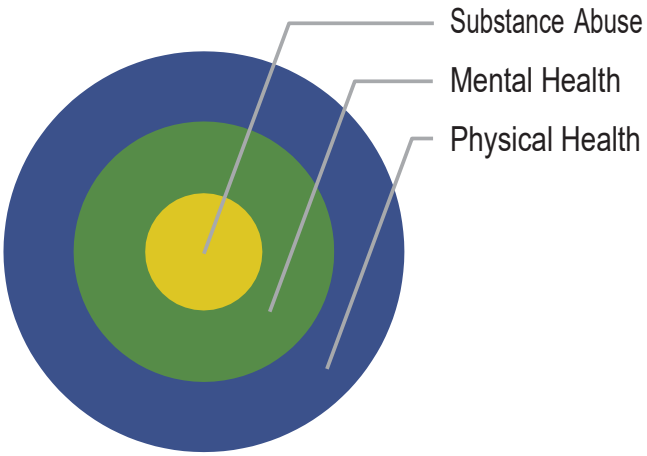


CHAPTER 14 | Confidentiality and Disclosure of Protected Health Information

I. Protected Health Information

Public Law 104-191 • Health Insurance Portability and Accountability Act

Confidentiality is an essential part of quality treatment. The confidentiality of an individual's health care data is highly protected and regulated by state and federal law. Health care, particularly behavioral health care, has strict standards on what information can be disclosed. The Health Insurance Portability and Accountability Act (HIPAA) is the federal law that protects individual's protected health information (PHI). HIPAA identifies how health information can be shared. Different types of health information have different levels of protection.



This diagram illustrates the degree to which different types of health information are protected. Substance use information has the most protections followed by mental health and then physical health.

With few exceptions, mental health information is handled the same as other health information regarding privacy and protections. Some elements of mental health information that may be found in the clinical record that are subject to the same HIPAA standards as protected health information for physical health include all the following:

- Medication prescriptions and monitoring programs
- The start and stop times of counseling or therapy sessions
- The treatment method and frequency of treatment
- Results of clinical tests
- Summaries of symptoms, diagnosis, treatment plans, progress in treatment, overall functioning, and prognosis

Most of the differences in the way protected health information is handled apply to information regarding substance use.

Each clinical record must contain unique identifying data that will separate the individual from all other individuals. PHI consists of individually identifiable health data. Documentation of clinical care must contain a minimum of two patient identifiers. There are 18 recognized patient identifiers including the individual's name, date of birth, street address, and phone number. This data, which is part of the individual's PHI, will have several elements to identify the individual in case of duplication or error in documentation.

In addition to demographic information, other PHI is required in the clinical record. This helps ensure that the individual is receiving the proper services for their symptoms. This includes all the following information:

- Identification of the individual
- Reason for referral
- Diagnosis

This information is generally safeguarded but can be shared for continuity of care or when an individual or their substitute decision-maker consents to the release of information.

II. Consent

42 U.S.C. 290dd-2	• Confidentiality of Records
42 C.F.R. Part 2	• Confidentiality of Substance Use Disorder Record
45 C.F.R. 164.508	• Uses and Disclosures for Which Authorization is Required
45 C.F.R. 164.510	• Uses and Disclosures Requiring Agreement or Objection
s. 394.4615, F.S.	• Clinical Records; Confidentiality
ch. 65E-5.250, F.A.C.	• Clinical Records; Confidentiality

Most information that is shared with persons and organizations can only be provided with consent from the individual or their substitute decision-maker. Consent is often documented with a signed release of information. While consent can be acquired verbally at times, best practice asserts that this consent is obtained in writing regardless of whether the information is being shared with another provider, a family member, or another member of the individual's support system. This release should specifically identify the information that the individual agrees to disclose and who is allowed to receive the information.

Confidential information is most often requested by a person in an individual's support system such as a family member, close friend, an individual provider, or another organization serving the individual. In addition to HIPAA, other laws must be considered when releasing an individual's information. For example, in the substance use field, confidentiality is governed by federal law (42 U.S.C. § 290dd-2) and regulation (42 C.F.R. Part 2). This law and regulation outline the limited circumstances information about the individual's treatment may be disclosed with and without consent. 42 C.F.R. Part 2 applies to any provider or program that:

(1) involves substance use treatment, Education, or prevention; and,
(2) is regulated by or receives assistance from the federal government.

Federally assisted treatment programs include programs and providers that are managed by a federal office or agency, receive any federal funding, and are registered with the Drug Enforcement Agency to prescribe controlled substances for substance use detoxification or treatment.

Unlike other types of protected health information, an individual's records related to substance use may expose him or her to criminal liability or other legal consequences. Requirements per 42 C.F.R. Part 2 are stricter than the HIPAA mandates and prohibits a qualifying program from the disclosure of any information that would directly or indirectly identify the individual as using substances without the individual's consent. This includes receiving an individual's express authorization to disclose substance use information for purposes of treatment and payment approval.

Information cannot be redisclosed without the individual's consent. 42 C.F.R. Part 2 also provides minors with more autonomy and control over their ability to consent to treatment. There are additional protections in court proceedings requiring a court order to permit the disclosure of information without the individual's consent.

Releases of information must include separate distinct categories for psychotherapy notes, HIV, and substance use information because that information must be disclosed and released differently than other parts of the clinical record.

A. Disclosure Without Consent

45 C.F.R. 164.512(j)	• Uses and Disclosures for Which Consent is Not Required
s. 394.4615, F.S.	• Clinical Records; Confidentiality
s. 395.3025(4), F.S.	• Patient and Personnel Records

Federal and state laws provide regulations for the protection and release of an individual's personal information. While consent is typically necessary to disclose information related to an individual's health, certain circumstances allow providers to disclose parts of an individual's protected health information without consent. For example, HIPAA dictates several procedures that must be followed to protect an individual's health information. Within those guidelines are circumstances that allow health care providers to disclose protected health information contained in the clinical record for the purposes of treatment, case management, and coordination of care.

Regardless of whether the information is being shared with a professional or another member of the individual's support system, when disclosing information without consent it is important to only share relevant information on a need-to-know basis.

Certain circumstances permit the disclosure of specific elements in an individual's clinical record without a signed release of information. This may occur when any of the following circumstances apply:

- An individual poses an imminent risk of significant physical harm to self or others and the disclosure of the information is necessary to improve safety and security.
- Information is used to directly assist in the evaluation or treatment of an emergency medical condition and the individual is either unable to provide consent or the time needed to obtain consent would be detrimental to their health.
- The individual is unable to consent or objects to treatment and has previously agreed to collateral contact with family members or friends.
- The individual is present and does not object to disclosure of information to those present, such as family members or close friends.
- The information is used to coordinate care between the individual's current treatment providers.
- The information is necessary for a new treatment provider to seamlessly continue services.
- An individual verbally agrees to have the information released.
- Disclosure is made to an individual's personal representative.
- There is a request for information by the individual's attorney.
- There is a request for information by law enforcement to locate a missing person.
- There is a request for information by law enforcement to locate a suspect, fugitive, or material witness and the individual is not in a designated receiving facility or state mental health treatment facility.
- There is a court order, warrant, subpoena, or summons for the records.
- Information is released about an individual when he or she is in the custody of the Department, the Department of Juvenile Justice, or the Department of Corrections.

- The records are being reviewed for an external audit by an oversight, governing, or accrediting agency such as the Department, AHCA, or the Joint Commission.
- There is a request for compensation from a third-party payor such as an insurance agency.
- The records are being reviewed for an internal audit such as risk management or quality assurance.

These circumstances override what is typically considered to be best practice in disclosing protected health information. The information disclosed should be limited to include only the amount necessary to achieve the desired outcome.

1. Law Enforcement Officers

HIPAA only governs what are classified as "covered entities" and their business associates. A covered entity is identified as any health care provider, health plan, or health care clearinghouse that electronically transmits health care information. Law enforcement agencies are not considered a covered entity and are not subject to HIPAA regulations.

Law enforcement agencies are, however, subject to state privacy laws and agency policies regarding the disclosure of an individual's identifiable health care data. The only exception applies to law enforcement officers who work in a correctional system where an individual's health information is still regulated by HIPAA.

A non-professional, such as a family member or friend, may provide as much information as they want without a release even though the professional may not be able to verify or comment on what is being said to them.

Information directly related to the Baker Act is protected and confidential and is not part of the public record. This includes information that is related to any of the following elements:

- The initiation of an involuntary examination.
- Transportation or transfer between receiving facilities or treatment facilities.
- The elopement of an individual from a facility.
- Other information that can identify the individual and their involvement with an involuntary examination or as receiving services at a designated receiving facility or state mental health treatment facility.

A law enforcement officer's incident report is public record even when it documents an incident that led to the initiation of an involuntary examination. The information contained in the incident report may be identical to that which is contained in the Report of a Law Enforcement Officer (CF-MH 3052a).

Since HIPAA does not apply to law enforcement, officers may provide information that cannot be provided by workers in the health care industry. For example, a law enforcement officer may tell a family member that the individual is being sent to a receiving facility for an involuntary examination; however, the facility will not be able to confirm or deny that information without the consent of the individual.

2. Emergency Situations

42 C.F.R. 489	• Emergency Medical Treatment and Labor Act
s. 401.445, F.S.	• Emergency Examination and Treatment of Incapacitated Persons
s. 394.4615, F.S.	• Clinical Records; Confidentiality
ch. 65E-5.250, F.A.C.	• Clinical Records; Confidentiality

There are certain conditions that dictate when protected health information can be disclosed as well as when treatment can be provided without the individual's consent. This kind of disclosure pertains to an individual who is experiencing an emergency medical condition and one or more of the following conditions apply:

- The individual is incapacitated and unable to provide consent.
- The individual is incompetent and unable to determine whether consent would be useful.
- The process of obtaining consent would waste valuable time that is necessary in providing critical health care services.

These circumstances often occur when an individual needs potential life-saving treatment. Proceeding without consent may involve the delivery of necessary treatment and the disclosure of the individual's current condition and location.

Disclosing this information may be required to gather vital collateral information about the individual's medical or psychiatric history if the individual is unable to provide that information. This may occur when treatment involves a trauma or medical emergency alert. Florida has protections in place for several medical professionals, such as physicians, medical technicians, and paramedics, who provide treatment to incapacitated individuals who are unable to provide consent for themselves.

a. EMTALA

The disclosure of information in emergency medical situations is governed by federal legislation under the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA states that if the individual is experiencing an emergency medical condition, information regarding their emergency condition may be disclosed without consent. This typically applies when medical information is shared between providers but may also apply to information provided to family members, close friends, emergency contacts, or other individuals that might be involved in the individual's care, if such disclosure is deemed in the individual's best interest. More information on EMTALA can be found in chapter 13 and the online course *Emergency Medical Treatment: Florida's Baker Act and Marchman Act.*

b. Imminent Danger

Information regarding a physical threat can be disclosed to the person who is the subject of the threat when it is reasonably believed the person is in imminent danger. When this notification is provided by a professional, it is often referred to as a 'duty to warn.' Florida law requires disclosure for threats of significant physical harm against another; however, many professional codes of ethics also require that the person is made aware of the threat made against them.

In addition, if it is believed that a vulnerable individual is in imminent danger due to abuse or neglect, it must be reported to The Florida Abuse Hotline. Everyone in Florida is considered a mandated reporter if it is believed that a child or vulnerable adult is being abused or neglected. More information about the duty to warn and mandated reporters can be found in chapter 13.

An individual may encounter barriers that make it difficult to engage in treatment and follow his or her treatment plan. The lack of engagement may occur for several reasons including transportation and financial constraints, stigma, or the belief treatment is ineffective or unnecessary. These reasons may contribute to the individual behaving in a way that places themselves or others in imminent danger. In these instances, a clinician may disclose limited information if the individual receiving services is believed to be in imminent danger and it appears to be in the best interest to inform a family member. For example, if an individual has missed an outpatient appointment or series of outpatient appointments and the clinician believes that the individual may be in imminent danger, the clinician may contact a family member and provide them with enough information to help reduce the threat. Information provided could include identifying an individual's current symptoms that the clinician believes could be placing the individual or others around them at risk of significant physical harm.

3. **Continuity of Care**

   a. **Providers**

   Florida laws allow for an appropriate disclosure to internal and external service providers for continuity of care without consent. Appropriate disclosure includes releasing only the information that is necessary for that provider to deliver an enhanced quality of care. Obtaining written consent is considered best practice whenever possible, even when an individual's consent is not required. For example, an individual referred to another provider for services after discharge is often requested to sign a release of information. Basic information can be disclosed to the referring provider to assist with continuity of care without a release. There may be some situations when obtaining consent is not advised including situations that may jeopardize someone's safety. This would include not notifying the individual when making an abuse report or warning someone who is the subject of a direct physical threat made by the individual receiving services.

   b. **Transfers**

   Some individuals require a transfer between inpatient or residential health care facilities like transfers that occur between receiving facilities or treatment facilities. These transfers require sharing an individual's protected health information. For example, an individual that is being transferred between facilities may not be asked to sign a release of information since sharing information between providers is allowed for continuity of care. Designated receiving facility transfers can sometimes occur at the discretion of the sending facility and does not require the consent of the individual.

III. Individual's Access to Personal Health Information

45 C.F.R. 164.524	• HIPAA Right of Access
s. 394.4615(10), F.S.	• Clinical Records, Confidentiality, and Access to Own Record
Form CF-MH 3110	• Restriction of Persons Access to Own Record

State and federal laws stipulate that individuals have the right to access most of the information in their personal health record upon request to the service provider. Access is restricted only if it is reasonably believed that the information would be harmful to the individual in their current state. Florida identifies parameters for individuals who would like to review their clinical record in a facility. If it is determined that such review would likely be detrimental to the individual's well-being, then a physician can restrict access (CF-MH 3110). The individual must be notified of the restriction in writing. The restriction, and its justification, must be documented in the clinical record. A single restriction can last up to seven (7) days and, if necessary, be renewed in subsequent seven (7) day increments.

Federal laws also recognize an individual's right to review their own medical record. HIPAA states that individuals should have easy access to the information in the clinical record that is used to make their health care decisions. This includes most of the information contained in the clinical record. For example, information used for internal audits, peer reviews, and administrative or legal proceedings are not used to make decisions about an individual's health care and, therefore, are not typically filed in the clinical record or accessible by the individual. Psychotherapy and progress notes are also not required to be disclosed during an individual's review of their record. When releasing records to another provider, these notes are not considered to be a principal part of the clinical record and require a specific authorization for release.

Appendix

Appendices A–K

Appendix A.
Oversight Organizations

Agencies Providing Oversight Under the Baker Act

Following is a list of agencies and their role in providing oversight to the Baker Act process.

Table A.1 Baker Act

Oversight Organization	Description	Contact Information
Department of Children and Families (Department) Office of Substance Abuse and Mental Health (SAMH)	As Florida's mental health authority, the Department provides licensure to substance use treatment facilities and designations for receiving facilities through their Office of Substance Abuse and Mental Health (SAMH). The Department provides information about the Baker Act including current forms, information on designated receiving facilities, and free online trainings. Along with AHCA, the Department also monitors all mental health services throughout the state and investigates complaints regarding designated Baker Act receiving facilities, not exclusively substance use treatment centers.	Florida Department of Children and Families Office of Substance Abuse and Mental Health 2415 N. Monroe Street, Suite 400 Tallahassee, FL 32303 Phone: 850-487-1111 https://www.myflfamilies.com/ service-programs/samh/
Office of Substance Abuse and Mental Health (SAMH) Regional Offices	The Department's SAMH division has six regional offices. These offices, with assistance from the MEs, handle various coordination and procedural issues. These offices perform several functions including oversight to Crisis Stabilization Units (CSUs) for both adults and children and Short-term Residential Treatment Centers (SRTs), State Hospital admissions and discharges, diversion efforts, and recovery-oriented system of care (ROSC) principles. The SAMH local office also provides designations to private facilities (which do not receive public funds) to hold and treat individuals under the Baker Act. Local SAMH offices issues licensure for private substance use treatment centers.	Florida Department of Children and Families Office of Substance Abuse and Mental Health 2415 N. Monroe Street, Suite 400 Tallahassee, FL 32303 Phone: 850-487-1111 http://www.myflfamilies.com/ contact-us https://www.myflfamilies.com/ service-programs/samh/managing- entities/
MEs	The Department contracts with MEs. In 2008, Florida enacted legislation that authorized MEs to oversee the daily operations of behavioral health services. MEs contract with agencies that provide an array of services, including emergency, outpatient, and residential services. Seven MEs serve the Department's six SAMH regions. MEs strive to organize the most effective and streamlined system of care throughout the counties they serve in their respective districts.	Refer to the Department's MEs webpage to locate contract information for your local ME.
State of Florida Division of Administrative Hearings	The Division of Administrative Hearings is responsible for cases when an individual is petitioned for continued involuntary inpatient placement. Filings for continued involuntary inpatient placement must include all the following documentation: • A justifying statement from the individual's physician or clinical psychologist • A brief description of treatment that has occurred during involuntary placement The continued plan of treatment	Division of Administrative Hearings The De Soto Building 1230 Apalachee Parkway Tallahassee, FL 32399-3060 Phone: 850-488-9675 Fax: 850-921-6847 https://www.doah.state.fl.us/ALJ/

Table A.2 Confidentiality

Oversight Organization	Description	Contact Information
Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS)	The Office for Civil Rights investigates violations related to the Health Insurance Portability and Accountability Act (HIPAA).	Office for Civil Rights Southeast Region 61 Forsyth Street SW Atlanta, GA 30303-8909 Customer Response Center: 800-368-1019 TDD: 800-537-7697 Fax: 202-619-3818 ocrmail@hhs.gov http://www.hhs.gov/ocr/privacy/psa/complaint/index.html https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Table A.3 Individual Rights

Oversight Organization	Description	Contact Information
Florida Abuse Registry	Managed by the Department, the Florida Abuse Registry processes incoming alleged reports of abuse, neglect, and exploitation of vulnerable persons. This includes populations of children, older adults, and individuals with a disability. For the duration of time an individual is receiving services at a designated receiving facility or state mental health treatment facility they are automatically considered to be a vulnerable person. In addition, many individuals receiving behavioral health services receive disability benefits.	Abuse Hotline: 800-96-ABUSE (800-962-2873) Florida Relay: 711 TTY: 800-955-8771 Fax: 800-914-0004 https://reportabuse.dcf.state.fl.us/ http://www.myflfamilies.com/ service-programs/abuse-hotline/ report-online
Disability Rights Florida	Disability Rights Florida works to ensure that individuals with a disability are being treated fairly. More information on *Disability Rights Florida* can be found in chapter eight (8).	Disability Rights Florida 2473 Care Dr. Suite 200 Tallahassee, FL 32308 Phone: 850-488-9071 Toll Free: 800-342-0823 TDD: 800-346-4127 Fax: 850-488-8640 http://www.disabilityrightsflorida.org/contact/contact_info
Americans with Disabilities Act (ADA)	The Americans with Disabilities Act is federal legislation that protects individuals from discrimination due to a disability. More information on the *Americans with Disabilities Act* can be found in chapter eight (8).	Southeast ADA Center Atlanta Office: 404-541-9001 Federal Office: 800-514-0301 http://adasoutheast.org/ http://www.adasoutheast.org/se_region/se_regionTemplate.php?st=FL

Table A.4 Oversight Agencies Including Licensure and Accreditation

Oversight Organization	Description	Contact Information
Agency for Health Care Administration (AHCA)	AHCA provides licensing for all hospitals, CSUs, and residential treatment centers throughout the state. AHCA provides monitoring for all of Florida's mental health services. This includes procedures relating to the Baker Act statutes and rules such as individual rights, standards of care, and procedures governing admissions, examination, and transfers. AHCA also ensures that hospitals are complying with federal regulations under the Centers for Medicare and Medicaid Services, such as the Emergency Medical Treatment and Labor Act (EMTALA). In addition to EMTALA complaints, AHCA investigates complaints about health care facilities for which they provide direct oversight. This includes handling reports and investigations of sentinel or other adverse events. AHCA also handles complaints regarding a provider engaging in business activities for which they are not licensed. AHCA may employ FDOH to assist with investigations. If the complaint is not regarding a healthcare facility for which they provide oversight services, the complaint can be directed to FDOH. AHCA also handles several Medicaid inquiries and complaints including fraud and abuse reports, general Medicaid inquiries, and assistance to Medicaid recipients who have questions regarding their Medicaid plan. They also review refund denials from nursing homes and assisted living facilities.	AHCA 2727 Mahan Drive Tallahassee, FL 32308 AHCA Consumer Hotline for General Complaints: 888-419-3456 TDD: 800-955-8771 Online Complaint Form: http://www.ahca.myflorida.com/ MCHQ/Field_Ops/CAU.shtml Online Complaint Form for Medicaid Fraud and Abuse: https://apps.ahca.myflorida.com/ mpi-complaintform/
The Joint Commission (formerly known as JCAHO)	The Joint Commission is a non-profit organization that provides voluntary accreditation to hospitals and other health care facilities who choose to abide by their standards. Many facilities throughout Florida choose to be recognized by the Joint Commission giving them an additional set of standards and surveys they must abide by in order to maintain their accreditation.	The Joint Commission One Renaissance Blvd. Oakbrook Terrace, IL 60181 Customer Service: 630-792-5800 Fax: 630-792-5005
Commission on Accreditation of Rehabilitation Facilities (CARF)	CARF is a non-profit organization that provides accreditation to providers of health and human services. CARF provides accreditation to behavioral health providers including specific accreditation for opioid treatment programs.	CARF International 6951 East Southpoint Road Tucson, AZ 85756-9407 Phone: 888-281-6531 TTY: 520-495-7077 Fax: 520-318-1129
Florida Department of Health (FDOH)	FDOH reviews and investigates concerns regarding the professional conduct of licensed health professionals and licensed health care facilities including the following types of complaints. • Licensure, including individuals practicing without a license and health care facility licensure and complaints. • Balanced billing FDOH does not handle customer service complaints as there is no regulatory statute or rule to cover this type of grievance. The professional or organization the complaint is with may be contacted directly.	FDOH 4052 Bald Cypress Way, Bin C75 Tallahassee, FL 32399-3260 Complaint Line: 850-245-4125 Consumer Services: 850-245-4339 Fax: 850-488-0796 MQA.ConsumerServices@flhealth. gov Florida Health Care Complaint Portal https://www.flhealthcomplaint.gov/ http://www.floridahealth.gov/ licensing-and-regulation/ enforcement/ documents/ complaint-form-2015.pdf

Oversight Organization	Description	Contact Information
Office of Medical Quality Assurance at FDOH	The Office of Medical Quality Assurance regulates actions of certain professionals in the health care field. If there is a concern regarding a health care professional (other than nurses), a report can be made to the Office of Medical Quality Assurance. They also help advocate for individual rights and safety of individuals receiving health care services.	FDOH Office of Medical Quality Assurance 4052 Bald Cypress Way Tallahassee, FL 32399 Phone: 850-245-4444 Toll-Free: 888-419-3456 health@flhealth.gov License Verification: https://appsmqa.doh.state.fl.us/MQASearchServices/ HealthCareProviders
The Florida Board of Nursing	The Florida Board of Nursing accepts complaints, reviews, and investigates concerns regarding the professional conduct of and potential violations performed by an individual nurse or organization.	FDOH Office of Medical Quality Assurance 4052 Bald Cypress Way Tallahassee, FL 32399 Complaint Line: 850-245-4125 https://floridasnursing.gov/help- center/file-a-complaint/ Verify a License: https://www.nursys.com/
The Florida Certification Board (FCB)	The Florida Certification Board (FCB) is a state- recognized, non-profit organization that certifies professionals in the areas of child welfare, addiction, mental health, and health. The FCB develops, administers, and regulates programs for over 30 health and human services professions. Professional development services are also provided that include online education related to Florida's Baker Act and Marchman Act.	The Florida Certification Board 1715 South Gadsden Street Tallahassee, FL 32301 Phone: 850-222-6314 Fax: 850-222-6247 Credential Verification: https://flcertificationboard.org/credentials/ File an Ethics Complaint: https://flcertificationboard.org/ policy-procedure/
Department of Business and Professional Regulation	Complaints can be made to the Department of Business and Professional Regulation against the professionals and organizations it regulates including independent living facilities and the illegal sales of alcohol and tobacco products. *Fraud complaints are handled by the* Florida Office of the Inspector General.	Department of Business and Professional Regulation 2601 Blair Stone Road Tallahassee, FL 32399-1027 Consumer Contact: 850-487-1395 Unlicensed Activity: 866-532-1440 http://www.myfloridalicense.com/ DBPR/division-of-regulation/ complaints/

Table A.5 Financial

Oversight Organization	Description	Contact Information
Florida Office of the Inspector General (OIG)	The Florida Office of the Inspector General (OIG) can be contacted with a request to conduct an investigation in an area such as abuse, fraud, misconduct, waste, and mismanagement of government resources in the State of Florida. The OIG also performs audits including those pertaining to compliance, performance, and financial accountability.	Florida Office of the Inspector General Capital Circle Office Complex 4052 Bald Cypress Way Bin #A03 Suite 210/220 Tallahassee, FL 32399-1704 Phone: 850-245-4141 Whistleblower Hotline: 800-543-5353 or 850-922-1060 Get LEAN Hotline: 800-GET-LEAN Fax: 850-413-8985 InspectorGeneral@flhealth.gov
Office of the Inspector General (OIG) at HHS	The federal Office of the Inspector General reviews complaints and warnings regarding potential health care fraud, abuse, and mismanagement. Authority ranges from Medicare and Medicaid fraud, kickbacks, abuse or neglect of a resident in a long-term care facility, and a hospital's failure to evaluate or stabilize an individual with an emergency medical condition. The Office of the Inspector General has the authority to warrant civil monetary sanctions for EMTALA violations.	U.S. Department of Health and Human Services Office of the Inspector General ATTN: OIG Hotline Operations P.O. Box 23489 Washington, DC 20026 Phone: 800-447-8477 (800-HHS-TIPS) TTY: 800-377-4950 https://www.oig.hhs.gov/fraud/ report-fraud/index.asp
Florida Department of Agriculture and Consumer Services	For complaints regarding general health care billing, including excessive charges for services provided, the Florida Department of Agriculture and Consumer Services can be contacted. They accept complaints in the following categories: • Continuing education providers • Insurance • Medical • Nursing homes and assisted living facilities • Social services	Florida Department of Agriculture and Consumer Services Plaza Level 10, The Capitol 400 S. Monroe Street Tallahassee, FL 32399-0800 Phone: 800-HELP-FLA (800-435-7352) En Español: 800-FL-AYUDA (800-352-9832) https://csapp.800helpfla.com/ CSPublicApp/Complaints/ FileComplaint.aspx
Centers for Medicare and Medicaid Services (CMS)	Providers who receive payment from Medicare or Medicaid must comply with the Conditions of Participation and Conditions for Coverage that are applicable to their program. Many behavioral health facilities, and most hospitals, accept Medicare; those that do not often accept Medicaid. CMS performs audits for those organizations to ensure that their standards are being complied with.	Centers for Medicare and Medicaid Region 4: Atlanta Office Office of the Regional Administrator Atlanta Federal Center 61 Forsyth St. SW Suite 4T20 Atlanta, GA 30303-8909

Florida Division of Consumer Services	The Florida Division of Consumer Services provides guidance and investigations into insurance complaints for insurance companies *other than* Medicaid. Medicaid complaints are processed separately and handled through AHCA.	Florida Division of Consumer Services 200 East Gaines St. Tallahassee, FL 32399-0322 Phone: 877-MY-FL-CFO (877-693-5236) Out of State: 850-413-3089 Consumer.Services@myfloridacfo. com https://apps.fldfs.com/ESERVICE/ Default.aspx

Table A.6 Medicaid

Oversight Organization	Description	Contact Information
Department of Children and Families	The Department offers many other services in addition to those provided through the mental health and substance abuse office including Medicaid eligibility, general information, and case status.	Florida Department of Children and Families Office of Substance Abuse and Mental Health 2415 N. Monroe Street, Suite 400 Tallahassee, FL 32303 Phone: 850-487-1111 https://www.myflfamilies.com/services/public-assistance
Agency for Health Care Administration (AHCA)	In addition to other oversight duties, AHCA also handles complaints regarding Medicaid fraud and abuse.	AHCA 2727 Mahan Drive Tallahassee, FL 32308 AHCA Consumer Hotline for General Complaints: 888-419-3456 TDD: 800-955-8771 Online Complaint Form for Medicaid Fraud and Abuse: https://apps.ahca.myflorida.com/ mpi-complaintform/

Oversight Authority Based on Specific Laws

Some of the key roles and responsibilities for different agencies and the primary oversight authority.

Table A.7 Emergency Medical Conditions

Oversight Provided for…	Oversight Organization and Legislation	Description
Conditions of Participation	Centers for Medicare and Medicaid (CMS) 42 C.F.R. 489.24(f)	Conditions of Participation apply to hospitals that provide emergency services and accept Medicare or Medicaid. Violations may result in sanctions including the termination of a participating hospital's Medicare or Medicaid provider agreement.
EMTALA Compliance and Disputes	AHCA 42 U.S.C. 1395dd 42 C.F.R. 489.24 s. 395.1041(5), F.S.	Monitors providers compliance with the Emergency Medical Treatment and Labor Act (EMTALA). This includes the authority to resolve all disputes related to EMTALA along with the ability to invoke licensing and monetary penalties.
EMTALA Violations	Office of the Inspector General (OIG) at HHS 42 C.F.R. 489.24(g)(3) 42 U.S.C. 1395dd(d)(1) 42 U.S.C. 1395dd(d)(3)	Authorized to invoke penalties for failure to examine or stabilize an individual with an emergency medical condition. These include the following penalties: • Civil monetary penalties to participating hospitals for EMTALA violations • Disciplinary action and fines to individual physicians who violate EMTALA
Individual Rights	Florida Statutes s. 394.463, F.S. s. 395.1041, F.S.	Provides State protection for individuals with emergency medical conditions to receive care, particularly in those facilities that do not meet EMTALA requirements.
Interfacility Transfers	Florida Statutes s. 395.1041, F.S. s. 394.4685, F.S. 42 U.S.C. 1395dd	Provides regulations for the transferring of individuals between facilities when the individual being transferred meets at least one of the following conditions: • Experiencing an emergency medical condition • Receiving services under involuntary status

Table A.8 Confidentiality

Oversight Provided for…	Oversight Organization and Legislation	Description
Confidentiality via the Health Insurance Portability and Accountability Act (HIPAA)	Office for Civil Rights (OCR) at HHS 42 U.S.C. 1320d-6 45 C.F.R. Part 160 45 C.F.R. Part 162 45 C.F.R. Part 164	Investigates complaints related to violations of: • The breach of privacy and security of health information under HIPAA. • Civil rights based on factors such as individual's sex, gender, race, and disability. • Conscience and religious freedoms.
Release of Information	AHCA	Creating forms for documenting the authorization for release of information.

Table A.9 Individual Rights

Oversight Provided for…	Oversight Organization and Legislation	Description
Access to Care Violations	AHCA	Responsible for ensuring that Floridians can appropriately access health care services and resources despite barriers that are protected by state and federal law such as the Americans with Disabilities Act.
Violations of Individual Rights	AHCA	AHCA, in collaboration with the Department's SAMH regional offices, ensures that individuals have their rights maintained while receiving services. Many areas of health care have individual rights outlined in the law including those receiving services in a designated receiving facility or state mental health treatment facility and residents of long-term care facilities.
Information and Advocacy for Individuals with Disabilities	Disability Rights Florida Americans with Disabilities Act (ADA)	Providing state education and advocacy working to ensure that individuals are receiving equal treatment despite experiencing an acute or chronic disability. Federal advocacy for individuals with disabilities providing protections in the areas of access to employment, government services, public buildings, telephonic communications, housing, and education.
Abuse Investigations of Vulnerable Populations	The Department in collaboration with local law enforcement	Reviews and investigates complaints of abuse, neglect, and exploitation when the subject of abuse, neglect, or exploitation is directed towards a member of a vulnerable population. This includes children, older adults, individuals with disabilities, and those receiving inpatient mental health services.
Abuse or Neglect of a Resident in a Long-Term Care Facility	Office of the Inspector General	Investigates mismanagement and misconduct in government programs and resources including kickbacks and Medicare and Medicaid fraud. The state office investigates the use of Florida's government resources while the national office investigates mismanagement and fraud at a national level.
Individual Rights and Safety	Office of Medical Quality Assurance at FDOH	Advocacy for safety and rights of individuals receiving services.

Table A.10 Seclusion and Restraint

Oversight Provided for	Oversight Organization and Legislation	Description
Behavioral Restraints	AHCA	Enforces the Centers for Medicare and Medicaid Federal Conditions of Participation for Behavioral Restraints and the Standards of The Joint Commission (formerly JCAHO) for Restraint Management.
Restraint and Seclusion Regulations	Centers for Medicare and Medicaid 42 C.F.R. 482.13	Part of the Conditions of Participation found in the section Patient Rights.
Restraint and Seclusion Reporting	The Department	Facilities must report each restraint and seclusion event to the Department in accordance with established reporting procedures.

Table A.11 Oversight Including Licensure and Accreditation

Oversight Provided for	Oversight Organization and Legislation	Description
Licensure for Health Care Facilities	AHCA, chapter 395, Florida Statutes, 59E, F.A.C.	Provides licensure for all Florida hospitals, CSUs, and residential treatment centers.
Designated Receiving Facilities	The Department	Provides designation for facilities to be able to accept individuals under the Baker Act's involuntary legal status and monitors them for ongoing compliance with applicable laws. Provides direct oversight to private designated receiving facilities.
Public Designated Receiving Facilities	MEs	Contracted through the Department, MEs provide direct oversight to public designated receiving facilities.
Licensure of Professionals	Office of Medical Quality Assurance at FDOH	FDOH provides licensure in a variety of health care professions including the following professions: • Clinical Social Workers • Mental Health Counselors • Marriage and Family Therapists • Psychologists • Advanced Practice Registered Nurses • Nurses including RN's, LPN's, and CNA's FDOH also oversees several facilities and systems including the following: • Pain management clinics • Nursing education programs • Trauma systems • Pharmacies Emergency medical services systems
Nursing Professionals	Florida Board of Nursing	Provides oversight to professional nurses and nursing organizations.
Certification for Health and Human Services Professionals	Florida Certification Board	The Florida Certification Board (FCB) is a state-recognized, non-profit organization that certifies professionals in the areas of child welfare, addiction, mental health, and health. The FCB develops, administers and regulates programs for over 30 health and human services professions. Professional development services are also provided that include online education related to Florida's Baker Act and Marchman Act.

Oversight Provided for…	Oversight Organization and Legislation	Description
Mental Health Services	The Department and AHCA	Provides oversight for all the mental health services delivered throughout the state including those delivered in inpatient, outpatient, and residential settings.
Substance Use Treatment Centers	The Department	Investigates complaints made against substance use treatment centers. The Department's local office also has the function of issuing the licensure for substance use treatment centers.
Health Care Facility Complaints	AHCA or FDOH	Provides investigations for facilities licensed under AHCA. This includes activity that a facility engages in that they have not been licensed for. Conducts investigations for facilities that are not licensed under AHCA.
Fraud	Florida Office of the Inspector General and AHCA	Both organizations investigate fraud complaints.

Table A.12 Financial

Oversight Provided for…	Oversight Organization and Legislation	Description
Health Care Billing	Florida Department of Agriculture and Consumer Services	Accepts complaints from consumers about health care charges, including excessive charges, for services provided.
Health Care Insurance	Florida Division of Consumer Services	Provides investigations and oversight for health care insurance complaints other than Medicaid.
Centers for Medicare and Medicaid Oversight	Centers for Medicare and Medicaid (CMS) and AHCA	Monitors providers compliance with federal regulations under the Centers for Medicare and Medicaid including the Conditions of Participation and the Emergency Medical Treatment and Labor Act (EMTALA).
Balanced Billing	FDOH	Investigates complaints about health care bills when it appears that the consumer is being billed more than the allowed amount. The amount a consumer may be billed is the difference between the provider's charge and the amount that the insurance company will pay.
Refund Denials from Nursing Home and Assisted Living Facilities	AHCA	Investigates denials for requests of refunds for payments.
Health Care Fraud	Office of the Inspector General (OIG)	Investigates mismanagement and misconduct in government programs and resources including kickbacks, Medicare and Medicaid fraud. The state office investigates the use of Florida's government resources while the national office investigates mismanagement and fraud at a national level.
Financial Audits	Office of the Inspector General (OIG)	Conducts financial, performance, and compliance audits. The state office investigates the use of Florida's government resources while the national office investigates mismanagement and fraud at a national level.

Table A.13 Medicaid

Oversight Provided for	Oversight Organization and Legislation	Description
Medicaid Eligibility, General Inquiries, Plan Questions, and Complaints including Fraud and Abuse Reporting	AHCA	AHCA answers general inquiries and questions regarding eligibility and specific plan benefits. AHCA also investigates complaints against Medicaid including those involving suspected fraud or abuse of the Medicaid system by a provider or consumer. This includes intentionally trying to manipulate the system so that payment is provided for services not rendered or to an individual who does not qualify for Medicaid benefits.

Table A.14 Other Facility and Provider Monitoring

Oversight Provided for	Oversight Organization and Legislation	Description
Baker Act Forms - Development	The Department	The Department's SAMH division provides oversight for the development and maintenance of Baker Act forms referenced in Florida law. These forms are usually part of rule, such as 65E-5, F.A.C.
Baker Act Forms - Data Collection	Baker Act Reporting Center at the University of South Florida	The Baker Act Reporting Center receives documents on behalf of the Department, collects the data received, and analyzes the data to produce reports. The Baker Act Reporting Center receives forms from receiving facilities initiating an involuntary examination which must be submitted within five (5) working days of receipt. Clerks of Court must also submit petitions and orders for both of the following: • Involuntary inpatient placement • Involuntary outpatient services along with accompanying treatment plans
Coordination of Mental Health Services	MEs	Contracted through the Department, MEs oversee daily operations of mental health services provided at all levels of care; MEs coordinate mental health services for public facilities only. They also work to coordinate and streamline services throughout a specific region to provide the most effective and efficient behavioral health care network possible.
Census Monitoring of Facilities	The Department	The Department monitors the census of facilities to ensure that they are within regulations. They can also assist with checking the census of a facility if there is a concern that the facility is not appropriately accepting transfers.
Funding	The Department	Provides funding for public receiving facilities and other programs that support Baker Act services.
Serious Patient Injury Reports and Trends	AHCA	AHCA, in collaboration with the Department, monitors and reviews serious injuries to individuals receiving services. They examine individual incidents as well as evaluate trends that may occur over a period of time in a single facility or region.
Complaint Investigations against Providers	AHCA	AHCA investigates complaints against providers of health care services.
Problem Resolution Programs	AHCA	Assists in finding solutions to complaints against AHCA licensed providers.
Medical Telecommunications and Transportation Violation Injunctive Relief and Civil Penalties	Florida Surgeon General s. 401.421, F.S.	The Florida Surgeon General may impose penalties for violations under the medical transportation services or emergency telecommunication system.
Illegal Sales of Alcohol and Tobacco Products	Department of Business and Professional Regulation	The Department of Business and Professional Regulation monitors and enforces violations related to the illegal sale of alcohol and tobacco products.

Appendix B.

Links to Important Resources

A list of all the links that were referred to in this guide are provided and listed by category.

Table B.1 Governing and Oversight Agencies

20 Judicial Circuit Courts	http://edr.state.fl.us/Content/area-profiles/criminal-justice-circuit/ circuits-map.png
Disability Rights Florida	http://www.disabilityrightsflorida.org/
Americans with Disabilities Act (ADA)	https://adata.org/find-your-region#region4 http://www.adasoutheast.org/se_region/se_regionTemplate. php?st=FL
Florida Department of Children and Families	
Abuse Reporting via the Florida Abuse Registry	https://reportabuse.dcf.state.fl.us/ http://www.myflfamilies.com/service-programs/abuse-hotline http://www.myflfamilies.com/service-programs/abuse-hotline/ report-online Child: https://reportabuse.dcf.state.fl.us/Child/ChildForm.aspx Adult: https://reportabuse.dcf.state.fl.us/Adult/AdultForm.aspx
Regions of the Department	http://www.dcf.state.fl.us/newsroom/media-guide/images/flmap.jpg http://www.myflfamilies.com/contact-us
MEs	https://www.myflfamilies.com/service-programs/samh/managing- entities/ http://www.usf.edu/cbcs/baker-act/for-consumers/managingentities. aspx https://www.myflfamilies.com/service-programs/samh/managing-entities/docs/ManagingEntitiesMap.pdf
Judicial Circuit Courts	http://edr.state.fl.us/Content/area-profiles/criminal-justice-circuit/ circuits-map.png
The Department's SAMH Website	http://www.myflfamilies.com/service-programs/samh
Designated Receiving Facilities and Baker Act Treatment Facilities	https://www.myflfamilies.com/service-programs/samh/crisis-services/docs/baker/Baker%20Act%20Receiving%20Faciliites.pdf
Baker Act User Reference Guide	https://www.myflfamilies.com/service-programs/samh/crisis-services/laws/BakerActManual.pdf https://www.myflfamilies.com/service-programs/samh/crisis- services/index.shtml

Florida Department of Children and Families	
Baker Act Forms	https://www.myflfamilies.com/service-programs/samh/crisis- services/baker-act-forms.shtml
Mental Health Advance Directive	https://www.myflfamilies.com/service-programs/samh/crisis- services/laws/mhadvdir.pdf
Frequently Asked Questions (FAQs)	https://www.myflfamilies.com/service-programs/samh/crisis- services/baker-act-faq.shtml
Online Courses	https://www.myflfamilies.com/service-programs/samh/crisis- services/training/index.shtml
Florida Medicaid	http://www.myflfamilies.com/service-programs/access-florida-food- medical-assistance-cash/medicaid
Baker Act Reporting Center	
Baker Act Reporting Center	https://www.usf.edu/cbcs/baker-act/
Louis de la Parte Florida Mental Health Institute (FMHI)	https://www.usf.edu/cbcs/fmhi/
Agency for Health Care Administration (AHCA)	
AHCA	http://ahca.myflorida.com/
Complaint Administration Unit	http://www.ahca.myflorida.com/MCHQ/Field_Ops/CAU.shtml
Medicaid Fraud and Abuse Online Complaint Form	https://apps.ahca.myflorida.com/mpi-complaintform/
The Joint Commission (formerly JCAHO)	
Behavioral Health Care Accreditation	https://www.jointcommission.org/facts_about_behavioral_health_care_accreditation/
Commission on Accreditation of Rehabilitation Facilities (CARF)	
Health and Human Services Accreditation	http://www.carf.org/About/WhoWeAre/
Florida Department of Health	
Medical Quality Assurance Services Licensing and Regulation	http://www.floridahealth.gov/licensing-and-regulation/index.html
License Verification	https://appsmqa.doh.state.fl.us/MQASearchServices/ HealthCareProviders
Florida Health Care Complaint Portal	https://www.flhealthcomplaint.gov/
Health Care Provider Complaint Form	http://www.floridahealth.gov/licensing-and-regulation/enforcement/_documents/complaint-form-2015.pdf
Florida Board of Nursing	
Florida Board of Nursing	https://floridasnursing.gov/
Verify a License	https://www.nursys.com/
File a Complaint	https://floridasnursing.gov/help-center/file-a-complaint/
Florida Certification Board	
Certification Site	https://flcertificationboard.org/
Credential Verification	https://adminfcb.cyzap.net/dzapps/dbzap.bin/apps/assess/webmembers/secure/manage?webid=FCB&pToolCode=cert- verify&pAdd=Yes

Florida Certification Board	
File an Ethics Complaint	https://flcertificationboard.org/policy-procedure/
Online Education Platform Training Site	https://fcbonline.remote-learner.net/
Florida Department of Business and Professional Regulation	
Verify a License	https://www.myfloridalicense.com/wl11.asp?mode=0&SID=
Complaints – Division of Regulation	http://www.myfloridalicense.com/DBPR/division-of-regulation/ complaints/
Florida Office of the Inspector General	
Florida Office of the Inspector General (OIG)	http://www.floridahealth.gov/about-the-department-of-health/ about-us/administrative-functions/inspector-general/index.html
Office of the Inspector General at HHS	https://www.oig.hhs.gov/
Report Fraud to HHS	https://www.oig.hhs.gov/fraud/report-fraud/index.asp
Florida Department of Agriculture and Consumer Services	
Division of Consumer Services	http://www.freshfromflorida.com/Divisions-Offices/Consumer- Services
File a Complaint	https://apps.fldfs.com/ESERVICE/Default.aspx
Consumer Complaint Form	https://csapp.800helpfla.com/CSPublicApp/Complaints/ FileComplaint.aspx
Centers for Medicare and Medicaid (CMS)	
Centers for Medicare and Medicaid	https://www.cms.gov/
Contact Information for Region 4	https://www.cms.gov/About-CMS/Agency-Information/ ContactCMS/index.html
Florida Medicaid	http://www.myflfamilies.com/service-programs/access-florida-food- medical-assistance-cash/medicaid
Conditions of Participation	https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/ Title42/42cfr482_main_02.tpl https://ecfr.io/Title-42/pt42.5.482#se42.5.482_113
The CMS Restraint Training Requirements Handbook	https://hcmarketplace.com/aitdownloadablefiles/download/aitfile/ aitfile_id/1880.pdf
Hospital Discharge Appeal Notices	https://www.cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices.html
US Department of Health and Human Services (HHS)	
HHS	https://www.hhs.gov/
Office of the Inspector General	https://www.oig.hhs.gov/
Report Fraud to HHS	https://www.oig.hhs.gov/fraud/report-fraud/index.asp
Office for Civil Rights (OCR)	
Office for Civil Rights (OCR)	https://www.hhs.gov/ocr/index.html
Florida Division of Elections	
Vote-by-Mail	https://dos.myflorida.com/elections/for-voters/voting/vote-by-mail/

Table B.2 Florida Statutes (F.S.)

Title XXIX: Public Health	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Index&Title_Request=XXIX#TitleXXIX
Mental Health	
Chapter 394: The Florida Mental Health Act	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0300-0399/0394/0394.html
Substance Use	
Chapter 397: Substance Abuse Services	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0300-0399/0397/0397.html
Other Key Legislation	
Chapter 393: Developmental Disabilities	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0300-0399/0393/0393.html
Chapter 395: Hospital Licensing and Regulation	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0300-0399/0395/0395.html
Chapter 400: Nursing Homes and Related Health Care Facilities	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0400/0400.html
Chapter 401: Medical Telecommunications and Transportation	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0401/0401.html
Chapter 415: Adult Protective Services	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0415/0415.html
Chapter 429: Assisted Care Communities	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0429/0429.html
Title XLIII: Domestic Relations	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Index&Title_Request=XLIII#TitleXLIII
Chapter 744: Guardianship	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0700-0799/0744/0744.html
Chapter 765: Health Care Advance Directives	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0700-0799/0765/0765.html
Chapter 825: Abuse, Neglect, and Exploitation of Elderly Persons and Disabled Adults	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0800-0899/0825/0825.html
Chapter 827: Abuse of Children	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0800-0899/0827/0827.html
Chapter 916: Mentally Ill and Intellectually Disabled Defendants	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0900-0999/0916/0916.html
Rule 5.900 Expedited Judicial Intervention Concerning Medical Treatment Procedures	https://floridarules.net/probate/rule-5-900-expedited-judicial-intervention-concerning-medical-treatment-procedures/

Table B.3 Florida Administrative Code (F.A.C.)

Chapter 65: The Department of Children and Families	https://www.flrules.org/gateway/Department. asp?toType=&DeptID=65
Mental Health	
Chapter 65E-4: Community Mental Health Regulation	https://www.flrules.org/gateway/ChapterHome. asp?Chapter=65E-4
Chapter 65E-5: Mental Health Act Regulation	https://www.flrules.org/gateway/ChapterHome. asp?Chapter=65E-5
Substance Use	
Chapter 65D-30: Substance Abuse Services Office	https://www.flrules.org/gateway/ChapterHome. asp?Chapter=65D-30
Other Behavioral Health Legislation	
Chapter 65E-9: Licensure of Residential Treatment Centers	https://www.flrules.org/gateway/ChapterHome. asp?Chapter=65E-9
Other Behavioral Health Legislation	
Chapter 65E-10: Psychotic and Emotionally Disturbed Children – Purchase of Residential Service Rules	https://www.flrules.org/gateway/ChapterHome. asp?Chapter=65E-10
Chapter 65E-12: Public Mental Health CSUs and Short-Term Residential Treatment Programs	https://www.flrules.org/gateway/ChapterHome. asp?Chapter=65E-12
Chapter 65E-14: Community Substance Abuse and Mental Health Services – Financial Rules	https://www.flrules.org/gateway/ChapterHome. asp?Chapter=65E-14

Table B.4 Other Key Legislation

Florida Attorney General Advisory Legal Opinions	http://myfloridalegal.com/ago.nsf/Opinions
Tarasoff v. Regents of the University of California	https://scocal.stanford.edu/opinion/tarasoff-v-regents-university- california-30278
Use of Restraint in Mental Health Treatment Facilities	https://www.dcf.state.fl.us/admin/publications/cfops/CFOP%20 155-xx%20Mental%20Health%20-%20Substance%20Abuse/ CFOP%20155-21,%20Use%20of%20Restraint%20in%20 Mental%20Health%20Treatment%20Facilities.pdf
Joint Commission Standards on Restraint and Seclusion/Nonviolent Crisis Intervention Training Program	https://www.crisisprevention.com/CPI/media/Media/ Resources/alignments/Joint-Commission-Restraint-Seclusion- Alignment-2011.pdf
National Patient Safety Goals	https://www.jointcommission.org/standards_information/npsgs. aspx

Table B.5 Federal Legislation: United States Code (U.S.C.) and Code of Federal Regulations (C.F.R.)

HIPAA	
42 U.S.C. 1320 Part C: Health Insurance Portability and Accountability Act (HIPAA)	http://uscode.house.gov/view.xhtml?req=(title:42%20 section:1320c%20%20edition:prelim)
42 C.F.R. Part 2: Confidentiality of Alcohol and Drug Abuse Patient Records	https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/ Title42/42cfr2_main_02.tpl
HIPAA Regulations and Guidance	https://www.cms.gov/Regulations-and-Guidance/Administrative- Simplification/HIPAA-ACA/index.html
HIPAA Privacy Rule	https://www.hhs.gov/hipaa/for-professionals/privacy/laws- regulations/index.html
HIPAA Security Rule	https://www.hhs.gov/hipaa/for-professionals/security/laws- regulations/index.html
HIPAA Administrative Simplification Rule	https://www.hhs.gov/sites/default/files/hipaa- simplification-201303.pdf
Patient Identifiers	https://www.hhs.gov/hipaa/for-professionals/privacy/special- topics/de-identification/index.html
How to File a Confidentiality Complaint with the Office for Civil Rights	http://www.hhs.gov/ocr/privacy/psa/complaint/index.html https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
EMTALA	
42 U.S.C. 1395dd: Examination and Treatment for Emergency Medical Conditions and Women in Labor (EMTALA)	http://uscode.house.gov/view.xhtml?req=(title:42%20 section:1395dd%20edition:prelim)
42 C.F.R. 489.24: Special Responsibilities of Medicare Hospitals in Emergency Cases	https://ecfr.io/Title-42/se42.5.489_124
42 C.F.R. 489.20: Basic Commitments	https://ecfr.io/Title-42/se42.5.489_120
CMS State Operations Manual Appendix V Interpretive Guidelines for Responsibilities of Medicare Participating Hospitals in Emergency Cases	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf
Other Key Federal Legislation	
42 C.F.R. 482: Conditions of Participation for Hospitals	https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/ Title42/42cfr482_main_02.tpl
Family Educational Rights and Privacy Act (FERPA)	https://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html
Protection of Pupil Rights Amendment (PPRA)	https://studentprivacy.ed.gov/faq/what-protection-pupil-rights- amendment-ppra

Table B.6 Terms, Definitions, and Criteria

Definitions: Baker Act	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_ Statute&URL=0300-0399/0394/Sections/0394.455.html
Criteria for Voluntary Admission	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_ Statute&URL=0300-0399/0394/Sections/0394.4625.html
Criteria for Involuntary Examination	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_ Statute&URL=0300-0399/0394/Sections/0394.463.html

Table B.7 Individual Rights

Patient's Bill of Rights	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_ Statute&URL=0300-0399/0381/Sections/0381.026.html
Individual Rights	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_ Statute&URL=0300-0399/0394/Sections/0394.459.html https://www.flrules.org/gateway/ruleno.asp?id=65E-5.140
Disability Rights Florida	http://www.disabilityrightsflorida.org/
Americans with Disabilities Act (ADA) Southeast Center	http://www.adasoutheast.org/se_region/se_regionTemplate. php?st=FL
Developmental Disabilities Bill of Rights	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_ Statute&URL=0300-0399/0393/Sections/0393.13.html http://uscode.house.gov/view.xhtml?req=(title:42%20 section:15002%20edition:prelim)
Residents Rights for Nursing Homes	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_ Statute&URL=0400-0499/0400/Sections/0400.022.html
Residents Bill of Rights for Assisted Care Communities	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_ Statute&URL=0400-0499/0429/Sections/0429.85.html
Rights of Forensic Clients	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_ Statute&URL=0900-0999/0916/Sections/0916.107.html
Restriction on Firearm Purchases	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_ Statute&URL=0700-0799/0790/Sections/0790.065.html

Table B.8 Developmental Disabilities

Developmental Disabilities	https://www.cdc.gov/ncbddd/developmentaldisabilities/index. html
Developmental Disabilities Bill of Rights	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_ Statute&URL=0300-0399/0393/Sections/0393.13.html http://uscode.house.gov/view.xhtml?req=(title:42%20 section:15002%20edition:prelim)
Involuntarily Admission to Residential Services	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_ Statute&URL=0300-0399/0393/Sections/0393.11.html
Intermediate Care Facilities for Developmentally Disabled Persons	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_ Statute&Search_String=&URL=0400-0499/0400/0400PARTVCon tentsIndex.html

Table B.9 Substitute Decision-Making

Proceedings Relating to Children	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0000-0099/0039/0039.html
Florida Guardianship Law	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0700-0799/0744/0744.html
Discharge of Guardian	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0700-0799/0744/Sections/0744.643.html
Florida Health Care Surrogate Act	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0700-0799/0765/0765.html
Mental Health Advance Directives	https://www.nrc-pad.org/states/florida/

Table B.10 Long-Term Care

Nursing Homes and Related Care Facilities	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0400/0400.html
Residents Rights for Nursing Homes	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0400/Sections/0400.022.html
Comparison of Assisted Living vs. Nursing Homes	https://www.skillednursingfacilities.org/resources/compare-to-assisted-living/
Assisted Care Communities	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0429/0429.html
Residents Bill of Rights for Assisted Care Communities	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0429/Sections/0429.85.html
Adult Family Care Homes	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0429/0429PARTIICon tentsIndex.html
Adult Day Care Centers	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0429/0429PARTIIICo ntentsIndex.html

Table B.11 Department of Veteran's Affairs (V.A.)

U.S. Department of Veteran's Affairs: How to Apply for Health Care Benefits	https://www.vets.gov/health-care/apply/
U.S. Department of Veteran's Affairs: Florida Locations	https://www.va.gov/directory/Guide/state.asp?dnum=ALL&STATE=FL
U.S. Department of Veteran's Affairs: Health Care Benefits Eligibility	https://explore.va.gov/health-care https://www.vets.gov/health-care/eligibility/
VA Benefits Guide	http://floridavets.org/resources/va-benefits-guide/ https://www.benefits.va.gov/TAP/docs/VA-Benefits-Participant-Guide.pdf
Benefits and Services	http://floridavets.org/benefits-services/

Benefits Delivery at Discharge	https://www.benefits.va.gov/PREDISCHARGE/claims-pre- discharge-benefits-delivery-at-discharge.asp
Emergency Care in Non-VA Facilities	https://www.tampa.va.gov/patients/emergency-care.asp
Guide to VA Mental Health Services for Veterans & Families	https://www.mentalhealth.va.gov/docs/MHG_English.pdf

Table B.12 Other Important Information

Crisis Intervention Team - About	http://cit.memphis.edu/aboutCIT.php
Crisis Intervention Team Training – Florida	https://www.flsheriffs.org/law-enforcement-programs/training/ crisis-intervention-team
De-Escalation Tips	https://www.crisisprevention.com/Blog/June-2011/De-escalation- Tips
Federal Firearms Prohibition	https://www.atf.gov/file/58791/download
Federal Requirements and Regulatory Provisions Related to Dementia Care & the Use of Antipsychotic Drugs	http://theconsumervoice.org/uploads/files/issues/ltccc- antipsychotic-drugs-oversight-ftags-2.pdf
Florida Attorney General Advisory Legal Opinion on Physician Assistants and the Baker Act	http://myfloridalegal.com/ago.nsf/Opinions/71F977AFC82AE8EC85257459006F292A
Florida Firearms Disqualifiers Forms	https://www.myflfamilies.com/service-programs/samh/crisis-services/laws/Mental%20Health%20Firearm%20Disqualifiers%20 Training%20-%20Sample%20Forms.pdf
Florida Health Care Association	http://www.fhca.org/
Florida Telecommunications Relay	https://www.ftri.org
Foreign Nationals	http://www.fdle.state.fl.us/OGC/Foreign-Nationals
Mental Status Exam	https://wchsa.org/wp-content/uploads/2017/04/brief_mental_status_exam.pdf
National Association of Social Workers Code of Ethics	https://www.socialworkers.org/About/Ethics/Code-of-Ethics/ Code-of-Ethics-English
Quality Credentialing Program Best Practice Tool: Behavior Management/Aggression Control Involuntary Baker Act Guidelines	http://www.fhca.org/members/qi/clinadmin/bakeract.pdf
The CMS Restraint Training Requirements Handbook	https://hcmarketplace.com/aitdownloadablefiles/download/aitfile/ aitfile_id/1880.pdf
Students with Emotional/Behavioral Disabilities	http://www.sednetfl.info/ http://www.fldoe.org/academics/exceptional-student-edu/ese- eligibility/emotional-behavioral-disability-e-bd.stml

Appendix C.

Laws Related to the Baker Act

Florida Baker Act laws and rules are found in the Florida Statutes and F.A.C. respectively. The Florida legislature passes statutes into law then grants authority to state agencies to create corresponding rules to help define and interpret the law.[1] It is important to be familiar with both.

The Florida Mental Health Act, commonly referred to as the Baker Act, is governed by Part I of chapter 394, Florida Statutes, and chapter 65E-5 of the F.A.C. Rules for CSUs and short- term residential facilities can be found in chapter 65E-12 of the F.A.C.

Table C.1 Laws and Rules

Laws	Rules
Specific Law	Corresponding rules supporting existing laws providing additional details, enforcement, and regulation.*
Makes Laws	Enforces Laws
State	
Statute (F.S. - Florida Statutes)	Rule (F.A.C. - Florida Administrative Code)
Enacted by the legislative branch, including the Florida Senate and the Florida House of Representatives.	Enacted by the executive branch, including Florida's Governor and Attorney General.
Federal	
U.S. Code (U.S.C.)	Code of Federal Regulations (C.F.R.)

* Note: not every statute has a corresponding rule

The Florida Mental Health Act (Baker Act) overlaps with several statutes and rules in other areas of the law. These will only be referred to in specific examples where the statutes and rules from different sections of the law directly impact the Baker Act. However, there may be other instances that are not mentioned in this guide where laws from other chapters of federal or state law has overlapping authority with the Baker Act. The Baker Act is established in chapter 394, Florida Statutes, and implemented through chapter 65E in the F.A.C. Below is a figure showing how statutes and rules will be referenced in this guide.

Table C.2 Mental Health Statutes and Rules

The following are some of the key statutes and rules to be aware of when considering Florida behavioral health laws.

Primary Florida Statutes and Rules Related to Mental Health

Legislation	Title and Description	Short Title
394, F.S.	Mental Health	Florida Mental Health Act or The Baker Act
65E-5, F.A.C.	Mental Health Act Regulation	
65E-12, F.A.C.	Public Mental Health CSUs and Short- Term Residential Treatment Programs	

Table C.3 Related Mental Health Laws

There are also several laws that do not apply directly to mental health but instead refer to common co-occurring conditions that an individual with a mental health condition may also be experiencing.

Other Florida Statutes Related to Mental Health

Legislation	Title and Description	Short Title
393, F.S.	Developmental Disabilities	
397, F.S.	Substance Abuse Services	Hal S. Marchman Alcohol and Other Drug Services Act

Appendix D.

Baker Act and Marchman Act Comparison Overview

This table provides a brief overview of the similarities and differences between the Baker Act and Marchman Act. For more information on the Baker Act and Marchman Act, please refer to the online courses *Introduction to the Baker Act* and *Marchman Act Basics* respectively.

Table D.1 Similarities Between the Baker Act and Marchman Act

The Baker Act and Marchman Act share several legal similarities that parallel each other.

Similarities	Mental Health Baker Act	Substance Use Marchman Act
Imminent Risk	The individual is engaging in behaviors that pose an imminent physical risk to themselves or others that could potentially and reasonably result in significant physical injury or death.	
Legal Status	Both the Baker Act and the Marchman Act allow individuals to receive services on either a voluntary and involuntary basis. • Individuals can sign in for voluntary services at the time of admission or to continue services voluntarily after an involuntary examination has been initiated • Individuals who are unable or unwilling to sign in voluntarily for services must be discharged once they no longer meet criteria for involuntary examination or placement • Individuals receiving services may transfer legal status multiple times during a single admission to a facility. Most individuals only experience one change of legal status (from involuntary to voluntary), if any at all • The court may order an individual to receive involuntary outpatient services	
Individual Rights	Those individuals receiving voluntary and involuntary Baker Act or Marchman Act services have nearly identical rights. All individuals, regardless of legal status (voluntary or involuntary), have rights while receiving services. These rights focus largely on the right to treatment and individual dignity. Individuals must be made aware of their rights upon admission including posting a copy of these rights in an area that is readily accessible to individuals receiving services.	
No-Wrong-Door Approach	In 2016 the Florida Legislature enacted chapter 2016-241, Laws of Florida creating a more comprehensive and seamless system of care by further aligning and coordinating the behavioral health system of services. Chapter 2016-241, Laws of Florida, includes the no-wrong-door provision identifying that if an individual seeks services with a health care organization or facility that cannot meet their needs, that individual will be directed to a more appropriate provider that can address the identified treatment goals.	
Central Receiving Facility	In line with the no-wrong-door model in chapter 2016-241, Laws of Florida, central receiving facilities are available in select parts of the state delivering integrated behavioral health assessment services. An adult experiencing a behavioral health crisis may go to a central receiving facility if they have either a mental health or substance use condition; some individuals may have both. The central receiving facility will assist in providing voluntary and involuntary assessment, stabilization, and treatment for both mental health and substance use conditions and route the individual to the most appropriate provider.	
Advance Directives & Substitute Decision-Makers	Both the Baker Act and Marchman Act recognize advance directives as one method an individual may use to express their preferences and intentions in the event they are unable to clearly communicate due to incompetence or incapacitation. This may be through written documentation or the designation of a substitute decision-maker. A substitute decision-maker may be someone the individual has previously identified as someone they would like to make their decisions or may be someone that the court appoints.	
	More information on substitute decision- making can be found in the online course *Guardian Advocate and the Baker Act.*	More information on substitute decision-making can be found in the online course *Guardian Advocate and the Marchman Act.*

Table D.2 Differences Between the Baker Act and Marchman Act

Despite their similarities, there are several differences between the Baker Act and the Marchman Act.

Differences	Mental Health Baker Act	Substance Use Marchman Act
Legislation	Chapter 394, Florida Statutes, 65E-5, F.A.C.	Chapter 397, Florida Statutes, 65D-30, F.A.C.
Facilities	• The Department designates Baker Act receiving facilities. There is a designated receiving facility located in about half of Florida's counties. A listing of all the designated receiving facilities is posted online. • All individuals who have an involuntary examination initiated will go to a designated receiving facility or a medical hospital for medical clearance. • Designated receiving facilities that receive funding from the Department for services are considered public facilities while those that do not receive funds from the Department are referred to as private facilities. Some public designated receiving facilities are classified as CSUs; those that exclusively serve minors are Children's Crisis Stabilization Units (CCSUs).	• The Department maintains a list of designated Marchman Act receiving facilities that is provided to each municipal and county public safety office. • The individual may be admitted to a hospital, a licensed detoxification facility, or an addictions receiving facility for emergency assessment and stabilization. If the individual does not meet criteria for admission, they may be directed to a less intensive component of a licensed service provider for assessment only.
Criteria	To meet criteria, behaviors must be primarily based on the symptoms of a mental health condition resulting in an examination at a designated receiving facility for voluntary or involuntary services.	Criteria for voluntary or involuntary admission is based primarily on the behaviors associated with the use, intoxication, or withdrawal of a substance.
	Remember, an individual may be actively experiencing symptoms of both a mental health condition and a substance use condition. Identifying the source of the symptoms will determine whether the Baker Act or Marchman Act is more appropriate.	
Initiation of Involuntary Services	An individual can have involuntary services initiated under both the Baker Act and Marchman Act in several ways including qualified professionals, law enforcement officers, and a court order.	
Qualified Professionals	Any of the following qualified professionals may initiate a Baker Act by completing a Certificate of a Professional. • Psychiatrist • Physician • Clinical Psychologist • Psychiatric Nurse • Clinical Social Worker • Mental Health Counselor • Marriage and Family Therapist • Physician Assistant	Any of the following qualified professionals may initiate a Marchman Act when an individual meets the criteria for involuntary admission. • Psychiatrist • Physician • Clinical Psychologist • Advanced Practice Registered Nurse • Psychiatric Nurse • Clinical Social Worker • Mental Health Counselor • Marriage and Family Therapist • Physician Assistant • Master's Level Certified Addictions Professional

Law Enforcement Officers	Law Enforcement Officers must initiate a petition for involuntary examination if the individual appears to meet criteria by completing a Report of a Law Enforcement Officer.	Law Enforcement Officers may initiate a protective custody order (CF-MH 4002) with or without the individual's consent. The law enforcement officer may bring the individual to a licensed detoxification or addictions receiving facility, a hospital emergency department, or the county jail where the individual may be held civilly for up to eight (8) hours.
Courts	A petition may be filed with the local Circuit or County Court for a hearing requesting the initiation of involuntary services via an ex-parte order.	Anyone who has personal knowledge of the individual's substance use may petition the court for a hearing requesting the initiation of involuntary services (if the individual is a minor, this petition must be filed by a parent).
Transportation	Once petitioned for an involuntary examination an individual must be transported by local law enforcement or a medical transport service. The transport method will be determined by law enforcement personnel on scene and the county's transportation plan. Self-transportation or transportation by a family member is not allowed once an individual is petitioned for an involuntary examination.	An individual, once petitioned for an examination by a qualified professional, may be transported by local law enforcement, a transportation provider under contract with the county, or a family member. If law enforcement initiates protective custody, law enforcement is tasked with completing the transport.
Law Enforcement Drop-Offs	Designated receiving facilities must accept any individual that has an involuntary examination initiated and is transported to the designated receiving facility by a law enforcement officer or another accepted mode of transport as identified in the county's approved Transportation Plan.	Facilities that qualify to provide Marchman Act services may deny acceptance of an individual for a substance use assessment or treatment even if the individual is transported to the facility by a law enforcement officer.
Minors	A minor may only sign in for voluntary services in a designated receiving facility once a court hearing has verified that the minor is able and willing to provide express and informed consent and a parent is also in agreement with the voluntary admission.	Minors may be voluntarily admitted to a Marchman Act facility without a court hearing or the permission of a parent.
Facility Security	All individuals receiving services in a designated receiving facility or state mental health treatment facility must be admitted to a locked unit regardless of whether they are on voluntary or involuntary legal status.	Marchman Act facilities often are not locked and the individual may be able to leave the facility on their own volition.

Receiving Involuntary Services	Individuals who have an involuntary examination initiated or are under petition for involuntary placement must receive services at a designated receiving facility or state mental health treatment facility. The only exceptions occur under one of the following conditions: • If the court orders continued involuntary outpatient treatment in which case the individual may go to an outpatient program or provider that is not affiliated with a designated receiving facility or state mental health treatment facility • The individual needs medical clearance and is either initially transported to or later transferred to a general medical hospital for examination or treatment	Individuals who have been ordered to involuntary services under the Marchman Act may go to a number of facilities. These include the following facilities: • Addictions receiving facilities • Medical hospitals, often accessed through an emergency department • Detoxification facilities • Local jails on a civil basis until intoxication is no longer posing an imminent risk or further examination can occur Individuals may also be court ordered to involuntary assessment or involuntary treatment. These may take place at inpatient settings, residential facilities, or with an outpatient provider
Co-Occurring Disorders	Many individuals in a designated receiving facility or state mental health treatment facility also have a substance use condition. The substance use should be identified on the treatment plan even if deferred to an outpatient provider. Some designated receiving facilities have specialized units that simultaneously focus on the treatment of both mental health and substance use symptoms and behaviors.	Marchman Act facilities are primarily focused on issues regarding substance use in their treatment. In fact, they are limited in their ability to provide mental health treatment.
Central Receiving System	In line with No-Wrong-Door model, central receiving facilities are available in select parts of the state delivering integrated behavioral health assessment services. An adult experiencing a behavioral health crisis may go to a centralized receiving facility if they have either a mental health or substance use condition; some individuals may have both. The central receiving facility will assist in providing voluntary and involuntary assessment, stabilization, and treatment for both mental health and substance use conditions and route the individual to the most appropriate provider.	

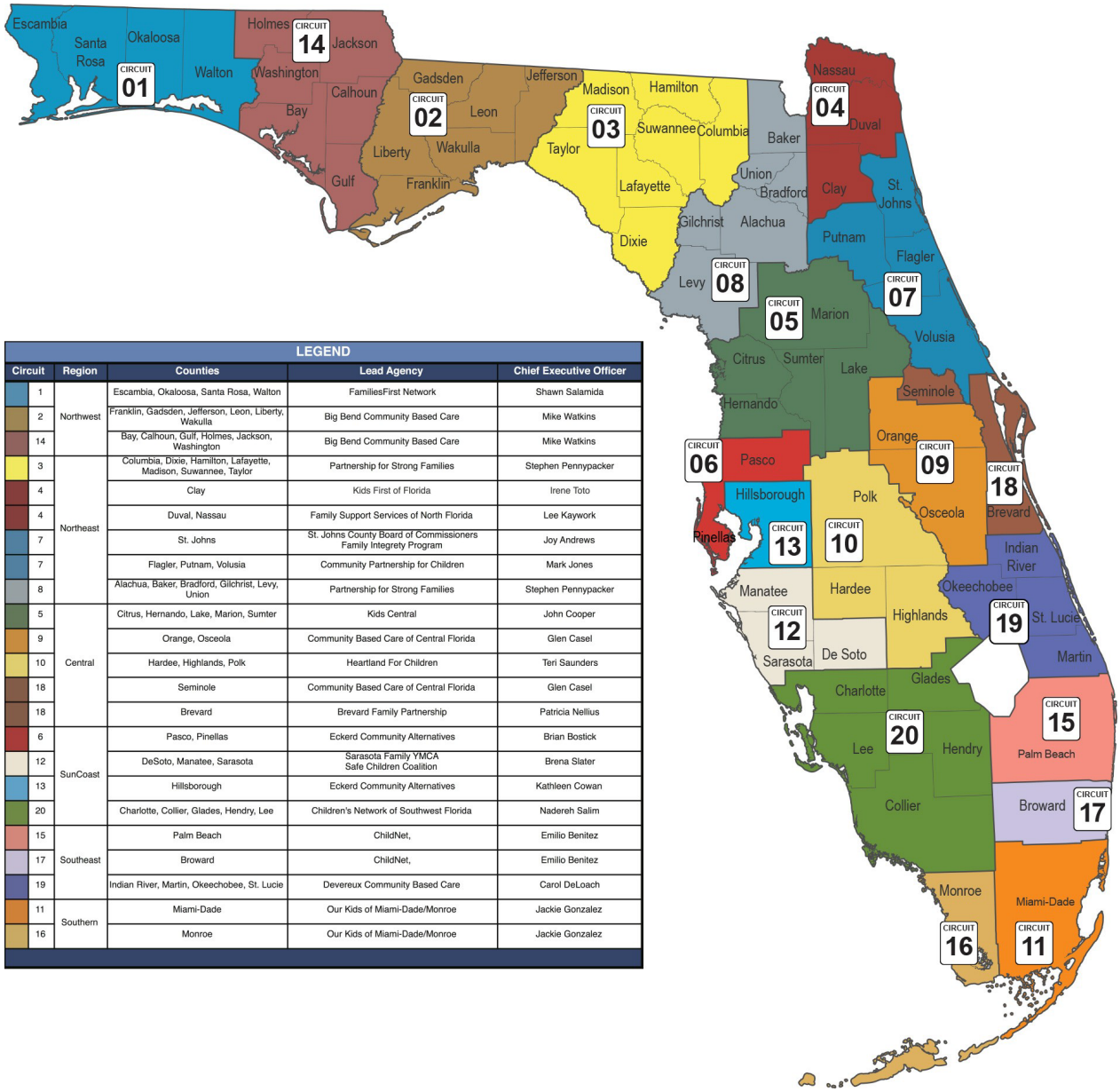
Appendix E.

Regions and Districts

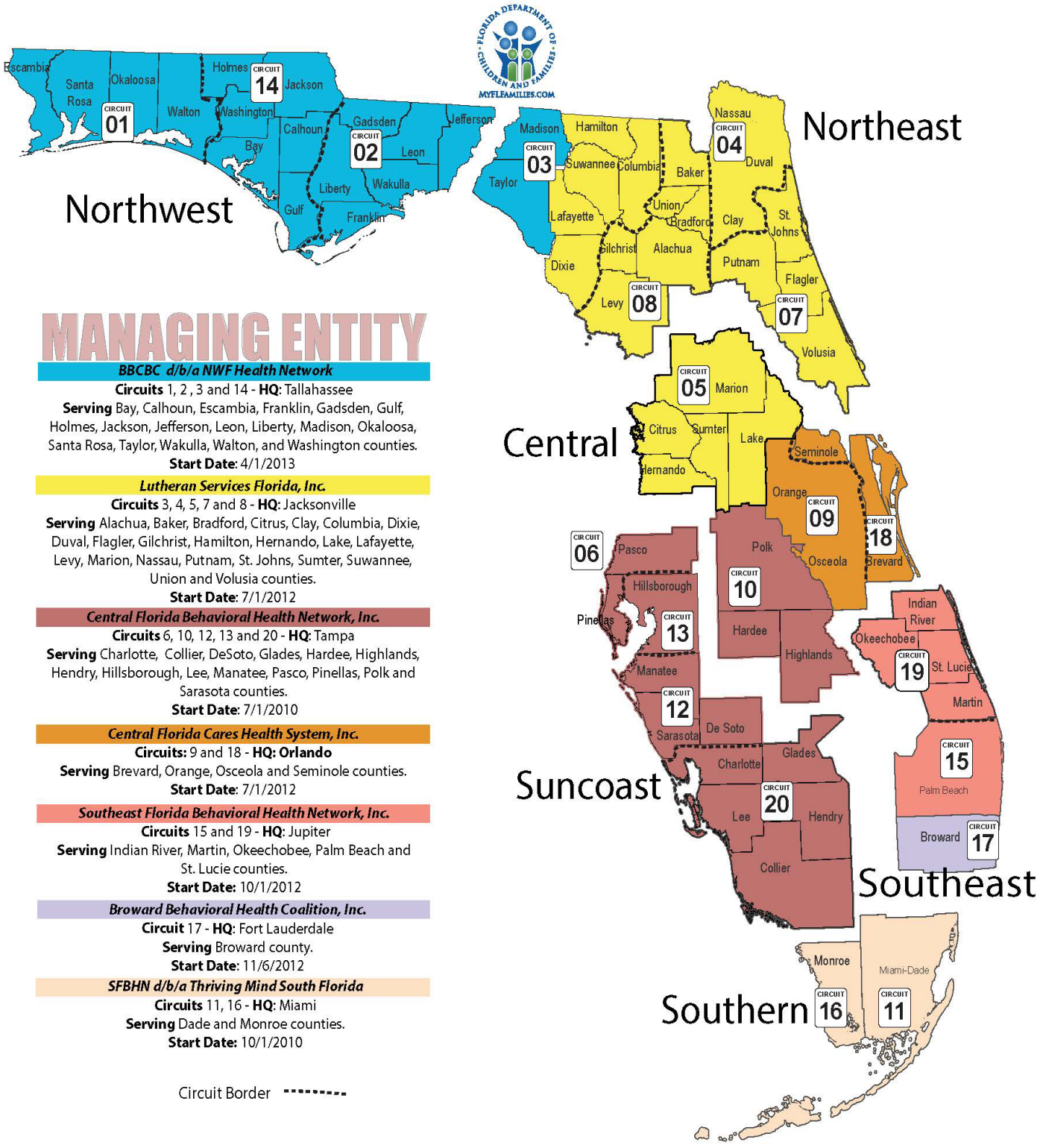
The Department is organized in different regions and districts through regional offices, MEs, and circuit courts.

Figure E.1 Regions of the Department and Judicial Circuits Map

The Department manages their services by regional areas based on Judicial Circuits. Florida's 20 Judicial Circuit Courts oversee Baker Act hearings in their respective districts. The map below displays the regions of the Department and their respective judicial circuits.



LEGEND				
Circuit	Region	Counties	Lead Agency	Chief Executive Officer
1	Northwest	Escambia, Okaloosa, Santa Rosa, Walton	FamiliesFirst Network	Shawn Salamida
2		Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla	Big Bend Community Based Care	Mike Watkins
14		Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Big Bend Community Based Care	Mike Watkins
3	Northeast	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families	Stephen Pennypacker
4		Clay	Kids First of Florida	Irene Toto
4		Duval, Nassau	Family Support Services of North Florida	Lee Kaywork
7		St. Johns	St. Johns County Board of Commissioners Family Integrety Program	Joy Andrews
7		Flagler, Putnam, Volusia	Community Partnership for Children	Mark Jones
8		Alachua, Baker, Bradford, Gilchrist, Levy, Union	Partnership for Strong Families	Stephen Pennypacker
5	Central	Citrus, Hernando, Lake, Marion, Sumter	Kids Central	John Cooper
9		Orange, Osceola	Community Based Care of Central Florida	Glen Casel
10		Hardee, Highlands, Polk	Heartland For Children	Teri Saunders
18		Seminole	Community Based Care of Central Florida	Glen Casel
18		Brevard	Brevard Family Partnership	Patricia Nellius
6	SunCoast	Pasco, Pinellas	Eckerd Community Alternatives	Brian Bostick
12		DeSoto, Manatee, Sarasota	Sarasota Family YMCA Safe Children Coalition	Brena Slater
13		Hillsborough	Eckerd Community Alternatives	Kathleen Cowan
20		Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida	Nadereh Salim
15	Southeast	Palm Beach	ChildNet,	Emilio Benitez
17		Broward	ChildNet,	Emilio Benitez
19		Indian River, Martin, Okeechobee, St. Lucie	Devereux Community Based Care	Carol DeLoach
11	Southern	Miami-Dade	Our Kids of Miami-Dade/Monroe	Jackie Gonzalez
16		Monroe	Our Kids of Miami-Dade/Monroe	Jackie Gonzalez



MANAGING ENTITY

BBCBC d/b/a NWF Health Network

Circuits 1, 2 , 3 and 14 - **HQ**: Tallahassee
Serving Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington counties.
Start Date: 4/1/2013

Lutheran Services Florida, Inc.

Circuits 3, 4, 5, 7 and 8 - **HQ**: Jacksonville
Serving Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union and Volusia counties.
Start Date: 7/1/2012

Central Florida Behavioral Health Network, Inc.

Circuits 6, 10, 12, 13 and 20 - **HQ**: Tampa
Serving Charlotte, Collier, DeSoto, Glades, Hardee, Highlands, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk and Sarasota counties.
Start Date: 7/1/2010

Central Florida Cares Health System, Inc.

Circuits: 9 and 18 - **HQ: Orlando**
Serving Brevard, Orange, Osceola and Seminole counties.
Start Date: 7/1/2012

Southeast Florida Behavioral Health Network, Inc.

Circuits 15 and 19 - **HQ**: Jupiter
Serving Indian River, Martin, Okeechobee, Palm Beach and St. Lucie counties.
Start Date: 10/1/2012

Broward Behavioral Health Coalition, Inc.

Circuit 17 - **HQ**: Fort Lauderdale
Serving Broward county.
Start Date: 11/6/2012

SFBHN d/b/a Thriving Mind South Florida

Circuits 11, 16 - **HQ**: Miami
Serving Dade and Monroe counties.
Start Date: 10/1/2010

Circuit Border ---------

Table E.3 Managing Entities Contact Information

Managing Entity		Counties Served	Region	Circuit Courts
Big Bend Community Based Care DBA NWF Health Network	525 North Martin Luther King Jr. Blvd. Tallahassee, FL 32301 (850) 410-1020 http://www.bigbendcbc.org	Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington	Northwest	01 02 03 14
Broward Behavioral Health Coalition	3521 West Broward Blvd., Suite 206, Lauderhill, FL 33312 (954) 622-8121 http://www.bbhcflorida.org	Broward	Southeast	17
Central Florida Behavioral Health Network	719 US Highway 301 South Tampa, FL 33619 (813) 740-4811 http://www.cfbhn.org	Charlotte, Collier, DeSoto, Glades, Hardee, Highlands, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, and Sarasota	Suncoast	06 10 12 13 20
Central Florida Cares Health System	707 Mendham Blvd., Ste. 201 Orlando, FL 32825 (407) 985-3560 http://centralfloridacares.org/	Brevard, Orange, Osceola, and Seminole	Central	09 18
Lutheran Services Florida	9428 Baymeadows Rd. Building III, Suite 320 Jacksonville, FL 33256 (904) 900-1075 http://www.lsfnet.org	Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia	Northeast	03 04 05 07 08
South Florida Behavioral Heath Network DBA Thriving Mind South Florida	7205 Corporate Center Dr. Ste. 200 Miami, FL 33126 (305) 858-3335 https://www.thrivingmind.org/	Miami-Dade and Monroe	Southern	11 16
Southeast Florida Behavioral Health Network	1070 E. Indiantown Rd. Ste. 408 Jupiter, FL 33477 (561) 203-2485 https://sefbhn.org/	Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie	Southeast	15 19

Appendix F.

Criteria for Initiation of Services and Legal Status

Table F.1 Advance Directives vs. Substitute Decision-Maker

The following table highlights some of the key differences between an advance directive and a substitute decision-maker.

Authority	Description	Examples
Advance Directive	Documents that are completed when an individual is competent to provide express and informed consent and outline the individual's wishes if they are unable to communicate them in times of incapacity or incompetence.	Living Will Mental Health Advance Directive Do Not Resuscitate Order (DNR)
Substitute Decision-Maker	Persons that make decisions for an individual based on what the person believes the individual would have chosen or, when unknown, what is believed to be in the individual's best interest. The extent of authority that the substitute decision- maker is granted is identified either in a written advance directive previously completed by the individual, Florida Statute, or a court order. The authority may be inclusive of all decisions (plenary) or explicitly designated to only specific areas of decision-making (limited).	Health Care Surrogate or Proxy Guardian Guardian Advocate

Table F.2 Individuals with Substitute Decision-Makers

Minors and individuals who have a substitute decision-maker, such as those who reside in a long-term care facility or have a full-time caregiver at home, will almost uniformly be involuntary when receiving services at a Baker Act facility. The following table will help clarify some of the circumstances when special populations receive voluntary or involuntary services in a Baker Act facility.

Competent	Voluntary	Involuntary
Minors	A minor must undergo a hearing verifying voluntariness including ability and willingness to provide express and informed consent AND the minor's parent will need to consent to the minor receiving voluntary services in a Baker Act facility.	Most minors will be admitted to a Baker Act Facility under involuntary status. Due to inpatient psychiatric hospitalizations urgency, taking additional time to wait for a court hearing may increase the risk of the situation.

<table>
<tr><td>Individual Residing in Long-Term Care Facility</td><td colspan="2">Relevant for individuals residing in a facility licensed under either chapter 400 or chapter 429, Florida Statutes. These include facilities such as an assisted living facility, skilled nursing home, and group home. These residents must, unless residing in an independent living apartment, have one of the following two documents present upon arrival to a designated receiving facility:
A petition for involuntary examination initiated by either a qualified professional, law enforcement officer, or ex parte order of the court prior to arriving at the receiving facility
An independent expert examination certifying competence
If a facility licensed under chapter 400 or chapter 429, Florida Statutes, sends a resident to a designated receiving facility without the initiation of an involuntary examination or an independent expert examination of competence, the receiving facility must report the sending facility to AHCA no later than the next working day.
An individual who was deemed competent through an independent expert examination may still revoke consent or refuse services. Like any other individual receiving voluntary services, if the individual meets criteria for involuntary examination or involuntary placement, the individual may be transferred to involuntary status.</td></tr>
<tr><td></td><td>Voluntary admissions may only take place after the individual undergoes an independent expert examination. The professional qualified to perform the examination must determine that the individual is competent to provide express and informed consent before the individual is eligible to sign in for voluntary services.</td><td>These individuals will almost always receive Baker Act services under involuntary status. This includes the duration of their services from admission to discharge even if both the individual and the substitute decision-maker were to agree to receive services voluntarily.</td></tr>
<tr><td>Substitute Decision- Maker</td><td>If an individual's competence to provide express and informed consent for mental health services is restored, and the rest of the criteria for voluntary services are met, then the individual can begin to receive voluntary services in a Baker Act facility.</td><td>Any individual who receives services in a Baker Act facility with an active substitute decision- maker for mental health services must receive services under involuntary status.</td></tr>
</table>

Appendix G.
Time Frames

Florida law specifies time frames when certain actions are required to be completed. Sanctions may apply, or an individual may be released from a facility prior to stabilization, if required time frames are not met. Some of the most common time frame requirements are listed below.

Table G.1 Designated Receiving Facilities

Statutes & Administrative Rule	Occurrence	Follow-Up Action…	Reported to…
394.463(2)(a)	Arrival of an adult or minor to a designated receiving facility for involuntary examination	Paperwork initiating involuntary examination (Certificate of a Professional, Report of a Law Enforcement Officer, or Ex Parte Court Order) along with the form Transportation to a Receiving Facility and the required cover sheet.	Baker Act Reporting Center within five (5) working days.
394.4599(2)(c)	Arrival of a minor to a designated receiving facility for involuntary examination	Minor's parent must be notified of the minor's whereabouts immediately upon arrival. Facility must continue to attempt to make contact with the parent every hour for the first 12 hours and then once every 24 hours until confirmation of notification is made. Notification can be delayed up to 24 hours only when a report has been made to the central abuse hotline to investigate allegations of abuse or neglect involving the parent.	Parent
394.4625(1)(f) 394.463(2)(f)	Initial Mandatory Psychiatric Examination - Adults	Must be completed without unnecessary delay. Individuals admitted under voluntary status must have competency verified within 24 hours of admission.	
394.463(2)(g)	Initial Mandatory Psychiatric Examination - Minors	Within 12 hours of facility arrival.	
394.459(2)(c)	Initial Mandatory Physical Examination	Within 24 hours of arrival for any individual who remains at the facility for at least 12 hours.	

394.463(2)(g)	Involuntary Examination	Within the initial 72-hour period the facility must release the individual from the facility, transfer to voluntary status, or file for involuntary placement. If the individual is being petitioned for involuntary placement and the involuntary examination period ends on a weekend or holiday, the paperwork may be filed with the court the next working day, but all other requirements for filing must be met within the 72-hour time frame. If an individual requires medical clearance during the initial 72-hour examination period, the 72-hour clock can be suspended. The clock can be suspended as soon as the physician in the emergency department identifies that an emergency medical condition may exist and resumes when the physician provides medical clearance for the individual to transfer to a designated receiving facility.	Individual Presiding court
394.459(2)(e) 65E-5.160(2)(i)	Individualized Treatment Plan	An initial treatment plan must be created and signed within five (5) days of admission. A treatment plan must be completed for every individual admitted regardless of whether they are discharged before or after the five- day deadline. Treatment plan updates must occur no later than every 30 days for those individuals who continue to receive services in the facility.	Individual Treatment Team
394.4625(2)(b)	Refusal of Treatment while on Voluntary Status or Request for Release	Notification of a request for discharge, either through a Right to Release or refusal to consent to services, must be made to the physician or clinical psychologist within 12 hours of the request. Within 24 hours the individual must be released from the facility or determined to meet criteria for involuntary placement. Individuals who continue to receive services on involuntary status must have the proper paperwork filed with the court.	Individual
394.4625(5)	Petition for Involuntary Placement from Voluntary Status	The facility administrator must file a petition for involuntary placement for individuals on voluntary status who meet criteria for involuntary services and either request release or refuse treatment. The petition must be filed within two (2) court working days after the request for discharge or refusal of treatment. The individual must be transferred immediately from voluntary to involuntary status.	Presiding court

394.467(6)(a)1	Hearing for Involuntary Placement	A hearing for involuntary placement must occur within five (5) court working days from the time the petition is filed with the court. A continuance can be granted by the court for up to four (4) weeks.	
65E-5.2301(5) 65E-5.1703(6)	Petition for Adjudication of Incompetence to Consent and Appointment of Guardian Advocate	Within two (2) court working days of the determination that an individual is incompetent to consent to treatment a petition must be filed by the administrator of the facility. If this is following a second emergency treatment order within any seven (7) day period, the filing must occur on the next court working day.	Presiding court

65E-5.180(7)(d)2	Face-to-Face Examination Following Seclusion or Restraint	A face-to-face examination must occur with the individual within one (1) hour of initiation. This is typically performed by the physician; however, responsibilities may be delegated to a trained APRN, Physician Assistant, or Registered Nurse.	
65E-5.180(6)(d)	Investigation of Complaint	Formal and informal complaints must be investigated and completed within seven (7) days from the date of entry.	
65E-5.601(3)	Response to Grievance	A response to a grievance must be provided within 14 calendar days.	Individual
65E-5.1303(2)(d)	Assistance with Timely Aftercare Appointment	An individual discharging from a designated receiving facility or state mental health treatment facility shall have access to an aftercare appointment within seven (7) days of discharge.	Individual
65E-5.280(4)(c)	Medical Clearance Within Initial 72- hour Examination Period	If an individual requires medical clearance for a physical emergency medical condition, the 72-hour clock can be suspended while the emergency medical condition is being evaluated and treated. Then the clock restarts once the individual is medically cleared for transfer.	

Table G.2 Emergency Departments

Statutes & Administrative Rules	Occurrence	Follow-Up Action	Reported to
394.463(2)(i)	Examination for Medical Clearance of Individual with Newly Initiated Involuntary Examination	Individuals who have a newly initiated involuntary examination must be examined and released or transferred to a designated receiving facility within 12 hours of medical clearance.	

Table G.3 Involving Residents of Long-Term Care Facilities

Statutes & Administrative Rule	Occurrence	Follow-Up Action…	Reported to…
394.463(2)(b)	An individual who has originated from a facility that requires initiation of an involuntary examination prior to arrival at a designated receiving facility arrives on voluntary status. This includes residents of assisted- living and skilled nursing facilities.	If an individual is sent from a facility licensed under chapter 400 or chapter 429, Florida Statutes, without either initiation paperwork for an involuntary examination or an independent expert examination identifying that the individual is competent to provide express and informed consent, the sending facility must be reported.	The Department by the next working day. Notification must occur by certified mail or by email.
394.4625(1)(c)	Assessment for Voluntary Admission of Individual in Long-Term Care Facility	When an assessment for voluntary admission is requested to be completed on an individual who resides in a long-term care facility, such as a nursing home or assisted living facility, the assessment must be initiated within two (2) hours of the request. This request may be fulfilled by a mobile crisis response team or a licensed professional. If a member of the mobile crisis response team is not available, any licensed professional who is qualified to initiate an involuntary examination may perform the assessment as long as the professional is not employed by, and does not have any financial interest in, either the long-term care facility or the receiving facility where the individual would be transferred.	

Table G.4 Other Time Frames

Statutes & Administrative Rule	Occurrence	Follow-Up Action…	Reported to…
394.463(2)(a)3 65E-5.280(3)(a)	Initiation of a Petition for Involuntary Examination by a Qualified Professional	When a qualified professional initiates an involuntary examination they must have first-hand evidence to support the initiation. The certificate must be completed within 48 hours of the professional's face-to-face contact with that individual.	
394.463(2)(a)1	Execution of Ex Parte Order	An ex parte order must be implemented within the time frame specified in the order or, if no time is specified, within seven (7) days after the order is written.	

Appendix I.

Seclusion and Restraint

ch. 65E-5.180(7), F.A.C. • Right to Quality Treatment - Seclusion and Restraint

There are many effective techniques for de-escalating an individual who is verbally or physically acting out. Staff working in a designated receiving facility are required to first employ de-escalation techniques before utilizing any seclusion or restraint measures. De-escalation techniques should begin with non-physical interventions based on the individual's personal safety plan (CF-MH 3124).

De-escalation techniques will not always be effective. Sometimes additional measures are required to immediately protect the individual and those around them. The following checklist provides measures that can be used when de-escalation techniques are not effective.

Table I.1 Seclusion and Restraint Requirements

De-escalation techniques must be implemented and fail to provide adequate security prior to the implementation of seclusion or restraint.
Seclusion or restraint may be initiated when there is imminent danger of significant physical harm.
Seclusion or restraint should be initiated by the highest-level staff member with seclusion and restraint training; this staff member must be no less than a registered nurse.
A physical restraint may be initiated without a physician order; however, the physician must be notified as soon as possible. All other seclusion and restraint techniques must have an order prior to initiation. This order typically comes from a physician; however, it may also come from an Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) if within the bounds of their profession and permitted by the facility.
Orders may be called in to the facility and taken by a Registered Nurse who has personally evaluated the individual.
If seclusion or restraint is ordered by anyone other than the attending physician, the attending physician must be notified of the order as soon as possible.
Each order for seclusion and restraint must identify the behaviors prompting the order, the time limit for seclusion or restraint, and the behavior necessary to end seclusion or restraint.
For restraint orders, the type of restraint and the individual's position during the restraint must also be included in the order.
Individuals must be immediately notified of the behavior that prompted the seclusion or restraint and the behavior that is necessary to terminate the practice.
Individuals must be searched for unsafe and prohibited items immediately before or after the initiation of seclusion or restraint.
Individuals must be appropriately clothed and may not be in seclusion or restraint in a nude or semi-nude condition.
Facilities must have written policies and procedures identifying how an individual will be allowed to drink and toilet when requested.

Orders are time limited based on age: • Age 18 and over = 4 hours / Age 9-17 = 2 hours / Age 8 and under = 1 hour These orders may be renewed as needed with continued justification.
If seclusion or restraint is renewed for a consecutive 24 hours the ordering physician, APRN, or PA must assess the individual in person before any further orders are made. In addition, the facility administrator or designee must be notified of the ongoing seclusion or restraint.

Minors 12 years of age and younger who are restrained must have continuous face-to-face observation by trained staff for the first hour and then at least once every 15 minutes.
Individuals at least 13 years of age in seclusion shall be observed by trained staff at least once every 15 minutes. At least one observation per hour must be conducted by a nurse.
Individuals placed in restraint must have a nursing assessment as soon as possible and no later than 15 minutes after initiation. This assessment must include checking pulse, respiratory rate, and bodily position.
After the initial nursing assessment an individual in restraint must continue to be assessed, with vital signs and body positioning, at least once every half hour.
Within one hour of the initiation of seclusion or restraint an individual must have a face-to-face examination. This examination may be conducted by a physician or delegated to a Registered Nurse, APRN, or PA in accordance with facility policy. The date and time the examination is completed must be documented in the individual's clinical record.
If the face-to-face examination is not conducted by the physician, the attending physician must be notified as soon as possible after the evaluation is completed.
The face-to-face examination must review the individual's current and pre-existing medical and behavioral conditions and medications that may contraindicate seclusion or restraint.
The face-to-face examination must review the individual's medication and assess if there is a need for any medication changes.
The face-to-face evaluation must review the individual's physical position during restraint and determine if the head and torso need to be elevated.
If the face-to-face evaluation determines that the risks outweigh the benefits of seclusion or restraint the practice must be terminated immediately.
The individual must be evaluated by trained staff including reviewing vital signs with respiratory and circulatory status, skin integrity, any signs of injury, and any additional requirements as specified by facility policy.
Individuals must be provided with opportunities to have range of motion at least once every two (2) hours.
Each facility must have policies on how the body position of an individual will be checked to help provide the highest degree of comfort and dignity during the event.
Orders must be signed within 24 hours.
Any individual under the age of 18 who has seclusion or restraint initiated must have their parent notified of the practice as soon as possible and no later than 24 hours after initiation of each event. Date and time of notification, along with the staff member providing notification, must be documented in the clinical record.
Each observation will be documented in the individual's clinical record including the name of the staff member providing the observation.
Seclusion or restraint will be discontinued as soon as the individual no longer appears to pose an imminent physical danger even if there is still time remaining on the order.

Once released from seclusion or restraint the individual's physical condition shall be evaluated and documented by trained staff. Documentation must include the date and time of release and the name and title of the staff releasing the individual from seclusion or restraint.
After discontinuing seclusion or restraint a debriefing must occur with the individual to provide support and help deter future seclusion or restraint events. This debriefing should occur as soon as possible but no longer than 24 hours after release.
Each instance of seclusion or restraint must be documented in the individual's clinical record including the event that initiated the seclusion or restraint, attempts at de-escalation or other less restrictive interventions, name and title of the staff member that initiated the seclusion or restraint, the date and time seclusion or restraint was initiated and discontinued, that the individual was notified of the behavior that initiated the seclusion or restraint and the criteria for release, the individual's response, and rational for any continued use of seclusion or restraint.

After each event of seclusion or restraint the individual's safety plan shall be reviewed by the treatment team and updated as necessary including the effectiveness of any specific interventions that were attempted during the de-escalation, seclusion, or restraint. The use of these techniques shall also be documented in the individual's clinical record.
Staff involved in the seclusion or restraint shall review the event as soon as possible once the individual is released to evaluate the circumstances leading to the initiation, the use of de-escalation techniques, how to assist the individual with improved coping mechanisms, and staff response to the event. The review must be documented and provided to the facility's Seclusion and Restraint Oversight Committee.
Within two (2) working days following the individual's release from seclusion or restraint the treatment team must meet to review the circumstances leading to the initiation of seclusion or restraint. The treatment team must review the individual's treatment plan and safety plan and identify if any changes are needed to help prevent any future use of seclusion or restraint. This review shall be documented in the individual's clinical record and analyzed by the Seclusion and Restraint Oversight Committee.
The treatment team must review the effectiveness of interventions used during both de-escalation and the seclusion or restraint event. The treatment team shall identify if there are more appropriate interventions for the individual to help prevent future seclusion or restraint incidents.
The treatment team must review the individual's clinical record and search for any emerging patterns that led to the initiation or release from seclusion or restraint.
The treatment team must assess the impact the seclusion or restraint event had on the individual and provide any additional services as needed.
The Seclusion and Restraint Oversight Committee must review each instance of seclusion or restraint seeking to identify any patterns of use and if there are any additional interventions or practices that can be employed to reduce the frequency or duration of use.
Seclusion and restraint orders shall never be an as needed or standing order.

Appendix J.

Notifications

Several notifications are required under the Baker Act, such as when an individual has an involuntary examination initiated. Notifications often need to be made to the individual receiving services, substitute decision-makers, and the court. The following table identifies the most frequently required notifications. The forms can be found on the Department's website.

Table J.1 Initiation of Involuntary Examination

Action	Notification	Legal Status
CF-MH 3001 Ex Parte Order for Involuntary Examination s. 394.463(2)(a)1, F.S.	Notification is provided to the Department via the Baker Act Reporting Center. Must attach the required cover sheet and submit within five (5) working days of individual's arrival at the designated receiving facility.	Involuntary
CF-MH 3052a Report of Law Enforcement Officer Initiating Involuntary Examination s. 394.463(2)(a)2, F.S.	Notification is provided to the Department via the Baker Act Reporting Center. Must attach the required cover sheet and submit within five (5) working days of individual's arrival at the designated receiving facility.	Involuntary
CF-MH 3052b Certificate of Professional Initiating Involuntary Examination s. 394.463(2)(a)3, F.S.	Notification is provided to the Department via the Baker Act Reporting Center. Must attach the required cover sheet and submit within five (5) working days of individual's arrival at the designated receiving facility.	Involuntary

Table J.2 Post Facility Arrival and Admission

Action	Notification	Legal Status
Request for an Individual to Provide Emergency Contact Information	No notification is provided unless warranted by an emergency. *If there is evidence of either a guardian or guardian advocate the individual should be evaluated for exclusionary criteria. If exclusionary criteria is met, the individual will need to be transferred to involuntary status.*	Voluntary

Action	Notification	Legal Status
Request for an Individual to Provide Emergency Contact Information	Names, addresses, and phone numbers are requested for emergencies and other required notifications of the individual's guardian or guardian advocate. If neither apply, information for a personal representative is requested. When unable or unwilling to identify anyone, a personal representative will be chosen by the facility in the following order: • Health care surrogate via advance directive • Spouse • Adult child • Parent • Adult next of kin • Adult friend Unless the individual requests no notification is made, the facility must notify the individual's identified representative that the individual is being held involuntarily as soon as possible and within 24 hours of arrival. The individual cannot deny notification to their guardian.	Involuntary
CF-MH 3103 Rights of Persons	A copy of the completed documentation must be provided to all the following that apply: • Individual • Guardian • Guardian advocate • Representative • Health care surrogate • Health care proxy	All
CF-MH 3043 Inventory of Personal Effects	A copy of the completed documentation must be provided to all the following that apply: • Individual • Guardian • Guardian advocate • Representative	All

Action	Notification	Legal Status
CF-MH 3051a Notice of Person on Voluntary Status to Request Discharge from a Receiving Facility	A copy of the completed documentation must be provided to all the following that apply: • Individual • Guardian of a minor	Voluntary
CF-MH 3051b Notice of Person on Voluntary Status to Request Discharge from a Treatment Facility	A copy of the completed documentation must be provided to the individual receiving services. This notification must be made upon admission or transfer of legal status from Involuntary to Voluntary.	Voluntary

CF-MH 3036 Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances	A copy of the completed documentation must be provided to all the following that apply: • Individual • Guardian • Guardian advocate • Representative • Health care surrogate • Health care proxy	All
CF-MH 3045 Notice of Person's Admission for Involuntary Examination	A copy of the completed documentation must be provided to all the following that apply: • Guardian • Representative	Involuntary (Examination Only)
CF-MH 3052b Certificate of Professional Initiating Involuntary Examination s. 394.463(2), F.S.	The Department via the Baker Act Reporting Center. Must attach the required cover sheet and submit within one (1) working day if the individual was transferred from voluntary to involuntary status while admitted to the facility.	Voluntary → Involuntary
CF-MH 3049 Restriction of Communication or Visitors	A copy of the completed documentation must be provided to all the following that apply: • Individual • Guardian • Guardian advocate • Representative • Individual's attorney • Health care surrogate • Health care proxy	All
Arrival of a Minor to a Designated Receiving Facility s. 394.4599(2)(c), F.S.	A minor's parent must be notified immediately upon a minor's arrival at a designated receiving facility. If the parent is unable to be reached the facility must continue to attempt to notify the parent every hour for the first 12 hours. If there is no response for 12 hours, the notification attempts must continue once every 24 hours until there is confirmation that the parent is aware of the minor's whereabouts. Notification may only be delayed for up to 24 hours if a report has been made to the central abuse registry to investigate allegations of abuse or neglect and it is believed that delayed notification is in the child's best interest.	Involuntary
Employing Seclusion or Restraint Measures in Minors	When a minor has seclusion or restraint applied to them their parent must be notified.	All

CF-MH 3090 Petition for Writ of Habeas Corpus or for Redress of Grievances	A copy of the completed documentation must be provided to all the following that apply: • Individual • Guardian • Guardian advocate • Representative • Individual's attorney • Health care surrogate • Health care proxy	All

Action	Notification	Legal Status
CF-MH 3110 Restriction of Person's Access to Own Record	A copy of the completed documentation must be provided to all the following that apply: • Individual • Guardian • Guardian advocate • Representative • Individual's attorney	All
CF-MH 3119 Notification of a Facility's Non-Compliance (Pursuant to chapter 400, Florida Statutes)	Notification must be provided to the Department via the Baker Act Reporting Center. Notification must be made via certified mail or email within one (1) working day of occurrence. *Notification must be made via certified mail within one (1) working day of occurrence*.	All Arrives at designated receiving facility without paperwork for involuntary examination or an independent examination
State Mental Health Treatment Facility Arrival	Notification must be made by the next regular working day to the following persons: • Individual's guardian • Individual's guardian advocate • Individual's representative • Individual's attorney	Involuntary
Involuntary Services Provided to Citizens of Other Nations	Detainment by Florida Department of Law Enforcement, including the provision of involuntary services under the Baker Act as well as the appointment of a guardian for minors or incompetent adults who are citizens of another nation (often referred to as foreign nationals), requires notification to the national consulate where the individual holds citizenship. This notification must only inform the consulate of the detention; the reason for the detention remains confidential to maintain the individual's privacy.	Involuntary

Table J.3 Facility Transfers

Action	Notification	Legal Status
CF-MH 3046 Application for and Notice of Transfer to Another Receiving or Treatment Facility	When there is an application or completion of a transfer to another designated receiving facility or state mental health treatment facility following admission, the following must be notified: • Individual • Guardian • Guardian advocate • Representative • Individual's attorney *If transfer occurs prior to receiving admission orders this form does not need to be completed.*	All
CF-MH 3089 Transfer Evaluation (To a State Mental Health Treatment Facility)	When a Transfer Evaluation is completed, notification must be provided to the following entities: • Circuit Court • District Office of SAMH	Involuntary

Table J.4 Express and Informed Consent

Action	Notification	Legal Status
CF-MH 3022 Application for Appointment of Independent Expert Examiner	A copy of the completed documentation must be provided to all the following that apply: • Individual • Guardian • Representative	Involuntary
CF-MH 3106 Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of Guardian Advocate	A copy of the completed documentation must be provided to all the following that apply: • Circuit Court • Individual • Representative • Guardian advocate (current) • Guardian advocate (prospective) • Individual's attorney	Involuntary

Action	Notification	Legal Status
CF-MH 3107 Order Appointing Guardian Advocate	A copy of the completed documentation must be provided to all the following that apply: • Individual • Guardian advocate • Representative • Facility administrator • Individual's attorney	Involuntary

CF-MH 3108 Petition Requesting Court Approval for Guardian Advocate to Consent to Extraordinary Treatment	A copy of the completed documentation must be provided to all the following that apply: • Circuit Court • Individual • Guardian advocate • Representative • Individual's attorney • Facility administrator	Incompetent
CF-MH 3109 Order Authorizing Guardian Advocate to Consent to Extraordinary Treatment	A copy of the completed documentation must be provided to all the following that apply: • Individual • Guardian advocate • Individual's Attorney • Facility administrator	Incompetent
CF-MH 3122 Certificate of Person's Incompetence to Consent to Treatment and Notification of Health Care Surrogate/Proxy	A copy of the completed documentation must be provided to all the following that apply: • Individual • Health care surrogate • Health care proxy • Representative	Incompetent

Table J.5 Involuntary Inpatient Placement

Action	Notification	Legal Status
CF-MH 3021 Notice of Petition for Involuntary Placement	A copy of the completed documentation must be provided to all the following that apply: • Individual • Guardian • Guardian advocate • Representative • State attorney • Individual's attorney	Involuntary
CF-MH 3024 Notice of Petition for Continued Involuntary Inpatient Placement	A copy of the completed documentation must be provided to all the following that apply: • Individual • Guardian • Guardian advocate • Representative • Individual's attorney	Involuntary
CF-MH 3031 Order for Continued Involuntary Inpatient Placement or for Release	A copy of the completed documentation must be provided to all the following that apply: • Individual • Guardian • Guardian advocate • Representative • Individual's attorney • Facility administrator • AHCA via the Baker Act Reporting Center	Involuntary
Action	**Notification**	**Legal Status**
CF-MH 3032 Petition for Involuntary Inpatient Placement	A copy of the completed documentation must be provided to all the following that apply: • Individual • Guardian • Individual's attorney • Representative • State attorney • The Department	Involuntary

CF-MH 3035 Petition Requesting Authorization for Continued Involuntary Inpatient Placement	A copy of the completed documentation must be provided to all the following that apply: • Clerk of Court • Individual • Guardian • Guardian advocate • Representative • Individual's attorney • State Attorney's Office • Administrative Law Judge • The Department	Involuntary
CF-MH 3113 Notice to Court Request for Continuance of Involuntary Placement Hearing	A copy of the completed documentation must be provided to all the following that apply: • Individual • Guardian • Representative • Facility administrator • State attorney	Involuntary
Mental Competency (MECOM) Database	Referred to by the Clerk of Court within 30 days after the Order for Involuntary Placement or court order for firearm disability. Individuals listed in this database are prohibited from purchasing firearms or maintaining a concealed carry permit.	Involuntary Inpatient Placement

Table J.6 Discharge and Aftercare

Action	Notification	Legal Status
CF-MH 3038 Notice of Release or Discharge	Notification from the Provider's Administrator is given to all the following that apply: • Court that ordered treatment • Individual • Guardian • Guardian advocate • Representative • Individual's attorney • Person or court initiating involuntary exam	All

Table J.7 Involuntary Outpatient Placement

Action	Notification	Legal Status

CF-MH 3021 Notice of Petition for Involuntary Outpatient Placement This includes notification of the right to an independent expert examination.	A copy of the completed documentation must be provided to all the following that apply: • Individual • The Department • Guardian • Guardian advocate • Representative • Individual's attorney • State attorney	Involuntary
CF-MH 3033 Notification of Court of Withdrawal of Petition for Hearing on Involuntary Inpatient Placement or Involuntary Outpatient Placement	The following must be notified, via phone, within one (1) business day when a petition for involuntary inpatient placement or involuntary outpatient services is withdrawn:* • Clerk of Court • Individual • Guardian • Representative • Individual's attorney • (Assistant) State attorney **If determination to withdraw petition is made with less than 24 hours, notification must occur immediately*.	Involuntary → Voluntary
CF-MH 3113 Notice to Court of Request for Continuance of Involuntary Placement Hearing	When a continuance for an involuntary inpatient placement hearing, all the following who are involved must be notified: • Individual • Guardian • Guardian advocate • Representative • Facility administrator • Individual's attorney • State attorney • The Department	Involuntary
CF-MH 3130 Petition for Involuntary Outpatient Placement	When an individual is petitioned for involuntary outpatient services the Circuit Court must be notified by the facility. The circuit court then notifies the following parties: • Individual • Guardian • Representative • Individual's attorney • State attorney • The Department	Involuntary

CF-MH 3145 Proposed Individualized Treatment Plan for Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement	When a treatment plan is created for the initiation or continuation of involuntary outpatient services the following must be notified of the treatment plan: • Individual • Designated receiving facility administrator • Proposed outpatient provider	Involuntary

CF-MH 3155 Order for Involuntary Outpatient Placement or Continued Involuntary Outpatient Placement	When an individual is court ordered to involuntary outpatient services, all the following who are involved must be notified: • Individual • Guardian • Guardian advocate • Representative • Individual's attorney • State attorney • Administrator of the designated receiving facility or state mental health treatment facility • AHCA via the Baker Act Reporting Center	Involuntary
CF-MH 3185 Notice to Court of Waiver of Continued Involuntary Outpatient Placement Hearing and Request for an Order	When the individual agrees to continue participating in involuntary outpatient services without a court hearing the following must receive a copy of the documentation: • Individual • Guardian • Guardian advocate • Representative • Service provider • State attorney	Involuntary

Appendix K.

Baker Act Forms

Forms in the Clinical Record

Clinical records for individuals in a designated receiving facility and a state mental health treatment facility must contain specific information. Forms contain all the required information to complete a specific action, such as a petition, notification, or request, but are not required.

All forms that are completed for an individual, even if they are no longer relevant to the current situation, must be retained in the clinical record.

Forms can be found on the Department's website.

Table K.1 General

❑ CF-MH 3043	Inventory of Personal Effects
❑ CF-MH 3084	Baker Act Service Eligibility
❑ CF-MH 3103	Rights of Persons in Mental Health Facilities and Programs
❑ CF-MH 3124	Personal Safety Plan

Table K.2 Voluntary Admission

❑ CF-MH 3022	Application for Appointment of Independent Expert Examiner
❑ CF-MH 3040	Application for Voluntary Admission (Receiving Facility)
❑ CF-MH 3097	Application for Voluntary Admission - Minors
❑ CF-MH 3098	Application for Voluntary Admission (State Treatment Facility)
❑ CF-MH 3099	Certification of Ability to Provide Express and Informed Consent for Voluntary Admission and Treatment of Selected Persons from Facilities Licensed Under chapter 400, Florida Statutes.
❑ CF-MH 3040	Application for Voluntary Admission of an Adult (Receiving Facility)

Table K.3 Involuntary Examination

❑ CF-MH 3001	Ex Parte Order for Involuntary Examination
❑ CF-MH 3002	Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination
❑ CF-MH 3045	Notice of Person's Admission for Involuntary Examination
❑ CF-MH 3052a	Report of Law Enforcement Officer Initiating Involuntary Examination
❑ CF-MH 3052b	Certificate of Professional Initiating Involuntary Examination
❑ CF-MH 3101	Hospital Determination that Person Does Not Meet Involuntary Placement Criteria
❑ CF-MH 3102	Request for Involuntary Examination after Stabilization of Emergency Medical Condition
❑ CF-MH 3118	Cover Sheet to the Department
❑ Firearm Prohibition	Finding and Certification by an Examining Physician of Person's Imminent Dangerousness

Table K.4 Involuntary Inpatient Placement

❑ CF-MH 3008	Order for Involuntary Inpatient Placement
❑ CF-MH 3021	Notice of Petition for Involuntary Placement
❑ CF-MH 3024	Notice of Petition for Continued Involuntary Inpatient Placement
❑ CF-MH 3031	Order for Continued Involuntary Inpatient Placement or for Release
❑ CF-MH 3032	Petition for Involuntary Inpatient Placement
❑ CF-MH 3033	Notification to Court of Withdrawal of Petition for Hearing on Involuntary Inpatient or Involuntary Outpatient Placement
❑ CF-MH 3035	Petition Requesting Authorization for Continued Involuntary Inpatient Placement
❑ CF-MH 3113	Notice to Court – Request for Continuance of Involuntary Placement Hearing
❑ CF-MH 3118	Cover Sheet to the Department
❑ CF-MH 7000	State Mental Health Facility Admission Form
❑ CF-MH 7001	State Mental Health Facility Discharge Form
❑ CF-MH 7002	Physician to Physician Transfer Form

Table K.5 Involuntary Outpatient Services

❑ CF-MH 3021	Notice of Petition for Involuntary Placement
❑ CF-MH 3024	Notice of Petition for Continued Involuntary Inpatient Placement
❑ CF-MH 3033	Notification to Court of Withdrawal of Petition for Hearing on Involuntary Inpatient or Involuntary Outpatient Placement
❑ CF-MH 3115	Order Requiring Evaluation for Involuntary Outpatient Placement
❑ CF-MH 3118	Cover Sheet to the Department
❑ CF-MH 3130	Petition for Involuntary Outpatient Placement
❑ CF-MH 3140	Designation of Service Provider for Involuntary Outpatient Placement
❑ CF-MH 3145	Proposed Individualized Treatment Plan for Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement
❑ CF-MH 3150	Notice to DCF of non-filing of Petition of Involuntary Outpatient Placement or Diminished Treatment Plan
❑ CF-MH 3155	Order for Involuntary Outpatient Placement or Continued Involuntary Outpatient Placement
❑ CF-MH 3160	Notice to Court of Modification to Treatment Plan for Involuntary Outpatient Commitment and/or Request for Approval of Material Modifications to Plan
❑ CF-MH 3170	Petition for Termination of Involuntary Outpatient Placement Order
❑ CF-MH 3180	Petition Requesting Authorization for Continued Involuntary Outpatient Placement
❑ CF-MH 3185	Notice to Court of Waiver for Continued Involuntary Outpatient Placement Hearing and Request for an Order

Table K.6 Facility Transfers and Transportation

❑ CF-MH 3046	Application for and Notice of Transfer to Another Facility
❑ CF-MH 3089	Transfer Evaluation (To a State Mental Health Treatment Facility)
❑ CF-MH 3100	Transportation to Receiving Facility
❑ CF-MH 7002	Physician to Physician Transfer Form

Table K.7 Consent, Confidentiality, and Disclosure

❑ CF-MH 3022	Application for Appointment of Independent Expert Examiner
❑ CF-MH 3044	Authorization for Release of Information
❑ CF-MH 3048	Confidentiality Agreement
❑ CF-MH 3049	Restriction of Communication or Visitors
❑ CF-MH 3099	Certification of Ability to Provide Express and Informed Consent for Voluntary Admission and Treatment of Selected Persons from Facilities Licensed Under chapter 400, Florida Statutes.
❑ CF-MH 3104	Certification of Person's Competence to Provide Express and Informed Consent
❑ CF-MH 3105	Refusal or Revocation of Consent to Treatment
❑ CF-MH 3106	Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of Guardian Advocate
❑ CF-MH 3107	Order Appointing Guardian Advocate
❑ CF-MH 3108	Petition Requesting Court Approval for Guardian Advocate to Consent to Extraordinary Treatment
❑ CF-MH 3109	Order Authorizing Guardian Advocate to Consent to Extraordinary Treatment
❑ CF-MH 3110	Restriction of Person's Access to Own Record
❑ CF-MH 3116	Findings and Recommended Order Restoring Person's Competence to Consent to Treatment and Discharging the Guardian Advocate
❑ CF-MH 3120	Certification of Guardian Advocate Training Completion
❑ CF-MH 3121	Notification to Court of Person's Competence to Consent to Treatment and Discharge of Guardian Advocate
❑ CF-MH 3122	Certification of Person's Incompetence to Consent to Treatment and Notification of Health Care Surrogate/Proxy
❑ CF-MH 3123	Affidavit of Health Care Proxy

Table K.8 Treatment

❑ CF-MH 3042a	General Authorization for Treatment Except Psychotropic Medications
❑ CF-MH 3042b	Specific Authorization for Psychotropic Medications
❑ CF-MH 3057	Authorization for Electroconvulsive Treatment
❑ CF-MH 3145	Proposed Individualized Treatment Plan for Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement

Table K.9 Grievances

❑ CF-MH 3036	Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances
❑ CF-MH 3090	Petition for Writ of Habeas Corpus or for Redress of Grievances
❑ CF-MH 3119	Notification of a Facility's Non-Compliance (Pursuant to chapter 400, Florida Statutes)

Table K.10 Discharge

❑ CF-MH 3036	Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances
❑ CF-MH 3038	Notice of Release or Discharge
❑ CF-MH 3051a	Notice of Right of Person on Voluntary Status to Request Discharge From a Receiving Facility
❑ CF-MH 3051b	Notice of Right of Person on Voluntary Status to Request Discharge From a Treatment Facility
❑ CF-MH 3090	Petition for Writ of Habeas Corpus or for Redress of Grievances
❑ CF-MH 3111	Approval for Release of Person on Involuntary Status from a Receiving Facility
❑ CF-MH 3114	Order Requiring Involuntary Assessment and Stabilization for Substance Abuse and for Baker Act Discharge of Person
❑ CF-MH 7001	State Mental Health Facility Discharge Form
❑ CF-MH 7002	Physician to Physician Transfer Form

Table K.11 Notifications

❑ CF-MH 3021	Notice of Petition for Involuntary Placement
❑ CF-MH 3024	Notice of Petition for Continued Involuntary Inpatient Placement
❑ CF-MH 3033	Notification to Court of Withdrawal of Petition for Hearing on Involuntary Inpatient or Involuntary Outpatient Placement
❑ CF-MH 3036	Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances
❑ CF-MH 3038	Notice of Release or Discharge
❑ CF-MH 3045	Notice of Person's Admission for Involuntary Examination
❑ CF-MH 3046	Application for and Notice of Transfer to Another Facility
❑ CF-MH 3051a	Notice of Right of Person on Voluntary Status to Request Discharge from a Receiving Facility
❑ CF-MH 3051b	Notice of Right of Person on Voluntary Status to Request Discharge from a Treatment Facility
❑ CF-MH 3113	Notice to Court – Request for Continuance of Involuntary Placement Hearing
❑ CF-MH 3119	Notification of a Facility's Non-Compliance (Pursuant to chapter 400, Florida Statutes)
❑ CF-MH 3121	Notification to Court of Person's Competence to Consent to Treatment and Discharge of Guardian Advocate
❑ CF-MH 3122	Certification of Person's Incompetence to Consent to Treatment and Notification of Health Care Surrogate/Proxy
❑ CF-MH 3150	Notice to DCF of non-filing of Petition of Involuntary Outpatient Placement or Diminished Treatment Plan
❑ CF-MH 3160	Notice to Court of Modification to Treatment Plan for Involuntary Outpatient Commitment and/or Request for Approval of Material Modifications to Plan
❑ CF-MH 3185	Notice to Court of Waiver for Continued Involuntary Outpatient Placement Hearing and Request for an Order
❑ Firearm Prohibition	Patient's Notice and Acknowledgement: Purchase of Firearms and Application for or Retention of a Concealed Weapons or Firearms License

Table K.12 Petitions to the Court

❑ CF-MH 3002	Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination
❑ CF-MH 3032	Petition for Involuntary Inpatient Placement
❑ CF-MH 3035	Petition Requesting Authorization for Continued Involuntary Inpatient Placement
❑ CF-MH 3090	Petition for Writ of Habeas Corpus or for Redress of Grievances
❑ CF-MH 3106	Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of Guardian Advocate
❑ CF-MH 3108	Petition Requesting Court Approval for Guardian Advocate to Consent to Extraordinary Treatment
❑ CF-MH 3130	Petition for Involuntary Outpatient Placement
❑ CF-MH 3170	Petition for Termination of Involuntary Outpatient Placement Order
❑ CF-MH 3180	Petition Requesting Authorization for Continued Involuntary Outpatient Placement
❑ Firearm Prohibition	Petition for Relief from Firearm Disabilities Imposed by the Court

Table K.13 Court Orders

❑ CF-MH 3001	Ex Parte Order for Involuntary Examination
❑ CF-MH 3008	Order for Involuntary Inpatient Placement
❑ CF-MH 3031	Order for Continued Involuntary Inpatient Placement or for Release
❑ CF-MH 3107	Order Appointing Guardian Advocate
❑ CF-MH 3109	Order Authorizing Guardian Advocate to Consent to Extraordinary Treatment
❑ CF-MH 3114	Order Requiring Involuntary Assessment and Stabilization for Substance Abuse and for Baker Act Discharge of Person
❑ CF-MH 3115	Order Requiring Evaluation for Involuntary Outpatient Placement
❑ CF-MH 3116	Findings and Recommended Order Restoring Person's Competence to Consent to Treatment and Discharging the Guardian Advocate
❑ CF-MH 3155	Order for Involuntary Outpatient Placement or Continued Involuntary Outpatient Placement
❑ Firearm Prohibition	Order of Court: To Present Record of Finding to Florida Department of Law Enforcement or Requiring Further Documentation on Voluntary Transfer
❑ Firearm Prohibition	Order on Petition for Relief from Firearm Disabilities

Table K.14 Miscellaneous

❑ CF-MH 3125	Application for Designation as a Receiving Facility
❑ CF-MH 3155	Order for Involuntary Outpatient Placement or Continued Involuntary Outpatient Placement
❑ Firearm Prohibition	Firearm Prohibition Cover Sheet

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