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2026 **BAKER ACT** REFERENCE GUIDE



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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 Training Website:
<https://www.floridalearner.org/>

Copies of this Handbook:

This handbook 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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Acronyms

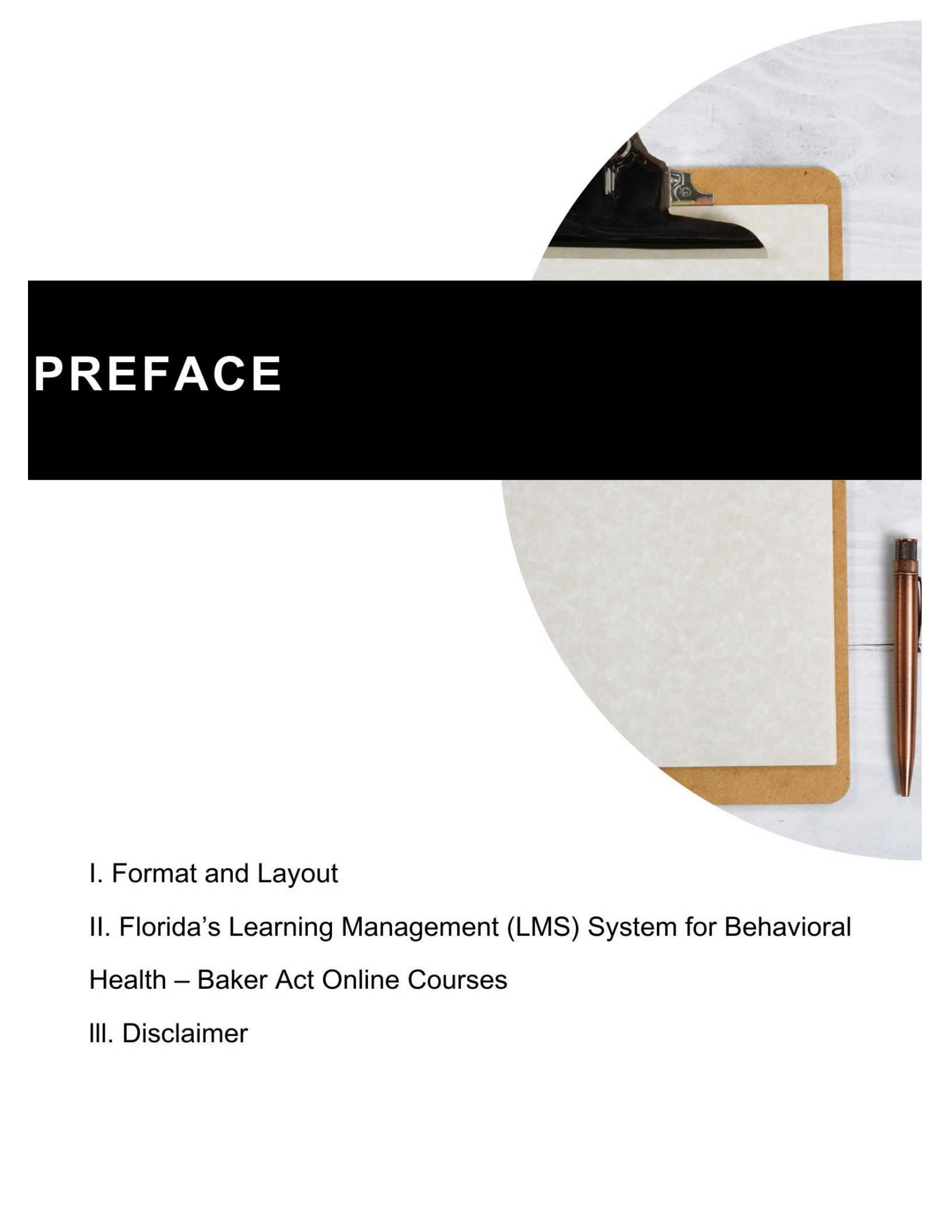
AHCA	Agency for Health Care Administration
APRN	Advanced Practice Registered Nurse
APD	Agency for Persons with Disability
BADCS	Baker Act Data Collection System
C.F.R.	Code of Federal Regulations
CIT	Crisis Intervention Team
CMS	Centers for Medicare and Medicaid Services
CoP	Conditions of Participation
CSU	Crisis Stabilization Unit
Department	Florida Department of Children and Families
DJJ	Department of Juvenile Justice
EMTALA	Emergency Medical Treatment and Labor Act
EMS	Emergency Management Services
ETO	Emergency Treatment Order
FADAA	Florida Alcohol and Drug Abuse Association
F.A.C.	Florida Administrative Code
FAQ	Frequently Asked Question
F.S.	Florida Statutes
Handbook	The Baker Act Information Handbook
MOU	Memorandum of Understanding
MRT	Mobile Response Team
SAMH	Office of Substance Abuse and Mental Health
SMHTF	State Mental Health Treatment Facility
U.S.	United States

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The background of the page features a light gray, textured surface. In the upper right, a clipboard with a wooden board and a black clip is visible. A large black rectangle spans across the middle of the page, containing the title 'PREFACE' in white. Below this rectangle, a copper-colored pen lies vertically on the right side of the page. A large, light gray circular shape is partially visible on the right side of the page.

PREFACE

I. Format and Layout

II. Florida's Learning Management (LMS) System for Behavioral Health – Baker Act Online Courses

III. Disclaimer

Preface

Purpose

The [Baker Act Information Handbook \(Handbook\)](#) was developed by the Florida Department of Children and Families' (Department) Office of Substance Abuse and Mental Health (SAMH). The purpose of the Handbook 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 established by Chapter 394, F.S. The Handbook 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.

I. Format and Layout

The Handbook 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 Code rules are shown in green bars. ■■■
- Baker Act forms are shown in yellow bars. ■■■

Detailed information on topics is hyperlinked and redirects readers to either another section within the Handbook or to an external website. For example, the individual Baker Act forms are not included in the Handbook but instead are 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 Handbook for those referencing a hard copy.

II. Florida's Learning Management System (LMS) for Behavioral Health – Baker Act Online Courses

The Department sponsors 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, and eligible learners also receive free continuing education credits. Courses can be accessed through FADAAs [Learning Management System](#) website. This year, Baker Act training courses have been revised to reflect the most current legislative mandates, policies, and procedures.

The updated training suite includes modules on the involuntary examination process and criteria for initiation under the Baker Act, transportation procedures, and documentation requirements specifically incorporating updates on the Transportation to Designated Receiving Facility form ([CF-MH 3100](#)) and law enforcement responsibilities under the revised statutes. In addition, specialized content has been revised for law enforcement officers, clinical professionals, and designated receiving facilities, with emphasis on changes regarding the use of discretion when initiating a Baker Act.

These updates are designed to promote consistent interpretation and application of the laws across all regions and professional roles.

III. Disclaimer

The Handbook 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 Handbook. It is important to keep apprised of any changes to the legislation, administrative rule, as well as the 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, the reader should refer to their organization's risk manager, legal counsel, or the appropriate governing authority.

CHAPTER 1

INTRODUCTION TO THE BAKER ACT

- I. Background
- II. Terminology
- III. Oversight

Chapter 1: Introduction to the Baker Act

I. Background

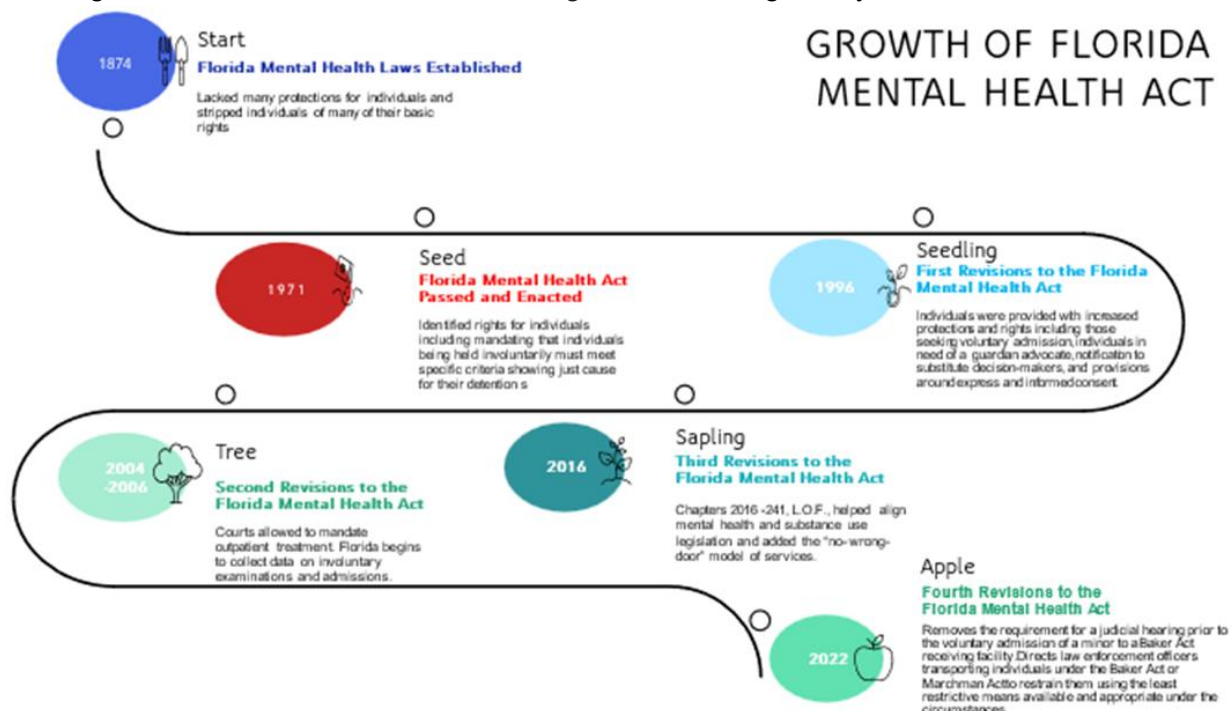
History of the Mental Health Act

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 designated receiving facility.



Current Law

The legal authority for the Baker Act is found in Part 1, Chapter 394, F.S. Administrative rules related to the Baker Act include 65E-5 and 65E-12 Florida Administrative Code (F.A.C.), which addresses public mental health Crisis Stabilization Units (CSUs) and Short-Term Residential Treatment Programs (SRTs). 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, 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 in Appendix D. A comprehensive chart can also be found on the Department's webpage. Additional legislation enacted in 2016 include:
 - [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 firearm 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 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 \(House Bill 1262\)](#) in 2022.
 - Prohibited restrictions on visitors, phone calls, and written correspondence for individuals in a Baker Act designated 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 designated 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 \(House Bill 1844\)](#) in 2022.
 - Removed the requirement for a judicial hearing prior to the voluntary admission of a minor to a Baker Act designated 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.
- The enactment of [Chapter 2024-245, Laws of Florida \(House Bill 7021\)](#) in 2024.
 - Enhances discharge planning and outlines a discharge transition process.
 - Combines and streamlines processes for courts to order individuals to involuntary outpatient services and involuntary placement.
 - Authorizes certain parties to appear remotely.
 - Gives law enforcement officers the option to initiate a Report of a Law Enforcement Officer.
 - Prohibits courts from ordering an individual with a developmental disability who lacks a co-occurring mental illness, to stay in a state mental health treatment facility against their will.
 - Includes psychiatric nurses as allowable practitioners to order an ETO under the direct guidance and protocol of an established psychiatrist.
 - Authorizes a person's legal custodian to access and authorize the release of an individual's medical record.
 - Removes the 30-bed size limit for Crisis Stabilization Units.
 - Requiring the Agency for Health Care Administration and DCF to jointly establish behavioral health interagency collaboratives throughout the state for specified purposes and provides requirements for the entities represented in each collaborative.
- The enactment of [House Bill 1091 in 2025 revised various sections of chapters 394, 397, and 916, F.S.](#)
 - Recognizes the Florida 988 Lifeline into Florida's coordinated crisis care continuum and empowers the Florida Department of Children and Families to authorize and oversee accredited 988 call centers.
 - Clarifies the roles of courts and Administrative Law Judges (ALJs) to specify that both circuit courts and ALJs are authorized to preside over continued involuntary service hearings.
 - ALJ orders are recognized as final agency actions subject to judicial review.
 - Authorizes the release of guardian advocates when an individual completes court-ordered involuntary outpatient services, aligning with updated language in s. 394.4598, F.S.

- Clarifies that clinical psychologists must have a minimum of three years of post-licensure clinical experience to authorize the transfer of an individual from voluntary to involuntary status. Eliminates the requirement for postdoctoral training, aligning clinical authority with practical experience rather than academic completion.
- Expands forensic evaluator training requirements through the department, including additional competency-based instruction for juvenile evaluators, with a compliance deadline of July 1, 2026, for existing evaluators.
- Removes the statutory prerequisite for an annual needs assessment to license Medication-Assisted Treatment (MAT) providers.
- Authorizes designated Baker Act facilities to retain individuals for the full statutory period- even if certain documentation timelines (12-hour transfer window) are exceeded, provided criteria continue to be met.
- The enactment of [Senate Bill 1620](#) in 2025 revised various sections of chapters 394, 1001, and 1004, F.S.
 - Adopts person-first language statewide, mandating professional use that emphasizes individuals over diagnosis in all behavioral-health communications and documentation.
 - Codifies crisis-intervention and trauma-informed best practices, establishing these as mandatory standards in care settings.
 - Mandates regular review of service plans, requiring updates every 30 days for those recovering or treatment facilities, and every 60 days for those in care longer than 24 months.
 - Integrates the Daily Living Activities (DLA-20) functional assessment tool statewide, ensuring consistent monitoring of daily living needs across facilities.
 - Directs biennial reviews of behavioral-health services in schools and telehealth, to be conducted collaboratively by the department and the Department of Education, aiming to optimize support for students.
 - Prioritizes access to short-term residential treatment, with the Department reviewing service gaps and AHCA fast-tracking licensing in underserved and high need counties.
 - Enhances behavioral-health workforce research, empowering the University of South Florida's Louis de la Parte Florida Mental Health Institute to access anonymized data from clinical boards for strategic workforce development.
 - Authorizes the administration of long acting injectables (LAI) antipsychotic medications to certain clinically approved individuals discharged from designated receiving facilities.

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 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 facilitate transfers to other acute services when needed or 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 designated 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.

Warm hand-offs are often used in the context of the no-wrong-door approach and are important to ensure the connection to another level of care or service provider is successful.

II. Terminology

Section 394.455, Florida Statutes

Definitions

The Handbook 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
Department	The Florida Department of Children and Families.
The Baker Act	The Baker Act is 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 designated receiving facility designated by the Department. A designated receiving facility that is authorized to receive involuntary examinations under the Baker Act may be licensed as a hospital or a CSU. Public receiving facilities receive funding from the Department whereas private receiving facilities are funded through private pay sources such as commercial insurance coverage and do not receive departmental funding.
State Mental Health Treatment Facility (SMHTF)	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.
Crisis Stabilization Units (CSUs)	A CSU or Children's CSU is licensed under Chapter 394, F.S., by AHCA and designated by the Department as a receiving facility.

Individual	Refers to the individual's receiving services. Unless specifically quoted from legislation, the terms patient and client will not be used.
Involuntary Outpatient Services	Refers to services provided in the community to a person who does not voluntarily consent to or participate in services under the Baker Act.
Involuntary Inpatient Placement	Refers to placement in a secure receiving or treatment facility providing stabilization and treatment services to a person 18 years of age or older who does not voluntarily consent to services, or a minor who does not voluntarily assent to services under the Baker Act.
Involuntary Services	Refers to both involuntary outpatient services and involuntary inpatient placement.
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.
General Hospital	A hospital licensed under Chapter 395, F.S by the Agency for Healthcare Administration (AHCA) and may be designated by the Department as a Baker Act receiving facility that provides medical care and services to the general population. A general hospital may also provide psychiatric services or operate a psychiatric unit. A hospital is any facility that carries the designation as a medical, psychiatric, or other specialty hospital.
Parent	Refers to any legal guardian of a minor including a biological parent, foster parent, or other legal guardian.
Psychiatric Hospital	A hospital that primarily provides care and treatment for individuals with mental health conditions. Psychiatric hospitals are licensed by AHCA and may also be designated by the Department as a Baker Act receiving facility.
Treatment or Service plan	Refers to an individualized plan detailing the recommended behavioral health services and supports based on a thorough assessment of the needs of the patient, to safeguard and enhance the patient's health and well-being in the community.
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	Refers to mental health and substance use disorder services.
Mental Health Condition	A mental health condition, referred to in section 394.455, F.S., 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 <i>not</i> include conditions or behaviors primarily due to any of the following: • A developmental disability as defined in Chapter 393, F.S. • 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

Section 394.457, Florida Statutes

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, Medicaid Health Plans, 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, who license and regulate medical and behavioral health professionals, provide executive and administrative oversight.

The Florida Department of Children and Families

The Department 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 Florida Administrative Code, (2) developing Baker Act forms; (3) designation of receiving and treatment facilities and (4) 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 Florida Administrative Code 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 designated 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 CSUs (public designated receiving facilities) and contracts much of the oversight responsibilities to Managing Entities 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 designated receiving facilities).

In 2024 the Department rolled out the Regional Behavioral Health Interagency Collaboratives across the state, bringing stakeholders together to address opportunities for improvement within Florida's behavioral health system of care. The Collaborative meetings are established to enhance local efforts to improve accessibility, availability and quality of services by fostering community partnerships, promoting cross-agency collaboration, and improving the crisis care continuum. Please visit the [Department's website](#) to find out about Regional Behavioral Health Interagency Collaborative meetings occurring near you.

The Department also serves as the Children's Behavioral Health Ombudsman. The Ombudsman advocates for individuals and families navigating the behavioral health system by ensuring access to services, resolving

concerns, and promoting accountability and quality in mental health and substance use care. The [Ombudsman](#) can be reached by phone, email or online submission.

Forms

Chapter 65E-5.120, Florida Administrative Code

Forms

The Department has developed [forms](#) for voluntary and involuntary procedures under the Baker Act. Providers may modify their formatting for integration into electronic health record 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. It is becoming more common for Baker Act forms to be transmitted electronically. This situation may occur if an individual is transported by law enforcement to a designated receiving facility from a hospital's emergency department, and presents with a copy of the [Certificate of Professional Initiating Involuntary Examination \(CF-MH 3052b\)](#) in place of the original document. A copy of the certificate may also be used 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 designated receiving facility following the individual's 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 [SAMH](#) website includes legislatively required reports and other helpful resources including:

- Links to the most [current forms](#).
- The Baker Act Data Collection System ([BADCS](#))
- [The Baker Act Dashboard](#)
- 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](#).

The Department's [Frequently Asked Questions \(FAQs\)](#) address Baker Act topics including emergency medical conditions, long-term care facilities, involuntary examinations, and voluntary admissions.

Managing Entities

Section 394.9082, Florida Statutes

Behavioral Health Managing Entities

The Department provides for the delivery of substance use and mental health services to underinsured and uninsured individuals. In 2010, the Department instituted a regional model of services administered by Behavioral Health Managing Entities. A Managing Entity 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 Managing Entities for the Department's six regions. Each of these regions are comprised of several judicial circuits. A map can be referenced in Appendix E.

Managing Entities manage the daily operations of behavioral health care for their region. Instead of providing direct services, a Managing Entity 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.

Baker Act Reporting Center

Chapter 65E-5.280(5), Florida Administrative Code

Involuntary Examination

Form CF – MH 3118

Cover Sheet to Department

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 designated 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 Florida Statutes
CF-MH 3118	Cover Sheet to the Department	Section 394.463
CF-MH 3052b	Certificate of Professional Initiation Involuntary Examination	Section 394.463
CF-MH 3052a	Report of Law Enforcement Officers Initiating Involuntarily Examination	Section 394.463
CF-MH 3001	Ex-parte Order for Involuntary Examination	Section 394.463
CF-MH 3100	Transportation to Designated Receiving Facility	Section 394.462

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 Services \(CF-MH 3032\)](#)
- [Order for Involuntary Inpatient Placement \(CF-MH 3008\)](#)
- [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 (MHC) 4202 E. Fowler Ave. Tampa, FL 33620

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.

The Agency for Health Care Administration

Section 394.463(2)(b), Florida Statutes	Involuntary Examination
Chapter 65E-5.280(6), Florida Administrative Code	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, CSUs, and residential treatment centers.

Designated 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 using AHCA's Complaint Administration's [online](#) form 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 serves as Florida's state Medicaid agency and is responsible for administering the Florida Medicaid program. AHCA also carries out certain health care facility regulatory and oversight responsibilities and works with the federal Centers for Medicare and Medicaid Services (CMS) in areas involving federal health care requirements. Anyone with concerns regarding a provider following state or federal regulations may report these concerns by calling AHCA's compliance hotline at 888-419-3456 or online at [Health Care Facility Complaint Form](#).

Florida Statewide Medicaid Managed Care- Managed Medical Assistance Program

Florida has transitioned to a delivery model in which the majority of fully Medicaid eligible recipients receive their services through a health plan. The Agency received approval from the Centers for Medicare and Medicaid Services (CMS) to operate the Statewide Medicaid Managed Care (SMMC) program through an 1115 Research and Demonstration waiver. In February 2025 the Agency implemented the new SMMC 3.0 program. The SMMC program has three components: the Managed Medicaid Assistance (MMA) program, the Long-term Care program, and the Dental Program. The new SMMC 3.0 program is focused on several core elements:

- Family focused plans and programs
- Significant new ways to improve health
- Fully integrated incentives for quality performance
- New SMMC regions and plan structure

The MMA program covers most medical and acute care services for health plan enrollees, including substance use and mental health treatment services. The objectives of the SMMC program are to improve health outcomes through care coordination, patient engagement in their own health care, and maintain fiscal responsibility. These objectives are achieved by providing care through nationally accredited managed care plans with broad networks, expansive benefits packages, top quality scores, and a high rate of customer satisfaction.

Florida Medicaid actively encourages all stakeholders to report any potential issue, concern, or complaint regarding the SMMC program to the Medicaid Helpline at 1-877-254-1055 or by using a [Florida Medicaid Complaint Form](#). This is one mechanism that enables the Agency to remain aware of performance of the SMMC program.

Most Medicaid recipients who are eligible for the full array of Medicaid benefits are enrolled in a health plan. In addition to providing coverage for an array of substance use and mental health treatment services, health plans are required to coordinate all aspects of care for their enrollees including the coordination of services that are not covered by the plan. Through care coordination efforts, health plans are responsible for assessing enrollees and identifying factors that may impact their ability to manage health care needs, such as homelessness and comorbid conditions.

For individuals who are uninsured, underinsured, or otherwise unable to obtain needed behavioral health services through Medicaid or other insurance coverage, the Department provides funding for a statewide behavioral health safety net. The Department contracts with regional Managing Entities, who use these funds to support behavioral health services through networks of local community providers.

When an individual has Medicaid or other health insurance, those available benefits should be used for covered services. Department-funded services may be available when an individual does not have coverage or when needed behavioral health services are not covered or authorized by another payer, subject to program eligibility and available funding.

Facilities should identify an individual's health coverage, when available, and coordinate with the individual's Medicaid health plan, Managing Entity, community providers or other resources to support access to services and continuity of care.

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.

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.

The Commission on Accreditation of Rehabilitation Facilities

[The Commission on Accreditation of Rehabilitation Facilities](#) 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, the Commission on Accreditation of Rehabilitation Facilities 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

Chapter 2: Facilities Providing Services Under the Baker Act

I. Requirements for Facilities Providing Baker Act Services

Chapter 65E-5.1802, Florida Administrative Code	Designation of Baker Act Facilities and Receiving Systems
Chapter 65E-5.350, Florida Administrative Code	Eligibility Criteria and Procedures for Designation

While many providers deliver mental health services, all Baker Act services, including every form of involuntary evaluation and treatment, must be provided only in a designated receiving facility or State Mental Health Treatment Facility (SMHTF). Designated receiving facilities and SMHTFs must provide voluntary services and the same Baker Act laws, rights, and protections apply.

A designated receiving facility is required to accept individuals transported for an involuntary examination by law enforcement and emergency transportation companies regardless of the facility's current capacity and capability. Acceptance by a designated receiving facility initiates an evaluation process and does not obligate 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 general 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 the 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 minors in need of placement. When considering capacity, the normal accommodations that are made for individuals are considered. If a facility regularly makes certain accommodations for admission, those variations become part of the facility's normal capacity.

Capability refers to the facility's ability to provide comprehensive services to an individual during admission duration. This includes providing assessment and treatment for both psychiatric and medical needs. While most medical needs can be managed within a designated receiving facility or State Mental Health Treatment Facility certain medical conditions may require a referral to a general hospital equipped to offer higher-level care. Designated receiving facilities licensed as CSU's tend to be more limited in their capability to provide medical services than those licensed as a psychiatric hospital and should coordinate appropriate transfers when higher-level services are available. Where telehealth and mobile response services are available, these methods may also support a facility's capability to manage more acute or specialized medical conditions.

Due to the Emergency Medical Treatment and Labor Act (EMTALA), any 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. Notably, 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 or involuntary. 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. In addition to face-to-face assessments, facilities must now incorporate telehealth and remote assessment technologies to expand accessibility and enhance real-time clinical decision making. Designated receiving facilities are designated as either public or private. The designation of designated receiving facilities as public or private is determined by how the facility is funded and affects the way in which individuals can be transferred between facilities.

More information on facility transfers can be found in Chapter Seven.

Public Facilities

Section 394.875, Florida Statutes	CSUs and Residential Treatment Facilities
Chapter 65E-12, Florida Administrative Code	Public Mental Health CSUs and SRTs

Public facilities are designated receiving facilities that operate primarily on public funds to deliver mental health services under the Baker Act. While some publicly designated receiving facilities are hospitals, most of these facilities are licensed as CSUs, reflecting their specialized role in providing immediate psychiatric stabilization. Public funds enable CSUs to provide services to individuals who are uninsured and underinsured, though individuals with insurance can also access services at a CSU.

Individuals may be provided 24-hour observation, medication, and other appropriate services by a physician, psychiatrist, or psychiatric nurse, or other qualified professional while admitted in the CSU. The CSU must provide services regardless of the individuals ability to render payment.

Section 394.461, Florida Statutes	Designation of Receiving and Treatment Facilities and Systems
Chapter 65E-5.351, Florida Administrative Code	Minimum Standards for Designated Receiving Facilities

CSUs are responsible for the central coordination of acute care services for mental health under the Baker Act. They serve as the connection between emergency response, designated receiving facilities, and State Mental Health Treatment Facilities. In addition to providing immediate crisis stabilization and treatment interventions, CSUs are tasked with assisting and managing situations when there is difficulty placing or transferring an individual in a designated receiving facility. If transfer challenges arise, whether due to full occupancy, limited specialized services, or operational constraints, the Department's regional office and the Managing Entity can assist with reviewing CSU census data and other capacity factors that may impact the refusal of an otherwise appropriate transfer. This coordinated approach ensures that all factors, including bed availability and clinical need, are immediately evaluated and documented before a refusal or delay in transfer is determined.

Private Facilities

Chapter 65E-5.350, Florida Administrative Code	Eligibility Criteria and Procedures for Designation
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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

Section 394.461, Florida Statutes

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. Under the current statutory framework, State Mental Health Treatment Facilities (SMHTFs) are structured to provide services for an extended duration beyond the acute stabilization provided in a designated receiving facility. These types of treatment facilities are commonly referred to as state hospitals.

Some individuals who are court ordered to involuntary inpatient placement may remain in a designated receiving facility for the duration of their services, however, when longer-term or residential treatment is clinically indicated, the individual will be transferred to a State Mental Health Treatment Facility. Transfer decisions are based on comprehensive clinical evaluations that include treatment history, real-time digital capacity reporting, and collaborative input from multidisciplinary teams. 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

Section 394.462, Florida Statutes

Transportation

Section 394.463, Florida Statutes

Involuntary Examination

An individual meeting the criteria for voluntary or involuntary Baker Act services may, under various clinical scenarios, be evaluated and treated in a general hospital. There are many scenarios allowing this to occur.

- **Initial Medical Clearance:** An individual may be sent to a general hospital immediately following the initiation of an involuntary examination for medical clearance prior to being transported to a designated receiving facility to complete the involuntary examination. In these cases, once the individual's attending physician documents the medical condition has stabilized or that an emergency medical condition no longer exists, the 72-hour examination period will begin as soon as the individual arrives at the designated receiving facility.
- **Transfer from Receiving or Treatment Facility:** An individual may be sent to a general hospital from a designated receiving facility or State Mental Health Treatment Facility for further medical clearance or treatment. Updated procedures now include real-time capacity checks, and secure, electronic exchange of health records between facilities. Supporting continuity of care while ensuring that transfers occur without unnecessary delays.
- **Evaluation in the Emergency Department:** An individual may be evaluated for mental health services in an emergency department. In this setting, if clinically appropriate, he or she may be encouraged to seek voluntary services. Alternatively, if the Emergency Department evaluation indicates the need for further stabilization, an involuntary examination may be initiated. **12-Hour Transfer and Retention Provision:** Once the attending physician determines that the individual's medical condition, has stabilized or that an emergency medical condition does not exist, one of the following must occur within 12 hours:

1. The individual is examined by a facility and released; or
2. The individual is transferred to a designated facility capable of delivering appropriate medical treatment.

House Bill 1091 passed in 2025 to clarify that if the transferring facility does not complete a transfer within the 12-hour timeframe or does not provide the required notification within two hours after stabilization, the designated receiving facility retains the authority to keep the individual for the remainder of the 72-hour examination period. This retention is permissible provided that the individual continues to meet the criteria for involuntary examination and ensures that there is no interruption in the continuum of care.

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.

CHAPTER 3

WHO CAN RECEIVE BAKER ACT SERVICES AND VOLUNTARY ADMISSION

- I. Who Can Receive Baker Act Services
- II. Voluntary Admission
- III. Exclusions to Voluntary Legal Status



Chapter 3: Who Can Receive Baker Act Services and Voluntary Admission

I. Who Can Receive Baker Act Services

Voluntary and involuntary examination or Baker Act services are intended for individuals experiencing significant symptoms of a mental health condition. Access to services in designated receiving facilities and State Mental Health Treatment Facilities is determined based on the clinical examination, legal status and the severity of symptoms.

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 the following information:

- The decision they are making; and
- The potential consequences of proceeding with or declining services; and
- Their 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 examination to a designated receiving facility or placement at a State Mental Health Treatment Facility, please refer to Appendix F.

II. Voluntary Admission

Section 394.4625, Florida Statutes	Voluntary Admissions
Form CF – MH 3040	Application for Voluntary Admission (Designated 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 staff 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. Designated facilities are encouraged to establish clear policies and procedures for recording consent 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 to achieve significant improvement of the individual's symptoms. Unlike involuntarily admissions, individuals seeking voluntarily admission do not need to present as posing an imminent threat of inflicting significant physical harm to self or others. Professionals must determine if inpatient is the most appropriate level of care.

Not everyone who requests voluntary 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 clinical 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 individuals 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. A request for discharge can be communicated either in writing or orally at any time following admission to the facility. Individuals admitted on a voluntary basis will determine those who may participate in their treatment and to whom the facility can release information.

Within 24 hours of admission, a physician, or psychiatric nurse must document both the individual's ability to provide express and informed consent and that this consent was provided voluntarily. This may 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.

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

- The minor's parent must provide express and informed consent to the voluntary admission.
- 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.

Voluntary admission for a minor has additional requirements and is discussed further 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](#).

III. Exclusions to Voluntary Legal Status

Section 394.4625(1), Florida Statutes	Authority to Receive Patients
Section 394.463(2), Florida Statutes	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 healthcare.
- 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 (DJJ).
- Is in the custody of the Department.
- Is a minor and the parent or legal guardian provides express and informed consent.

It is important to note that there are times when an individual is admitted under voluntary status without the facility knowing that an exclusion for voluntary legal status is present. This is often due to receiving inaccurate information such as not reporting or being unaware 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



Chapter 4: Legal Status in Designated Receiving Facilities

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.

II. Transfer of Legal Status

When an individual no longer appears to meet criteria for their current legal status it is important for a physician, psychiatrist or psychiatric nurse 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

Section 394.4625(1)(f), Florida Statutes	Physician Documentation of Express and Informed Consent
Section 394.4625(4), Florida Statutes	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 because symptoms stabilize and the criteria 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 department that is not part of a designated receiving facility, the individual can be examined and discharged by an emergency department physician who has experience in diagnosing and treating mental illness. 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.

When additional behavioral health support is needed, emergency department physician may consult with a treating practitioner at a designated receiving facility, request a behavioral health assessment through telehealth, or work with a mobile response team. These resources can help determine the individual's needs and whether they can safely receive services in the community instead of being transferred to a designated receiving facility.

During the involuntary examination process at a designated receiving facility, if an individual is transferred to an emergency department due to an emergency medical condition, the individual is typically transferred back to the designated 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 to Involuntary Status

Section 394.4625(5), Florida Statutes	Transfer to Involuntary Status
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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, or
- 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 treating practitioner believes that the individual is not safe to be discharged, and the individual continues to meet the criteria for involuntary services.

EXPRESS AND INFORMED CONSENT

[illegible]

I. Express and Informed Consent for Admission and Treatment

Chapter 5: Express and Informed Consent

I. Express and Informed Consent for Admission and Treatment

Section 394.455, Florida Statutes	Definitions
Section 394.459, Florida Statutes	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

Section 394.4625, Florida Statutes	Voluntary Admissions
Chapter 65E-5.170, Florida Administrative Code	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 (Designated Receiving Facility)

The ability to provide express and informed consent is required for an individual to be eligible for 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.

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

- The minor's parent must provide express and informed consent to the voluntary admission.
- 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.

Voluntary admission for a minor has additional requirements and is discussed further 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.

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. Many individuals under involuntary examination will be able to provide their own express and informed consent. If a medical practitioner determines that the individual is incompetent or incapacitated, he or she will not be asked to provide consent; instead, a substitute decision-maker will provide express and informed consent on the individual's behalf. The petition for involuntary services may be filed by the administrator of a designated receiving facility, the administrator of a treatment facility, or a service provider who is treating the individual.

Written notice of filing the petition for involuntary services must contain the following:

- Involuntary services filed with the circuit or county court and contain the address of such court.
- Notice of appointment of a public defender.
- The date, time, and location of the hearing, name each examination expert, and those expected to testify.
- Notice that the individual or guardian, proxy, etc. may apply for change of venue.
- Notice that the individual is entitled to an independent expert examination, the court will provide if the individual cannot afford such examination.

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. However, an individual may be retained by the facility that examined the individual until completion of the individual's court hearing. An individual

who no longer meets criteria for involuntary examination and is only being recommended for involuntary outpatient services must be released from the facility while awaiting completion of the court hearing.

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 determined to be clinically incompetent by a physician or psychiatric nurse, 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 or psychiatric nurse 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 lacks the ability to make a rational decision about treatment. 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 developmental disability or an advanced neurocognitive disorder such as Alzheimer's disease. If an individual is determined to be 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.

Prior to appointing a guardian advocate, the facility must provide the prospective guardian advocate with information about their duties and responsibilities including the concept of ethical medical decision making. They must be informed of the service planned for the individual and understand it is needed for their stabilization and future recovery, any possible side effects. Before giving consent to treatment, the guardian advocate must meet with the individual and their physician or psychiatric nurse in person or by telephone to discuss the recommended treatment.

More information on an individual's capacity to consent to treatment and apply for voluntary services can be found in Appendix F, 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 or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist if determined that such treatment is necessary for the safety of the individual or others at the facility. This is a clinical decision made 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.

CHAPTER 6

CRITERIA AND INITIATION OF AN INVOLUNTARY EXAMINATION

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- I. Involuntary Examination
 - II. Criteria for an Involuntary Examination Under the Baker Act
 - III. Initiating an Involuntary Examination
 - IV. Examination and Evaluation

Chapter 6: Criteria and Initiation of an Involuntary Examination

I. Involuntary Examination

Section 394.463, Florida Statutes	Involuntary Examination
Chapter 65E-5.280, Florida Administrative Code	Involuntary Examination

It is the intent of the legislature that treatment programs for mental health conditions include comprehensive health, social, educational, and rehabilitative and discharge planning 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; and
- 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 further involuntary services. Involuntary examinations are initiated due to the individual experiencing a mental health emergency. The individual must pose an imminent physical risk to themselves or others due to current symptoms of a mental health condition. This includes self-harming behaviors, psychosis, serious depression or unstable mood, episodes of aggression, suicidal or homicidal ideations, or self-neglect that poses a significant risk to the individuals, 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 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 make the decision 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. The 72-hour examination period begins when an individual arrives at a receiving facility.

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 further 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.

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

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 must be 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.

II. Criteria for an Involuntary Examination Under the Baker Act

Section 394.463(1), Florida Statutes	Involuntary Examination – Criteria
Section 394.4625(1)(e), Florida Statutes	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:

- Refuses voluntary admission after careful explanation as to the reason for examination.
- 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:**
- 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 help of willing, able, and responsible family members or friends or community services or other supports.
- 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.

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.

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:**
 - Regulate their own actions.
 - 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

¹ National Institute of Mental Health (2019). *Mental Illness*. Retrieved from <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>.

² Mental Health America (2018). *The State of Mental Health in America*. Retrieved from <http://www.mentalhealthamerica.net/issues/state-mental-health-america#Key>.

An individual meets the criteria for an involuntary examination if the individual is, because of a mental health condition, posing an imminent physical danger to self or others and either refuses voluntary admission to a designated receiving facility for further evaluation or is unable to determine for themselves whether examination is necessary.

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.

1. Unlawful Assessment

Section 394.463, (5), Florida Statutes

Unlawful Activities and Penalties

A person may not knowingly and willfully:

- Provide false information to have someone admitted to an emergency or involuntary treatment.
- Cause, arrange, conspire with, or help someone to initiate an emergency or involuntary procedure for another person under false pretenses.
- Cause, conspire with, or help someone to unjustly deny any person's rights without legal justification.

A person who violates this order commits a misdemeanor of the first degree, punishable by imprisonment not exceeding one year and fined not to exceed \$5,000.

III. Initiating 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 based on testimony of a family member.

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

A. Certificate of a Qualified Professional

Section 394.463(2)(a)(3), Florida Statutes

Professionals Qualified to Initiate an Involuntary Examination

Form CF – MH 3052b

Certificate of Professional Initiating Involuntary Examination

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, FS.
- Marriage and Family Therapist – Section 394.455, F.S
- Psychiatric Nurse – Section 394.455, F.S.
- Advanced Practice Registered Nurse – Registered Under Section 464.0123, FS

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.
- Psychiatric nurses must hold a minimum of a master's degree in psychiatric nursing and have completed at least one (1) 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 have both:

- 1) Examined the individual within the preceding 48 hours.
- 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, 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 needs to ensure other services and supports are in place that are appropriate to the individual's needs.

Once a qualified professional completes the certificate to initiate an involuntary examination, law enforcement is typically responsible for transporting the individual to the designated receiving facility, unless one of the exceptions outlined in the county's transportation plan applies. These exceptions include situations in which the individual is transported to a medical facility by emergency medical personnel; is already in a secured facility; or there is an alternative method identified in the county's approved transportation plan. As reflected in the legislative updates effective July 2024, counties are encouraged to collaborate with managing entities to ensure consistency, safety, and efficiency in transportation practices. The person providing transport will deliver the

initiating paperwork including the transportation form, [CF-MH 3100 Transportation to a Receiving Facility](#). The 72-hour examination period begins upon arrival at the designated receiving facility, not at the issuance of the certificate or transfer between facilities.

More information on transportation regulations and methods can be found in Chapter Seven 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

Section 394.463(2)(a)(2), Florida Statutes	Involuntary Examination
Chapter 65E-5.280(2)(a), Florida Administrative Code	Involuntary Examination – Law Enforcement
Form CF – MH 3052a	Report of Law Enforcement Officer

Law enforcement officers are central to many of the Baker Act’s operational procedures and play an important role in initiating involuntary examinations and keeping Floridians safe. As first responders, law enforcement officers are on the front lines of emergencies and frequently encounter individuals who are experiencing a mental health crisis. As a result, officers often engage with individuals who are in emotional turmoil and meet criteria for an involuntary examination. It is important for law enforcement officers to be familiar with Florida laws that direct their interactions with individuals who appear to be experiencing a mental health crisis.

Strong collaboration between law enforcement and behavioral health providers is essential to Florida’s crisis response system. Florida data highlights the significant role law enforcement already play in connecting people with timely care. According to the Baker Act Reporting Center’s 2024-25 report, law enforcement officers initiated 51.1 percent of involuntary examinations statewide, while health professionals initiated 45.9 percent and courts ordered 3 percent. For children, law enforcement initiated nearly 63 percent of involuntary examinations.

These findings underscore the value of equipping officers with high-quality training, practical tools, and strong behavioral health partnerships. With these resources, officers can build upon their experience as first responders, recognize behavioral health needs, respond with care and compassion, and act in accordance with the law. In communities where crisis intervention systems are still developing, law enforcement officers provide a vital connection to support by identifying individuals who may need assistance and transporting them safely to designed receiving facilities.

Law enforcement officers must 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

⁴ Florida Department of Children and Families (n.d.). Law Enforcement, 1-2. Retrieved from <https://www.myflfamilies.com/service-programs/samh/crisis-services/laws/LawEnforcement.pdf>.
⁵ Smith, J.A. Lopez, R.M., & Chen, L.T. (2025). Police referrals to psychiatric emergency departments: A meta-analysis of global trends and outcomes. *Psychiatric Services*, 76(2), 123-134.
<https://doi.org/10.1176/appi.ps.202500123>

In 2024, Senate bill 7021 revised section 394.463, F.S. reframing the process law enforcement officers use to initiate a Baker Act petition. For the first time, law enforcement officers have discretion to determine if an individual meets the criteria and needs to be examined under the Baker Act. Law enforcement officers **may** initiate an examination using [Baker Act Form CF-MH 3052a](#), if there is reason to believe that the individual meets criteria for an involuntary examination.

This change supports law enforcement officers that are working with Mobile Response Teams or Co-Responder teams that can quickly assess the situation and often de-escalate the individual while connecting them to resources and avert a Baker Act. Law enforcement officers are no longer required to initiate a Baker Act petition when the crisis can be safely resolved.

When a Baker Act petition is necessary, 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 an officer identifies that an individual is experiencing a medical issue, the individual must first be transported to the nearest medical emergency department.

Law enforcement officers can use their training, professional judgment, and available community resources to resolve a crisis safely without initiating a Baker Act examination when appropriate. The 988 Lifeline provides Floridians with immediate, around-the-clock mental health and substance use support. When in-person assistance would be beneficial, 988 can connect individuals with Mobile Response Teams or Co-Responder Teams. These skilled partners can assess needs, help stabilize the situation, connect individuals with appropriate services, and support the least restrictive response.

There are several factors to consider regarding law enforcement and the Baker Act. The Department has [Frequently Asked Questions \(FAQs\)](#) on their website that may assist with clarifying different practices under the Baker Act. There are many topics covered including law enforcement, transportation, and involuntary examinations.

1. Crisis Intervention Teams

The Crisis Intervention Team (CIT) program originated in Memphis Tennessee, providing training for law enforcement officers to help them understand how to interact with individuals experiencing a behavioral health crisis. Law enforcement agencies recognized that many of their 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 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 teaches 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 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 your agency provides specialized CIT training, there are two free [online courses](#) sponsored by the Department that may benefit law enforcement officers:

⁵ City of Baltimore (2016). Memphis Police Crisis Intervention Team Works to Defuse Mental Health Calls. Retrieved from <http://baltimorecity.md.networkofcare.org/mh/news-article-detail.aspx?id=69186>.

⁷ University of Memphis CIT Center (n.d.). About CIT. Retrieved from <http://cit.memphis.edu/aboutCIT.php>.

⁸ National Alliance on Mental Illness (n.d.). Crisis Intervention Team Toolkit CIT Facts. Retrieved from <http://nisonger.osu.edu/images/odhp/First%20Responder%20Resources/NAMI%20CIT%20FACT%20Sheet.pdf>.

⁹ Wendel, A. (n.d.). Crisis Intervention Teams: A Study of the Benefits of the Memphis Model for Officers and Florida Agencies. Retrieved from <https://www.fdle.state.fl.us/FCJEI/Programs/SLP/Documents/Full-Text/wendel-Anne-Marie-final-paper.aspx>.

¹⁰ Florida Sheriffs Association (n.d.). Crisis Intervention Team Training. Retrieved from <https://www.flsheriffs.org/law-enforcement-programs/training/crisis-intervention-team>.

- 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 their moment 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 Florida Lifeline

The 988 Florida Lifeline is a free behavioral health support service, available 24/7, that connects Floridians experiencing suicidal thoughts, substance use, mental health crises, or any other kind of emotional distress to a crisis counselor in their immediate area. It provides a universal entry point to a modernized crisis response system that begins when an individual dials 988 and has their call answered by a 988 crisis counselor. For individuals who are not yet suicidal or experiencing an acute crisis event, having the ability to call and talk to someone confidentially when they are feeling depressed or overwhelmed, and receive coping skills and other services focused on reducing stress and enhancing wellbeing, may reduce their future risk of becoming suicidal or needing services such as crisis stabilization.

All 988 Florida Lifeline crisis counselors are equipped with specialized skills and knowledge gained through completion of the 988 Lifeline Clinical Training Program to de-escalate and link callers to community-based providers who can deliver a full range of crisis care services, if needed. When an individual in crisis contacts 911, they receive a dispatcher whose responsibility is to send law enforcement or emergency medical services to respond to the individual. The most recently reported statistics show this results in individuals being Baker Acted at higher numbers than when behavioral health professionals are involved.¹⁰ In contrast, when an individual in crisis contacts 988, they connect with a counselor who is specifically trained to listen, assess, and divert where possible.

¹¹ University of South Florida. (2024). *Baker Act reporting center annual report 2023-2024* (Version 2). University of South Florida. [ba_usf_annual_report_2023_2024_v2.pdf](#), p.3

For those experiencing less acute crises, 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 offer regular follow up calls until an individual feels they no longer need that service.

As the statutory authority for mental health and substance use in Florida, the Department's Substance Abuse and Mental Health Program Office has overseen the implementation of the 988 Florida Lifeline since its rollout in July 2022. In July 2025, House Bill 1091 amended s. 394.4573, F.S. to include 988 as an essential element of the state's coordinated system of care. In February 2026, administrative rule 65E-5.604 was adopted to establish minimum standards for 988 call centers and implemented a cohesive statewide plan for 911 and 988 interoperability.

In fiscal year 2024-2025, the 988 Florida Lifeline saved the lives of 1,382 callers who reached out for an intervention during a suicide attempt in progress with zero calls resulting in a death by suicide while on the phone with a 988 crisis counselor. In that same span of time, 988 also made 64,519 referrals to mental health or related services, serving more than 145,289 Floridians.

In cases where a caller cannot be de-escalated and the crisis counselor determines the caller to be at imminent risk, all Florida Lifeline Centers provide warm hand-offs to local Mobile Response Teams (MRTs) or Co-responder Crisis Teams in the caller's area. 988 Lifeline Centers also work in coordination with local 911 Public Service Answering Points (PSAPs) to dispatch immediate law enforcement or EMS response when there is a caller with an active suicide in progress.

Data from fiscal year 2024-2025 shows 96 percent of callers were able to receive help from a 988 crisis counselor without the need for a higher level of care. Imminent suicides in progress accounted for about 1 percent of 988 calls requiring immediate dispatch of emergency medical services. The remaining 3 percent were callers experiencing a mental health crisis that could not be de-escalated over the phone and required a referral to mobile response services.

In fiscal year 2024-2025, the 988 Florida Lifeline experienced an 18 percent increase in call volume compared to the previous fiscal year, reflecting sustained program growth. This increase in demand is projected to continue with heightened national and local awareness of 988's mental health crisis and suicide prevention services.

3. Someone to respond – Mobile Response Teams

Mobile Response Team's (MRTs) provide immediate 24-hour, 365 days per year crisis care to individuals of all ages. They offer an increased opportunity to stabilize individuals experiencing an emotional or behavioral health crisis in the community. The MRT's goal is to de-escalate, prevent unnecessary psychiatric hospitalization, divert from juvenile justice or criminal justice settings while utilizing the least restrictive setting. MRT's offer 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 community service provider(s) as clinically indicated. Statewide MRT diverted 78 percent of individuals requiring an acute response from a Baker Act during fiscal year 2024-2025. Contact information for each MRT is located on the Department's website at <https://www.myflfamilies.com/specialty-treatment-team-maps>. MRT's can also be dispatched by calling 988.

C. Ex Parte Court Order

Section 394.463(2), Florida Statutes	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 sworn oral 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.

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 is 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 officer has specific time frames 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 (7) 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 (7) days. Once located, the individual will be transported to a designated receiving facility or to a general 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 general 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 72-hour examination period begins when the individual arrives at the designated receiving facility. The end of the 72-hour examination period does not mean the "Baker Act expires." It means 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 services with [Baker Act Form CF-MH 3032](#)
- 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](#). Prior to the individual's release a discharge plan must be prepared, reviewed with the individual and their guardian, family or other natural support.

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

During the 72-hour examination period, the individual may receive several evaluations and assessments within specified time frames as described in the following sub-sections.

2. Initial Involuntary Examination

Section 394.463(2)(f), Florida Statutes	Involuntary Examination
Chapter 65E-5.2801, Florida Administrative Code	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. This examination is used to determine if the individual meets voluntary or involuntary criteria for services and must include several elements including:

- 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, which can be completed through telehealth.
- Patient's treatment history at the facility.
- Information regarding the individual's condition/behaviors from other knowledgeable adults.

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 examination determines that the individual does need additional stabilization services and meets 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.

This 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 virtually. If the second professional agrees that the individual meets criteria for involuntary placement and the individual is not competent, or is unwilling to sign in for services voluntarily, the facility administrator must file the petition for involuntary services with the appropriate court.

3. Physical Examination

Section 394.459(2), Florida Statutes	Right to Treatment
Chapter 65E-5.160(3), Florida Administrative Code	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. This examination 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 but not limited to:

- 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.

CHAPTER 7

TRANSPORTATION AND TRANSFERS UNDER THE BAKER ACT

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- I. Transportation Plan
 - II. Transportation Responsibilities of Law Enforcement
 - III. Medical Transportation Companies
 - IV. Medical Emergencies
 - V. Facility to Facility Transfers

Chapter 7: Transportation and Transfers Under the Baker Act

I. Transportation Plan

Section 394.462, Florida Statutes	Transportation
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Section 394.462, F.S. statute identifies specific procedures that must be followed when transporting individuals on involuntary status under the Baker Act. All counties 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; this may include identifying emergency medical transport services or private transport companies rather than a law enforcement agency as part of the transportation plan.

II. Law Enforcement Transportation Responsibilities

Section 394.462, Florida Statutes	Transportation
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Chapter 65E-5.260, Florida Administrative Code	Transportation
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Form CF-MH 3100	Transportation to a Designated Receiving Facility
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The transportation plan may identify a single law enforcement agency, medical transportation services or private transportation company 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. The county's designated law enforcement agency, medical transportation or private transport company 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.

The designated 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 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, co-responder 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 designated receiving facility.

Section 394.462, Florida Statutes

Transportation

Chapter 65E-5.260, Florida Administrative Code

Transportation

When transporting individuals under involuntary status pursuant to the Baker Act, law enforcement officers must follow the county's designated transportation plan, which may include central designated receiving facility (CRF), the nearest designated receiving facility, or the most appropriate facility based on the individual's needs. This provision allows officers to bypass closer facilities that are not licensed or equipped to serve certain populations, such as minors or individuals requiring specialized care, to ensure the individual receives appropriate evaluation and treatment upon arrival. This approach is intended to reduce the number of times an individual is transferred between facilities which can be frustrating to individuals and delay their mental health examination.

The integration and use of Behavioral Health Managing Entities (ME's) and coordinated systems of care play a significant role in streamlining these transportation processes. Legislation emphasizes regional collaboration to reduce the strain on law enforcement and improve system efficiency.

Additionally, it is important to note, House Bill 1091 clarified section 394.463, F.S. that the Baker Act clock begins at the time the individual arrives at a designated receiving facility, not at the time of detainment emphasizing the importance of direct and appropriate placement avoiding unnecessary time delays and non-clinical holds.

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 is not responsible for transporting individuals who 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 transported by a friend, family member in a private vehicle or public transportation, such as an 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 a Designated 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. The law enforcement office must provide this form is provided to the designated receiving facility along with the petition for involuntary examination. Staff at the designated receiving facility must submit the Transportation Form to the Department's Baker Act Data Collection System (BADCS) and must include the form the individual's clinical record. A copy of the form may be retained by the law enforcing agency and the transport company.

The transportation form must be completed by the Law Enforcement Officer and provided to the designated receiving facility. The designated receiving facility must submit the form to the Departments BADCS 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 transportation to a designated receiving facility will be provided.

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.

C. Transfer of Custody to Facility Staff

Section 394.462(3), Florida Statutes

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.

A key component of the hand-off includes the delivery of all required documentation to initiate the involuntary examination. This must include:

- Properly completed initiating document ([e.g. Form CF-MH 3052a or 3052b](#)).
- Transportation Form ([CF-MH 3100](#)).
- Any supporting documentation pertinent to the individual's mental or physical health.

While some designated receiving facilities prefer to be given the original copies of forms; electronic transmission of these documents is becoming more common. Pursuant to modernization efforts under Phase II of the Baker Act Modernization Plan, the Department is actively working to digitize transportations forms and streamline electronic transmission protocols. Such as, electronically signed forms and accurate 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 when feasible.
- 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 evaluation and 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

Section 394.459(1), Florida Statutes

Individual Dignity

Every Floridian has a right to safe, dignified and trauma-informed transportation when experiencing a behavioral health crisis. Each law enforcement agency responsible for transporting 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 and coordinated with 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.

Transportation of individuals under the Baker Act is a clinical response, not a criminal one, and the person is experiencing a behavioral health crisis, that must be handled with care, professionalism, and respect for the individual's rights. Law enforcement must restrain the individual in the least restrictive 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. Agencies should take particular care when transporting minors. Inappropriate use of restraint, especially on young children, can result in psychological harm and has drawn public criticism and legal concern. Restraint use should be developmentally appropriate and justifiable based on the child's behavior and the circumstances of the transport.

When transporting a minor law enforcement officers must inform parents or legal guardians who are present of where their child is being transported for involuntary examination including the name, address and contact information for the facility.

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

Initiating an involuntary examination under the Baker Act is not an arrest. It is a health care intervention in response to a behavioral health crisis. Typically, the individual is not being taken into custody for criminal activity, but needs clinical evaluation and care.

E. Co-Occurring Legal Charges

Section 394.462, Florida Statutes

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 ([CF-MH 3052a](#)) and transport the individual to the designated receiving facility identified in the county's transportation plan. The individual's behavioral health crisis must be addressed without delay, and the involuntary examination process must proceed in accordance with the statutory timeline.

However, individuals charged with a felony who appear to meet the criteria for an involuntary examination are first transported to the local jail for standard processing. Despite their legal status, individuals who meet the criteria for involuntary examination retain their rights under the Baker Act, including the right to timely clinical assessment. It is the responsibility of the jail to ensure that after the initiation of an involuntary examination individuals in their custody receive the proper behavioral health examination and any necessary services within the statutory timeframes outlined in the Baker Act. A designated receiving facility is not required to admit a person charged with a felony for whom the facility is unable to provide adequate security but must provide examination and treatment to the individual on-site where they are held or by telehealth.

These additional options ensure that individuals with felony charges receive needed mental health care, including prescribed medication, regardless of custodial constraint, while also protecting facility staff and other patients.

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

III. Medical Transportation Company Responsibilities

Chapter 65E-5.260, Florida Administrative Code

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 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 law enforcement officer must respond 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.

A county transportation plan may identify a medical transportation company as an alternative to law enforcement for Baker Act transportation. In this instance, or when an individual has an emergency medical condition, law enforcement will only be required to assist with transport for individuals under involuntary status when necessary for safety reasons.

For example, Crisis Center of Tampa Bay operates TransCare Medical Transportation Services, which provides psychiatric transportation for Hillsborough and Pasco County Schools. TransCare was originally established to provide an alternative to transporting youth experiencing a behavioral health crisis in law enforcement vehicles and provides transportation using trained medical and behavioral health transportation staff. Shifting the transit of stable, low-risk youth to a health-focused medical model directly utilizes the alternative mechanism authorized under s. 394.462(1)(b)1., F.S., provides a safe, recovery-oriented, and dignified encounter for children in crisis while successfully returning critical road patrol capacity to core public safety functions.

IV. Medical Emergencies

42 U.S. Code 1395dd

Emergency Medical Treatment and Labor Act

Section 394.462, Florida Statutes

Transportation

Section 395.002(8), Florida Statutes

Definitions – Emergency Medical Condition

Chapter 65E-5.260, Florida Administrative Code

Transportation

An individual demonstrating signs of an emergency medical condition may initially be transported to a local emergency department if 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.

- There is a substantial risk 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. After the individual arrives at a designated receiving facility, if the clinical staff determine that the individual requires immediate medical clearance from an emergency department, the staff at the designated receiving facility must arrange the transport even when 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 transferred to a general hospital from a designated receiving facility or State Mental Health Treatment Facility due to symptoms of an acute medical condition or injury. Transfers must be conducted in accordance with the guidelines of the county's transportation plan, applicable law, and the facility's written policies and procedures.

When an individual in the facility's care exhibits signs or symptoms of a medical condition that cannot be safely assessed or managed within the facility, staff should promptly activate emergency medical services (911), to facilitate transport to the nearest emergency department.

Designated receiving facilities should maintain written policies and procedures that clearly identify the circumstances requiring activation of emergency medical services, establish staff roles and responsibilities during a medical emergency (including who is responsible for initiating the 911 call), and provide guidance for ongoing monitoring and communication while awaiting Emergency Medical Services arrival. At a minimum, designated receiving facilities should review and update policies and procedures annually to ensure they remain consistent with current statute, administrative rule, accepted standards of care, and evolving clinical best practices. Policies and procedures will contain additional guidance regarding medical emergencies, emergency response, and transfer of individuals requiring medical evaluation.

In situations where an individual admitted to a designated receiving facility is transferred to a local emergency department for medical clearance, the individual remains under the legal authority of the Baker Act and should not be discharged from the designated receiving facility unless either of the following circumstances occur:

- The emergency department admits the individual to the general 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. Code 1395dd(e)(4)

Transfer – Definition

Section 394.4685, Florida Statutes

Transfer of Patients Among Facilities

Section 394.4685, F.S. has clear guidelines for transferring an individual under involuntary status between designated receiving facilities, State Mental Health Treatment Facilities, and other appropriate clinical settings. 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 are typically 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 to provide. A transfer may also occur if the individual, or someone acting on the individual's behalf requests the transfer. The sending facility is responsible for arranging safe and appropriate transportation to the designation facility. Facility-to-facility transfers are arranged by the sending facility in accordance with applicable state and federal requirements. The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires the sending hospital to arrange an appropriate and safe transport of individuals between hospitals when necessary.

Transfers are conducted to ensure the individual is cared for 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 receives and ranges from outpatient and home-based services to inpatient and residential services. Individuals can be transferred to a higher, lower, or parallel level of care based on their assessed need.

Transfers to a lower level of care will typically involve a discharge to the community, for example 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 general hospital and needs to be transferred to a designated receiving facility for an involuntary examination. Transfers without 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 general hospital for medical examination and clearance at an emergency department.

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 requirements for 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. However, it is considered best practice for the transferring facility to also coordinate with community service providers and resources especially when the individual may need wraparound support post-discharge. 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 or their legal guardian or representative to provide consent before the release of relevant records to another provider when the individual is being transferred to a designated receiving facility. The individual or their representative should be asked to sign a release of information, if they are unwilling or unable to provide consent, some confidential information about the individual may still be shared with the designated receiving facility when permitted by law and necessary to ensure care is coordinated. These circumstances are discussed further in Chapter 14.

The 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 by the Agency for Health Care Administration (AHCA).

A general hospital may also be designated by the Department as a designated receiving facility. These hospitals can provide general medical care as well as the psychiatric evaluation and treatment required for individuals receiving Baker Act services.

Once an individual is admitted to a hospital's medical floor for treatment of a medical condition, EMTALA may no longer apply to the sending hospital in the same way it did when the individual first arrived for emergency care. This is because EMTALA requires a hospital to screen an individual for an emergency medical condition and provide stabilizing treatment or an appropriate transfer. When the hospital admits the individual as an inpatient to provide the necessary treatment, the hospital has generally satisfied EMTALA's

screening and stabilization responsibilities. The hospital remains responsible for providing appropriate care to the individual under other applicable federal and state requirements.

Further clarification can be found in Appendix B, Table B.5 - [CMS State Operations Manual Appendix V Interpretive Guidelines for Responsibilities of Medicare Participating Hospitals in Emergency Cases.](#)

If the individual later needs services that the hospital cannot provide, the hospital may seek transfer to another hospital with the necessary specialized services. A hospital being asked to accept the individual may have separate EMTALA obligations if it has the specialized psychiatric services, capacity needed to treat the individual, and the ability to provide the level of behavioral health care the individual requires.

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 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 general 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 CSU or free-standing psychiatric hospital sends an individual to a local emergency department for medical examination and clearance, it is best practice to contact the destination hospital as soon as possible to coordinate care, 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. CSUs are licensed by AHCA and designated and regulated by the Department under chapter 394, F.S. Hospitals are licensed by AHCA under chapter 395, F.S. and designated by the Department under chapter 394, F.S. 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.

Transfers Between Designated Receiving Facilities

Section 395.1041, Florida Statutes	Access to Emergency Services and Care
Section 394.4599(2), Florida Statutes	Notice
Section 394.4685, Florida Statutes	Transfer of Patients Among Facilities
Chapter 65E-5.310, Florida Administrative Code	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 depend on 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 designated receiving facility must accept an appropriate transfer regardless of the individual's ability to pay or health insurance coverage.

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 general 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 designated receiving facilities. Public designated 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.

Continuation of Services

Florida law stipulates that while an individual may be transferred from a designated receiving facility to a general hospital for more specialized services, once those hospital services are no longer needed, the sending facility is required to readmit the individual if all 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 readmit the individual once the medical issues are within the facility's capability if criteria are 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. Emergency Department Transfers

Section 394.463(2)(h)-(i), F.S. outlines the requirements for individuals who are on involuntary status under the Baker Act and receiving services in a general hospital. These guidelines help ensure the individual receives proper mental health care. For example, when an individual is sent to a general hospital from a designated receiving facility or State Mental Health Treatment Facility, the individual needs to return to the same designated 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 capability to meet the individual's needs.

If a general hospital is unable to meet the 12-hour transfer deadline, hospital staff are required to notify the Department's Regional Office of SAMH as soon as possible. SAMH Regional Offices can be contacted as follows:

Northwest Region: nwr.samh.support@myflfamilies.com

Northeast Region: ner.samh.support@myflfamilies.com

Central Region: cnr.samh.support@myflfamilies.com

Suncoast Region: scr.samh.support@myflfamilies.com

Southeast Region: ser.samh.support@myflfamilies.com

Southern Region: snr.samh.support@myflfamilies.com

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 CSU 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

Unless otherwise established within the county transportation plan, transfers between secure facilities generally do not require law enforcement as a method of transportation. These transfers are completed by a medical transportation company or trained facility staff using an appropriate and safe vehicle owned by the facility. A secure facility generally includes a facility setting with increased security and supervision, 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.

When an individual is under arrest or in law enforcement custody, and transfer to another location is necessary, the designated receiving facility should contact law enforcement, correctional staff, and other appropriate providers to coordinate transportation and custody arrangements.

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

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- I. Overview of Individual Rights
 - II. Inclusive Individual Rights Afforded Under the Baker Act
 - III. Treatment
 - IV. Access to Clinical Records
 - V. Exercise and Fresh Air Rights
 - VI. Right to Release
 - VII. Representatives and Substitute Decision-Makers
 - VIII. Other Individual Rights
 - IX. Grievances
 - X. Violation of Rights

Chapter 8: Rights of Individuals with Mental Health Conditions

I. Overview of Individual Rights

Section 394.459, Florida Statutes	Rights of Patients
Section 381.026, Florida Statutes	Florida Patient's Bill of Rights and Responsibilities
Chapter 65E-5.140, Florida Administrative Code	Rights of Patients
Chapter 59A-3.154, Florida Administrative Code	Patient Rights and Care

While individuals in designated receiving facilities and State Mental Health 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. 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 committed any crime and deserve the same treatment as any other person seeking care for a medical condition.

Section 394.459, F.S., requires that individuals are provided with due process rights regardless of whether the individual receives services voluntarily or involuntarily. 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 general hospital. There are only a few variations in 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 adopts many of these rights for individuals receiving services in a designated receiving or treatment facility. Individuals who are receiving psychiatric examination or treatment in a general hospital 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 including receiving and treatment facilities that accept Medicare and/or Medicaid payments. These facilities are regulated by several federal organizations including the U.S. Department of Health and Human Services and the CMS. More information on these organizations is found in Appendix A. Oversight Organizations.

Section 394.459(12), Florida Statutes	Posting of Notice of Rights of Patients
Chapter 65E-5.140, Florida Administrative Code	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.

II. Individual Rights Under the Baker Act

The rights of individuals receiving services under the Baker Act are explained in the section below. These rights affirm each person's dignity, autonomy, and connection to their community. They include the ability to retain many personal belongings during admission and to communicate with people outside the facility by phone, mail, and in-person visits. Together, these protections help ensure that every individual is treated with respect, compassion, and humanity while receiving care.

Any Floridian may need behavioral support at some point in their lifetime. The rights established under the Baker Act belong to and protect all of us, reflecting Florida's commitment to person-centered care and safeguarding individuals from neglect, mistreatment, and inhumane 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

Chapter 65E-5.150, Florida Administrative Code

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. All individuals must 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

Chapter 65E-5.200, Florida Administrative Code

Right to Care and Custody of Personal Effects

Form CF - MH 3043

Inventory of Personal Effects

Preserving individual dignity includes 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 keep possession of 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 individuals' 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 not allowed on the unit for safety reasons..

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. Facility staff may use [Inventory of Personal Effects \(CF- MH 3043\)](#) to document which the belongings that the individual keeps with them on the unit and which items are maintained by the facility for safety reasons.

C. Communication and Visits

Chapter 65E-5.190, Florida Administrative Code	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 evaluation or treatment of an emergency medical condition or for discharge.

While information cannot be provided without consent (unless as stated above), 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 assume 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 personal identification number (PIN) 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. Facility staff 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 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.

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. Facility staff should not monitor or record phone calls or listen in on conversations. Individuals have the right to be provided with space from other individuals waiting to make a phone call. This 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 qualified professional may write an order for communication to be restricted or monitored if their assessment determines that communication is detrimental to the well-being of the individual receiving services or others. Written notice must be provided to the individual, the individual's attorney, and the individual's guardian, guardian advocate, or representative within three (3) hours of notice and documented in the clinical record within 24 hours. This notification may be provided with the form [Restriction of Communication or Visitors \(CF-MH 3049\)](#). Communication restrictions 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.
- A complaint is made about calls from the individual being unwanted or inappropriate, such as repeatedly 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 qualified professional. 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 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 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

Chapter 65E-5.170, Florida Administrative Code	Right to Express and Informed Consent
Chapter 59A-3.254(4), Florida Administrative Code	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.

Section 394.463, Florida Statutes	Involuntary Examination
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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 Service Planning

Treatment planning must occur with the individual receiving services, their substitute decision-maker, if applicable, family members, and significant others with the individual's consent, 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 needs of the individual as well as the individual's progress and desired treatment and recovery goals. 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 the following domains.

- Medical
- Vocational
- Social
- Educational
- Rehabilitative Services
- Discharge

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 designated receiving facility, this often means that the treatment team meets daily or 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 at 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. An individual's progress, or lack thereof, should be documented both in the progress notes and 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 be involved 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 follow up treatment upon discharge. Community agencies are expected to work together to increase awareness of the services needed, 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 are necessary to determine when the individual is ready to be transitioned to the next level of care.

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.

Discharge planning, which includes transitions between providers or levels of care within the same provider, must begin at the time of admission and, similarly to the treatment plan, must be continuously adapted to the individual's need throughout his/her stay.

IV. Access to Clinical Records

Section 394.4615, Florida Statutes	Clinical Records; Confidentially
Chapter 65E-5.250, Florida Administrative Code	Clinical Records; Confidentially

Individuals receiving services in a designated receiving facility, or a State Mental Health Treatment Facility have the right to access their clinical record. Clinical records must be released when the individual, or the individual's guardian, parent of a minor, or legal custodian authorizes the release. The individual's guardian, guardian advocate, parent of a minor, or legal custodian are authorized to have access to the individual's clinical record.

A physician or psychiatric nurse, 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.

The Florida Department of Juvenile Justice is considered a legal custodian and is thereby authorized to release and access the clinical records of individuals in their custody. This ensures proper coordination of care upon discharge.

V. Exercise and Fresh Air Rights

Chapter 65E-5.150, Florida Administrative Code	Individual Dignity
Chapter 65E-5.350(h), Florida Administrative Code	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

Section 394.4625, Florida Statutes	Voluntary Admissions
Section 394.459(8), Florida Statutes	Rights of Patients
Chapter 65E-5.220, Florida Administrative Code	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 designated receiving facility can be used to document 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 the individual is safe to be discharged or the involuntary criteria is met. If involuntary criteria are met, the individual must be transferred to involuntary status unless the request for discharge is rescinded. Pending the filing of a petition for involuntary treatment, the individual may

be held and provided emergency treatment, upon the verbal or written order of a physician or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, if it is determined that such treatment is necessary for the safety of the patient or others.

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

Chapter 59A-3.254(4)(b), Florida
Administrative Code

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. Advance directives are 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. A 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 and the online course entitled [Guardian Advocate and the Baker Act](#).

VIII. Other Individual Rights

Section 394.459(7), Florida Statutes	Rights of Patients
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Chapter 65E-5.210, Florida Administrative Code	Right to Vote in Public Elections
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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. Code 922(g)(4)	Unlawful Acts
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Section 394.463, Florida Statutes	Involuntary Examination
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Section 790.06, Florida Statutes	License to Carry Concealed Weapon or Firearm
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Section 790.064, Florida Statutes	Firearm Possession and Firearm Ownership Disability
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Section 790.65, Florida Statutes	Sale and Delivery of Firearms
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Section 790.401, Florida Statutes	Risk Protection Orders
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State and federal law can restrict individuals from purchasing or possessing firearms if they are determined to pose a risk of harming themselves 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.

Conversion to Voluntary Status and Acknowledgement of Firearm Rights

Pursuant to s. 790.065, F.S., individuals who have been involuntary examined under the Baker Act and who are subsequently determined to require continued treatment may elect to convert to voluntary status. As part of this process, the individual must acknowledge that such conversion may result in the loss of the right to possess firearms and other weapons.

Designated receiving facilities must ensure the following procedures are followed:
Execution of the [Patient's Notice and Acknowledgement form](#).

The Patient's Notice and Acknowledgement form must be voluntarily signed by the individual prior to agreeing to voluntary admission or treatment. The Patient's Notice and Acknowledgement form documents that the individual has been informed that agreeing to voluntary treatment following an involuntary examination may result in the loss of the right to possess firearms or other weapons.

Voluntary Process

Execution of the Patient's Notice Acknowledgment form and agreement to voluntary treatment must both occur voluntarily. If an individual declines to sign the Patient's Notice and Acknowledgement form or declines to consent to voluntary admission or treatment, the designated receiving facility may not treat the individual as having waived their firearm rights under s. 790.065, F.S.

Required Action if Declined

If an individual refuses to sign the Patient's Notice and Acknowledgement form or declines voluntary treatment following an involuntary examination, the designated receiving facility must proceed in accordance with the Baker Act by either:

- Releasing the individual if the criteria for involuntary services are no longer met; or
- File a petition for involuntary placement if the statutory criteria are met.

Facilities **must not** submit documentation to the court requesting firearm prohibition unless the statutory requirements have been met.

Certification Accuracy

Any documentation submitted to the court related to firearm rights must accurately reflect the individual's status and the services provided. Facilities must ensure that certifications indicating an individual requires continued treatment are supported by clinical determination and the individual's treatment status.

Individual Awareness

Facilities must ensure that individuals are informed of the implications of signing the Patient's Notice and Acknowledgment for and converting to voluntary status, including the potential loss of firearm rights as provided in s. 790.065, F.S.

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 from a 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 general hospital and, before going to a designated receiving facility, are either discharged or transferred to voluntary status.
- Do not meet statutory criteria demonstrating a risk of harm to self or others.

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 themselves 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
Section 381.026, Florida Statutes	Florida Patient's Bill of Rights and Responsibilities
Chapter 65E-5.180, Florida Administrative Code	Right to Quality Treatment
Chapter 65E-5.352, Florida Administrative Code	Procedures for Complaints and Investigations
Chapter 65E-5.400, Florida Administrative Code	Baker Act Funded Services and Standards
Chapter 59A-3.254(4)3(c), Florida Administrative Code	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 Facility. 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. Complaints and grievances can also be filed with the Department, AHCA, Office of Children's Behavioral Health Ombudsman, or the Managing Entity.

As established by section 394.4915, F.S., the Office of Children's Behavioral Health Ombudsman serves as a central point to receive concerns on behalf of children and adolescents with behavioral health disorders who are receiving behavioral health services, in order to identify information that can improve or otherwise enhance the child and adolescent mental health treatment and support systems. The Ombudsman serves as a trusted advocate and point of contact for children and families navigating the behavioral health system. Their role is to support, inform, and guide those experiencing challenges related to mental health and substance use services with the goal of improving access, accountability, and outcomes across Florida's behavioral health network. The Ombudsman plays a vital role in ensuring that Florida's behavioral health system remains person-centered,

responsive, and effective. The Ombudsman can be reached by phone at 850-717-4199, email at dcf.ombudsmand@myflfamilies.com or through a web-based inquiry: dcf.ombudsmand@myflfamilies.com.

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.

Chapter 65E-5.220, Florida Administrative Code

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

Section 394.4593, Florida Statutes

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 that occur 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

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- I. General Management of the Treatment Environment and Behavioral Management Programs
 - II. Alternatives to Behavioral Management Programs
 - III. Following the Release of Seclusion or Restraint

Chapter 9: Behavioral Management, Seclusion, Restraint, and Emergency Treatment Orders

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 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 are safety interventions that may be used only when documented as the least restrictive means of protecting the physical well-being of an individual or others. Because these interventions temporarily limit a person's freedom of movement, staff must prioritize prevention and de-escalation whenever possible. Before participating in seclusion or restraint, staff must receive age-appropriate training that includes verbal de-escalation, safe intervention techniques, and strategies for responding to individuals with care and respect.

Many designated receiving facilities in Florida are committed to reducing or eliminating the use of physical restraint through trauma-informed, person-centered care. By creating supportive environments, recognizing signs of distress early, responding to each person's needs, and equipping staff with effective verbal de-escalation skills, facilities can often resolve challenging situations without physical intervention. This approach promotes dignity, strengthens trust, and supports the safety of both the individual's receiving services and the professionals caring for them.

Section 394.459(2)(e), Florida Statutes	Rights of Patients
Chapter 65E-5.1601, Florida Administrative Code	General Management of the Treatment Environment
Chapter 65E-5.1602, Florida Administrative Code	Individual Behavioral Management Programs
Chapter 65E-5.180(7), Florida Administrative Code	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

Chapter 65E-5.180(7), Florida Administrative Code	Right to Quality Treatment – Seclusion and Restraint
Form CF – MH 3124	Personal Safety Plan

Addressing trauma is an essential component of effective behavioral health care. In designated receiving and treatment facilities, trauma-responsive practices help create environments where individuals feel safe, respected, and supported. Because seclusion and restraint may cause distress or reawaken the effects of earlier traumatic experiences, facilities should apply the principles of trauma-informed care throughout their operations. This approach recognizes that trauma may affect individuals receiving services, their families, and the professionals who support them.

A trauma-responsive approach assumes that any person may have experienced trauma, even when that history is not known to staff. By working with individuals to identify sources of distress, early signs that additional support may be needed, and strategies that help them feel calm and safe, staff can tailor their interactions to each person's strengths and preferences. The [Personal Safety Plan \(CF-MH 3124\)](#) can support this partnership by giving individuals an opportunity to share what helps them, what may cause distress, and how they would prefer staff to respond. This information allows staff to offer effective support early and reduce the likelihood that distress will intensify.

An understanding of trauma should also inform treatment planning and service delivery. When appropriate and known, the treatment team should consider an individual's experiences, strengths, needs, and preferences when developing and providing care. Staff training should also build awareness of how interactions and the physical environment can affect a person's sense of safety, helping staff promote trust, choice, collaboration, and healing throughout treatment.

Trauma-responsive care is essential during a crisis because it helps staff understand how a person's experiences may shape their needs and responses. By listening to the individual and using calm, respectful, and supportive approaches, staff can build trust, promote a sense of safety, and draw upon the person's strengths and preferences. This person-centered approach can reduce distress and support a safer, more effective path toward stabilization and recovery.

B. Behavioral Management Practices

Section 394.457(5)(b), Florida Statutes	Operations and Administration
Chapter 65E-5.180(7), Florida Administrative Code	Right to Quality Treatment – Seclusion and Restraint

Positive, person-centered behavioral support is an important part of a safe and therapeutic treatment environment. Effective approaches build upon each individual's strengths, needs, experiences, and preferences while supporting dignity, choice, and recovery. When selecting and implementing behavioral management practices, staff should consider 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 help an individual feel safe, manage distress, or regain a sense of calm, those strategies should be incorporated into the individual's treatment and safety plans. Following any use of seclusion or restraint, both plans should be updated with careful documentation of the circumstances, potential sources of distress, and the individual's response to the supports provided. This review should identify what worked well, what could be improved, and any strengths or preferences that can guide future interactions. Collecting and applying this information supports more individualized care, strengthens prevention efforts, and promotes the individual's safety and well-being.

[Documentation related to the use of seclusion or restraint must be included in the individual's clinical record to support continuity of care and inform future safety planning. The incident report must be maintained separately and should not be filed in the clinical record.](#)

C. De-Escalation Techniques

Section 394.453(2), Florida Statutes	Legislative Intent
Section 394.457(5)(b), Florida Statutes	Operations and Administration
Chapter 65E-5.1703, Florida Administrative Code	Emergency Treatment Orders
Chapter 65E-5.180(7), Florida Administrative Code	Right to Quality Treatment – Seclusion and Restraint
Chapter 65E-5.330, Florida Administrative Code	Training

Individuals receiving specialized care, such as inpatient psychiatric services and residents of long-term care facilities, often experience disturbing symptoms such as hallucinations or delusions and may have triggers that evoke emotional and behavioral responses. 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. Refer to the individual's safety plan. Use simple and clear verbal instructions.
- 3) Avoid the use of restraint when at all possible.
- 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 H. 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.

Best Practices Tool

Section 394.457(5)(b), Florida Statutes

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.
- Be aware 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, use 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 may be used only when they are the least restrictive interventions necessary to protect the immediate physical safety of an individual or others.

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:

- That a single staff member is responsible for watching that individual within proximity until the order is completed.
- 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 supervision responsibilities. An individual receiving one-to-one supervision must remain under continuous staff observation, including during shift changes and while using the restroom or showering. Staff should provide the greatest degree of privacy possible while maintaining the level of supervision necessary to support the individual's safety.

II. Alternatives to Behavioral Management Programs

Section 394.457(5)(b), Florida Statutes

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 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 that an individual is escalating based on verbally aggressive behavior, and 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.

When an individual continues to display behaviors that present an immediate physical threat after less restrictive de-escalation techniques have been unsuccessful, seclusion or restraint may be necessary to maintain safety. A physician may order seclusion or restraint based on the individual's current behavior and information provided by staff. The least restrictive intervention that can safely and effectively address the immediate threat should be used.

A. Guidelines for Seclusion and Restraint

Section 394.457(5)(b), Florida Statutes	Operations and Administration
Chapter 65E-5.180(7), Florida Administrative Code	Right to Quality Treatment – Seclusion and Restraint

State and federal laws regulate the use of seclusion and restraint for the safety of individuals in need of crisis care. These policies are monitored and enforced by AHCA and the CMS. Each designated receiving and State Mental Health Treatment Facility must have explicit seclusion and restraint policies and procedures that include all the following elements, at a minimum:

- 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.
- New hire and 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.

Seclusion or restraint may be used only to protect immediate physical safety and must never be used as punishment, coercion, or for staff convenience.

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 behavior that is a danger to the individual's or another's 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 ETO.

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 themselves 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 and attempted. Orders must 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 seclusion and restraint are 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+): Four (4) Hours
- Minors (Age 9-17): Two (2) Hours
- Minors (Age 8 years and under): One (1) Hour

If continued seclusion or restraint remains necessary to protect immediate physical safety, a new order must be written before the current order expires. Continuing the intervention beyond 24 hours requires an in-person assessment by the reviewing physician, psychiatric nurse, advanced practice registered nurse, or physician assistant. A telephone order is not sufficient. The individual must be released as soon as they no longer present an imminent danger, even if time remains on the order.

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 – Age 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 – Age 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 continues to warrant 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 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 position of the individual's body is accommodated for physical disability, medical condition, or age.
- The individual must be provided reasonable opportunities to toilet and drink fluids 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.

Individuals must not be restrained in a face-down (prone) position. Prone containment may be used only when immediately necessary to prevent imminent serious harm to the individual or others, and the individual must be repositioned as quickly as possible to reduce the risk of positional asphyxiation. Throughout the restraint, trained staff must continuously observe the individual, closely monitor respiration, circulation, coloring, and other signs of distress, and respond immediately if distress is observed. Nursing staff must assess the individual as soon as possible, but no later than 15 minutes after the restraint begins, and at least hourly thereafter. Monitoring must include vital signs, skin integrity, signs of injury, and respiratory and circulatory status, with pulse and respiratory rate measured at a minimum. The individual must also receive a face-to-face medical and behavioral assessment within one hour after the restraint begins. Nothing that could impair breathing may be placed over the individual's face; staff may wear appropriate protective equipment when necessary. The individual must be released from restraint as soon as they no longer present an imminent danger to themselves or others. These requirements are established in Rule 65E-5.180(7), F.A.C. 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 discontinued.

This information must also be documented in the clinical record. Parents of minors must be notified as soon as possible and no later than within 24 hours that these methods were used.

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, addressing 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.

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

Oversight Committees

Chapter 65E-5.180(7), Florida Administrative Code

Right to Quality Treatment – Seclusion and Restraint

Each facility using seclusion and restraint must establish an oversight committee. This committee, at minimum, must include the following:

- 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, including an analysis of the event and confirmation that 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. This information can be used to implement improvements such as modifying policies and procedures or bolstering staff training materials.

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 (CoP). The CoP identify several individual rights that must be observed including rights regarding confidentiality, personal representatives, advance directives, and seclusion and restraint.

The CoP 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.

Accrediting Organizations

The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities 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 Commission on Accreditation of Rehabilitation Facilities must follow their seclusion and restraint practices in addition to state and federal laws.

B. Emergency Treatment Orders

Section 394.459(2)(c), Florida Statutes	Rights of Patients
Chapter 65E-5.150(1), Florida Administrative Code	Person's Right to Individual Dignity
Chapter 65E-5.1703, Florida Administrative Code	Emergency Treatment Orders
Chapter 59A-3.254(4)(h), Florida Administrative Code	Right to Be Free of Restraints

Emergency Treatment Order (ETO) means a written or verbal order for psychotropic medication or 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. ETOs 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 may be ordered when: de-escalation techniques are ineffective and consent for the administration of psychotropic medications is declined; the individual is not competent to consent; 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 the ETO is being administered. Staff may use additional restraint practices to administer the ETO, if necessary. The reason for an ETO must be documented in the order and the progress notes. This documentation must include identification of the imminent risk and why less restrictive alternatives were insufficient. ETOs may be ordered by a physician, or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist 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 or psychiatric nurse must review the circumstances leading to the ETO and determine if there are any metabolic or biological factors that could influence the individual's 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

Section 394.457(5)(b), Florida Statutes	Operations and Administration
Chapter 65E-5.180(7), Florida Administrative Code	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 APRN, registered nurse, 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.

Reporting

Chapter 65E-5.180(7), Florida Administrative Code

Right to Quality Treatment – Seclusion and Restraint

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

- 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.

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

CoP, a report must also be made to the Centers for Medicare & Medicaid Services. 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.

Hospitals must report patient deaths associated with restraint or seclusion to the Centers for Medicare & Medicaid Services. Reportable deaths must be submitted using electronic form [Report of a Hospital Death Associated with Restraint or Seclusion \(CMS-10455\)](#).

CHAPTER 10

INVOLUNTARY SERVICES

I. Requirements for Involuntary Placement



Chapter 10: Involuntary Services

I. Requirements for Involuntary Services

In 2024, Section 394.467, F.S. combined processes for involuntary inpatient placement and involuntary outpatient services, now referred to collectively as involuntary services. Individuals may only be held in a designated receiving facility for an involuntary examination during the initial 72-hour examination period. If 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.

Involuntary Inpatient Services

Section 394.467, Florida Statutes	Involuntary Inpatient Placement and Involuntary Outpatient Services
Chapters 65E-5.285 and 65E-5.290, Florida Administrative Code	Involuntary Services

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 [Petition for Involuntary Services \(CF-MH 3032\)](#) 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 services or involuntary outpatient services. The court will then hold a hearing to determine if the individual meets criteria for involuntary services.

Criteria

The criteria for involuntary inpatient services requires clear and convincing evidence that, because of a mental health condition, the individual meets 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.
 - Without treatment, poses a significant threat to themselves or others as evidenced by recent behavior that cannot be reasonably managed at a lower level of care.
 - Alternative less restrictive treatment that is reasonably likely to improve the individual's condition are not appropriate or not available.

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 services, these behaviors or symptoms must continue to be evident during the 72-hour involuntary evaluation period.

Petition Requirements

A [Petition for Involuntary Services \(CF-MH 3032\)](#) 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 services, 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 or a psychiatric nurse and must be provided after personally assessing the individual within the initial examination period.

Consistent with section 394.467(4)(d), F.S., the petition must recommend involuntary inpatient services, involuntary outpatient services, or a combination of both, the recommended length of time for each time of involuntary service, the reason for the recommendation, the service provider that has agreed to provide involuntary outpatient services, and the service plan for involuntary outpatient services addressing the level of care, medications, and discharge criteria. The petition must also contain a detailed service plan, developed in consultation with the individual or their guardian, that outlines recommended care type, duration, responsible provider, medications, and discharge criteria. All determinations must be clinically appropriate by a licensed clinician who works for the service provider that has agreed to provide the involuntary outpatient services.

The facility must make the clinical record available to the individual's attorney and the state attorney representing the state for the purpose of preparing their case. These records are confidential and may not be used for any criminal investigation or prosecution purposes or any other purpose.

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.

Notifications

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

- 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 I. Notifications.

Legal Representation

In accordance with s. 394.467, F.S., individuals subject to a petition for involuntary inpatient or involuntary outpatient services are entitled to prompt legal representation. A public defender must be appointed within one (1) court working day from when a petition for involuntary inpatient services 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.

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 services is like any other court hearing where testimony is provided under oath in a recorded session. It may be presided over by an administrative law 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 state attorney and their witnesses may attend the hearing remotely and testify at the hearing under oath. If attending remotely, any relevant documents must be provided by the close of business the day before the hearing.

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 \(CF-MH 3107\)](#). If a guardian advocate is appointed, before consenting to treatment the individual, guardian advocate and individual's physician or psychiatric nurse must meet in person or by phone to discuss the treatment and implementation treatment. For more information on guardian advocates and the court system, please see the online course [Guardian Advocate and the Baker Act](#).

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:

- Grant a continuance;
- Order the individual to initial or continued involuntary inpatient services 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 inpatient services 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 services \(CF-MH 3155\)](#) 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 designated receiving facility where they will continue to receive services for the duration of their involuntary inpatient services without transferring to a treatment facility. Once the individual no longer meets criteria for involuntary inpatient services, 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 services 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 designated receiving facility for continued services until the treatment facility has the capacity to accept. The designated 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 the following:

- The Psychiatric Evaluation
- Assessments Performed by a Clinical Psychologist or Clinical Social Worker
- Advance Directives
- [State Mental Health Treatment Facilities Admission form \(CF-MH 7000\)](#)
- [Physician to Physician Transfer form \(CF-MH 7002\)](#)

If the individual no longer meets criteria for involuntary inpatient services prior to being transferred to the treatment facility, the individual may be released from the designated receiving facility with required discharge 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 \(CF-MH 3033\)](#).

Continued Involuntary Inpatient Services

Section 394.467(6), Florida Statutes	Procedure for Continued Involuntary Inpatient Services
Chapters 65E-5.285 and 65E-5.290, Florida Administrative Code	Involuntary Services
Chapter 65E-5.300(5), Florida Administrative Code	Continued Involuntary Inpatient Services at Treatment Facilities

If an individual is currently ordered to involuntary inpatient services and continues to meet the criteria, the administrator of the designated receiving facility or State Mental Health Treatment Facility is required to file one continuance ([CF-MH 3035](#)) for up to seven (7) days 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.

The patient and his/her attorney may also request a continuance for up to seven (7) days and additional requests for up to 21 calendar days by showing good cause.

A hearing for involuntary inpatient services that is held while the individual is at the designated receiving facility occurs in the judicial system. A hearing for continued involuntary inpatient services for an individual who is receiving services in a treatment facility occurs in the administrative system. The individual may waive their right to be present at the hearing.

Many of the other procedures (e.g., court filings, time frames) for initial and continued involuntary services 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 services, 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 services. 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

Section 394.467, Florida Statutes	Involuntary Inpatient Services and Involuntary Outpatient Services
Chapters 65E-5.285 and 65E-5.290, Florida Administrative Code	Involuntary Services

It is important for individuals with mental health conditions to receive treatment, resulting in benefits to both 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 to 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, 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 in the community setting, 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 or the outpatient treatment provider 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.

Involuntary outpatient services may be ordered upon a finding of the court, by clear and convincing evidence, that 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 designated 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 F. Criteria for Involuntary Outpatient Services.

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.

Petition Requirements

A petition for involuntary outpatient services, involuntary inpatient services or a combination of both is completed by the administrator of the designated receiving facility, a service provider who is treating the individual, or State Mental Health Treatment Facility. The petition for involuntary outpatient services must be based on two professional opinions, a psychiatrist and one clinical psychologist with three years of clinical experience or psychiatric nurse who have personally evaluated the individual within the past 30 days. The second opinion must be a face-to-face examination that may be conducted in person or virtually and can be conducted by a clinical psychologist or a psychiatric nurse. 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. A comprehensive treatment plan must be developed with the individual, their guardian, and the proposed treatment provider. The petition must then be completed by the administrator of a designated receiving facility, current service provider or treatment facility and be accompanied by a copy of the

treatment plan. For a designated 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 Treatment Facility Discharge Form \(CF-MH 7001\)](#). If the individual is still being held in a designated 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.

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 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.

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.](#)

Promotion 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.

Continued Involuntary Outpatient Services

Section 394.467, Florida Statutes

Procedure for Continued Involuntary Outpatient Services

Chapter 65E-5.285, Florida Administrative Code

Continued Involuntary Outpatient Services

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.

Hearings for continued involuntary outpatient services will be conducted by the same court that ordered the initial involuntary outpatient services and are held in the county or facility where the individual is physically located. 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.

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 I. Notifications.

CHAPTER 11

CONTINUITY OF CARE AND DISCHARGE

- I. Continuity of Care
- II. Discharge Planning
- III. Discharge Requirements
- IV. Right to Discharge
- V. Notice of Discharge or Release from a Facility

Chapter 11: Continuity of Care and Discharge

I. Continuity of Care

42 C.F.R. 482.43	Condition of Participation: Discharge Planning
Chapter 65E-5.130, Florida Administrative Code	Continuity of Care Management System
Chapter 65E-5.1303(2)(e), Florida Administrative Code	Discharge from Receiving and Treatment Facilities
Chapter 59A-3.254(2), Florida Administrative Code	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 criminal justice system involvement. Being discharged from an inpatient setting after an involuntary examination indicates that a crisis event has been stabilized and the individual is out of danger, but it does not mean the mental health condition is cured and symptoms will never re-occur. Mental health conditions can be lifelong like many other chronic health conditions and may require continued treatment and support to manage symptoms and maintain stability.

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' refers to how connected, consistent, and seamless an individual's healthcare feels across time, settings, and providers.

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. 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 to manage the long-term care of persons with ongoing mental health conditions.

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

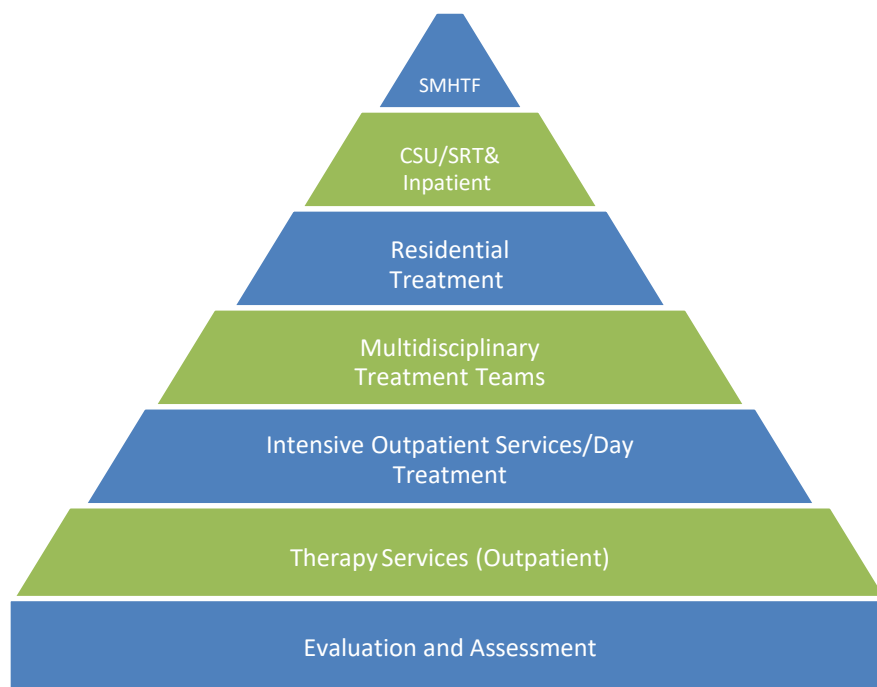
Behavioral health services can be categorized into levels of care, based on their purpose and intensity level. These services range from highly specialized inpatient services to less intensive levels of care, such as outpatient therapy. Individuals can move through various levels of care based on their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

Florida has a person-centered, coordinated, and recovery-oriented network of community-based services and supports. This network builds on the strengths and resiliency of individuals, families, and communities to improve the health, wellness, 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 Services and Wellness Supports
- 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. This integration, as well as the blending of primary and preventive medicine into traditional mental health settings, represents a more holistic approach. People desire whole person care in one coordinated, accessible environment. This model recognizes that physical health care and mental

health care are deeply interconnected and treating them separately leads to missed needed, fragmented experiences and poor outcomes.

Despite these advances in practice, transitions between levels of care or service components can be disruptive and the system of care can be difficult to navigate. This includes transitions between home, hospital, residential care settings, and consultations with different providers in outpatient facilities. 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.

A warm handoff supports a smooth and coordinated transition by connecting an individual directly with their new health care practitioner. During this real-time, personal transfer of care, the current provider introduces the individual to the new provider and helps communicate relevant needs, strengths, and preferences. This approach promotes continuity, builds trust, reduces uncertainty, and increases the likelihood that the individual successfully connects with ongoing services. The warm hand-off process helps to facilitate trust between the individual and the new practitioner or provider agency. Examples of warm hand-offs include assisting the individual in making the initial call to the new practitioner or provider agency, staying with the individual when the initial appointment is made and walking the individual over to the new provider. According to the Agency for Healthcare Research and Quality, during a warm hand-off, ideally the new practitioner or provider agency 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. This often occurs through care coordination activities.

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

Chapter 65E-5.130, Florida Administrative Code

Continuity of Care Management System

Case management is a collaborative process of assessment, planning, coordination, monitoring, and advocacy to meet an individual's comprehensive needs. Behavioral health case management includes symptom management, psychosocial supports, and recovery planning. Case managers serve important functions in several areas including:

- 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 designated receiving facility. Case managers are also expected to assist facility staff in discharge planning.

C. Peer-Based Recovery Support Service

Peer-based recovery support involves individuals with lived experience of mental health or substance use conditions offering non-clinical, empathetic support to those on their own recovery journey. Peer-based recovery support services may complement clinical services by providing strategies for self-empowerment. Peer support specialists provide another level of acceptance, understanding, and validation beyond the traditional therapeutic relationship, acting as relatable guides who have walked the path before. 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. Obtaining certification as a Recovery Peer Specialist or being engaged in the process to earn certification is often required and ensures that the peer specialist has the training and knowledge to provide quality services. Recovery Peer Specialists bring their lived experience of recovery, along with training and supervision, to assist others in initiating and maintaining recovery.

These services may be offered before formal treatment begins, during inpatient or outpatient care, or as part of aftercare and long-term recovery planning. During a formal treatment program, peer recovery support services give the individual a connection to the 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. Natural Supports

Natural supports are unpaid, naturally occurring supports from family members, friends, neighbors, coworkers, faith communities, and other informal networks. Individuals often can gain encouragement and assistance from their existing support system to help them cope with difficult situations. A strong, healthy natural 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 health difficulties like substance use and conduct disorders. Sometimes individuals with serious mental illness or substance use disorders are cut off or disconnected from their natural supports. In those circumstances, case managers and peer specialists may be integral to assisting individuals with reconnecting with or establishing new, healthy natural supports.

II. Discharge Planning

Chapter 65E-5.100(4), Florida Administrative Code	Definitions – Discharge Plan
Chapter 65E-5.1303, Florida Administrative Code	Discharge from Receiving and Treatment Facilities

Discharge planning begins when an individual starts receiving services and continues throughout the course of treatment. 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 the assistance needed and support following discharge from the current provider.

Discharge planning is an important part of today's recovery model.¹⁹ 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,

¹⁹ [Recovery Oriented System of Care \(ROSC\) | Florida DCF](#)

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.

Individuals receiving mental health services have the right to participate in discharge planning. With the individual's consent, it is essential to involve their family members or natural support system. These supports can play a key role in helping the individual understand and follow discharge recommendations and may be critical to ensuring a smooth transition to outpatient care. For individuals with chronic or severe mental health conditions, additional support is often needed, for example, to assist with filling prescriptions and attending follow-up appointments.

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 unique needs of the individual.

Individuals should be asked where they want to receive services upon discharge. If they do not know, they should be assisted in understanding their options and making that decision. Individuals who received services from another service provider prior to admission can be referred to that provider for continuity if the individual agrees. The facility discharge planner 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 is ongoing support, monitoring and engagement to help individuals with behavioral health disorders maintain recovery, build stability, stay connected to resources to sustain wellness over time.

Discharge planning ensures that individuals leaving the facility have the support and information they need to stay safe, connected and stable. Key benefits of discharge planning are reduced risk of relapse or deterioration, decreased readmissions from future crisis episodes, improved continuity, strengthened patient safety and enhanced patient satisfaction and trust. Specific risk factors and needs must be evaluated and documented when planning discharge from a designated receiving facility and State Mental Health Treatment Facility. Providers should offer referrals to community resources, appointments for aftercare services and educational information that anticipate the individual's needs at discharge even if an individual does not actively engage in discharge planning. Discharge planning best practice is to provide a follow-up appointment within seven days of discharge when ongoing mental health services are recommended after discharge. Individuals are more likely to follow up when a detailed and specific plan has been established and reviewed with them prior to discharge, including a review of the date, time and location of all appointments and a review of any prescribed medications.

Discharge planners working in facilities should do everything possible within their resources to address potential barriers to a successful discharge. Consideration should be given to the following factors.

Long-Acting Injectables:

Effective July 1, 2025, section 394.468(2), F.S., was amended to address the administration of long-acting injectable (LAI) antipsychotic medications to certain clinically approved individuals discharged from a designated receiving facilities. This provision was designed to enhance continuity of care for individuals with serious mental illness who are at heightened risk of deterioration following crisis stabilization or inpatient treatment. Designated receiving and treatment facilities may administer a clinically appropriate LAI prior to discharge, provided the individual has a documented history of a qualifying diagnosis – such as schizophrenia or bipolar with psychotic features and was previously prescribed the medication.

The administration of the LAI must be based on medical necessity and align with the individual's existing treatment plan. Informed consent is required and must be obtained directly from the individual, or, if the individual lacks capacity, from a legally authorized representative. If no representative is available and the individual lacks capacity, facilities must comply with existing statutory procedures for court-authorized treatment. The use of LAIs under this provision does not override or replace any due process protections required under the Baker Act, nor does it justify the initiation or extension of involuntary placement.

Facilities must document the medical necessity, prior prescription history, and consent within the individual's clinical record. Discharge planning must include coordination with the individual's outpatient mental health provider to ensure continuity of care and support medication adherence in the community. All administration must comply with established pharmaceutical guidelines and agency-approved protocols.

Transportation:

Transportation is an important consideration of discharge planning. Individuals are brought to the designated receiving facility for examination by law enforcement or other means and may not have transportation home. Some questions to ask are:

- Does the individual have Medicaid? Medicaid will cover transportation to medical and behavioral health appointments and transportation home after a discharge from a facility. Certain forms to request this from the Medicaid health plan may be needed.
- How will the individual get home following discharge? Are there friends or family members who can assist? Does the facility provide transportation? If not, are bus passes available?
- How will the individual access future appointments? Is the individual willing to receive services through telehealth?

When an individual needs continued 24-hour care following discharge from a crisis setting, a referral to an appropriately licensed provider supports a safe transition, high-quality services, and continuity of care.

Housing:

- Does the individual have a place to live? Discharge planners should be knowledgeable about local housing resources that the individual can be referred to. Each Managing Entity has a housing coordinator that can provide information about housing resources in the community. Is the physical and emotional home environment safe? Remember to only refer individuals to licensed levels of care, if seeking placement in a facility setting such as an Assisted Living Facility.
- Are the living conditions stable? If not, the individual may have family members that they can live with or a case manager that can assist with longer-term follow-up coordination with local housing resources.

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 services and medication.
- Individuals and their family 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 and the [988 Florida Lifeline](#)?
- Provide information on the purpose and use of advance directives in mental health care.
- Offer resources and guidance to assist individuals in preparing and utilizing advance directives to support their preferences in future treatment decisions.

- For individuals diagnosed with intellectual or developmental disability, the facility must supply parents or legal guardians with information on accessing appropriate services and supports. Including referral guidance and contact information for the Agency for Persons with Disability (APD) to ensure continuity of care post discharge.
- Has the individual been provided with a referral to care coordination services, if the individual meets the requirements and needs such services?
- Has the individual been provided with information on community resources, including peer specialists or support groups to assist them in their recovery process?

The clinical record must contain documentation about potential barriers to discharge and how these will be addressed. There are several common and significant barriers that can complicate discharge planning for this population. System level barriers include limited availability of appropriate next level of care, insurance or funding limitations, and lack of transportation. Community level barriers may include lack of safe and affordable housing, limited access to licensed settings, wait lists for services and others. Individuals who cannot access safe and appropriate housing face a significant barrier to recovery. 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 services when appropriate.

Many designated receiving facilities employ care coordinators to improve discharge planning and engage individuals who are not connected to services or don't 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.

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.

III. Discharge Requirements

Once an individual is admitted to a designated receiving facility, sections 394.463 and 394.468, F.S. establish 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.

Section 394.463(2)(f), Florida Statutes	Involuntary Examination
Section 394.468, Florida Statutes	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 the following:

- 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.
- Defined 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.

Designated receiving facilities must include and document the individual's needs and steps to address identified needs including, at minimum:

- Follow up behavioral health appointments.
- Information on how to obtain prescribed medications.
- Available living arrangements and transportation options.
- Referral to care coordination services if the individual meets criteria as a member of a priority population identified in section 394.9082(3)(c), F.S. and needs services.
- Referral to recovery support opportunities such as a peer specialist.

The discharge transition process must include:

- Implementation of policies and procedures for addressing the needs of high utilizers.
- Development and inclusion of a personalized crisis prevention plan in discharge paperwork.
- Documented face-to face or electronic engagement with family members, legal guardian, legal representative, or natural support to review discharge instructions.
- Ensure referrals to appropriate providers to address the individual's needs when the recommended level of care is not available at discharge.

42 C.F.R. 482.43

Condition of Participation: Discharge Planning

Section 395.3025(4), Florida Statutes

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:

- 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 communication between providers and engage the individual and their family 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

Section 395.4625, Florida Statutes

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 admitted on a voluntary basis refuses to consent or revokes consent for treatment, it is treated like a request for discharge.

Individuals often make a verbal request to be discharged to staff members who are not qualified to authorize a discharge. This information must be shared with one of the professionals who is qualified to approve the discharge 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 practitioner, 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.

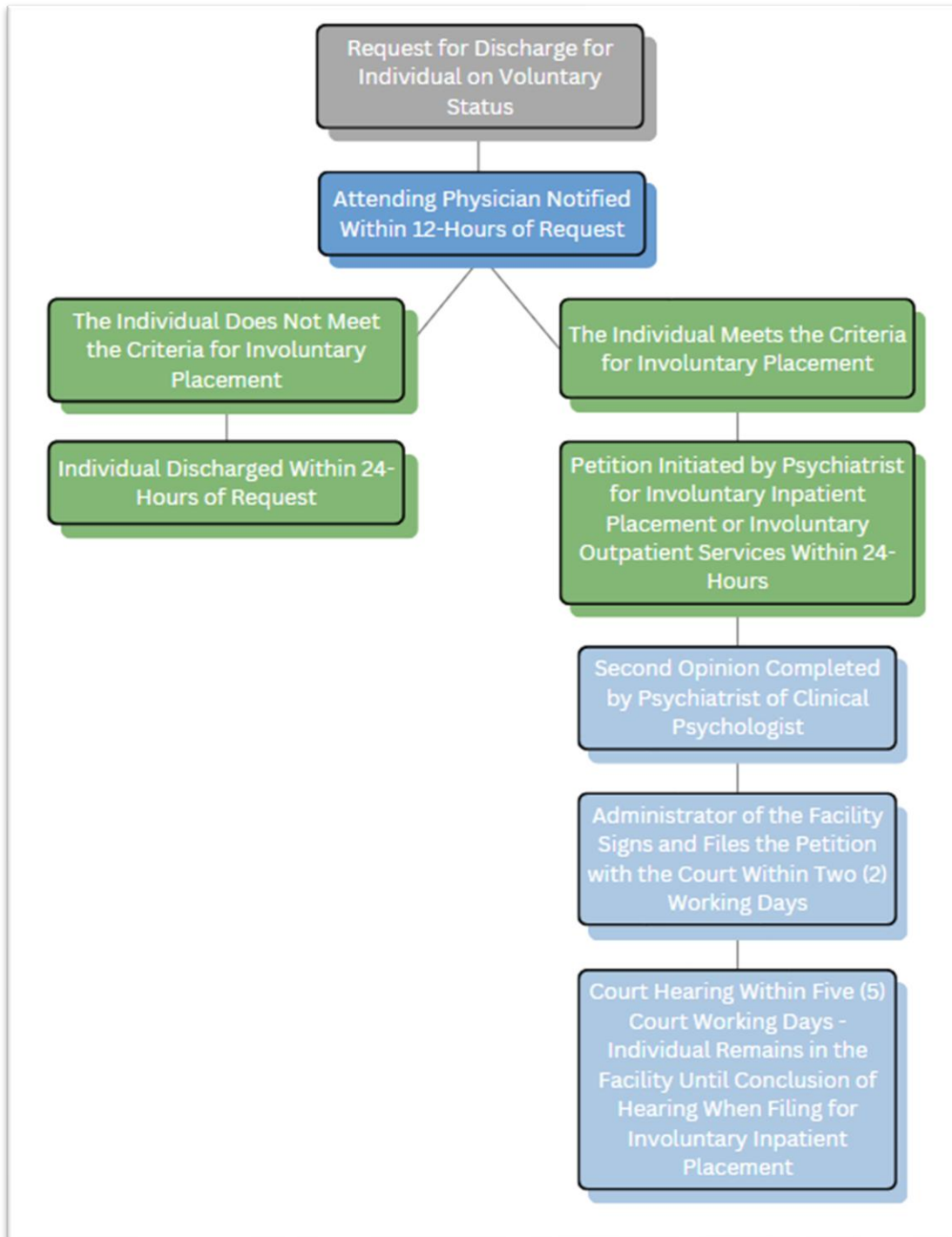
The timeframes for discharge are different for a State Mental Health Treatment Facility than they are for a designated receiving facility when an individual is discharged due to a request made through a right to release or writ of habeas corpus. In these instances, the treatment facility has up to three (3) working days to release an individual and to complete a discharge plan that meets the required components based on the needs of the individual.

A. Discharge of Individuals on Voluntary Status

Section 394.4625(2), Florida Statutes	Discharge of Voluntary Patients
Chapter 65E-5.1303, Florida Administrative Code	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 Designated 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 or involuntary outpatient services 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 timeframe, or the individual does not meet the 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

Section 394.469, Florida Statutes	Discharge of Involuntary Patients
Chapter 65E-5.320, Florida Administrative Code	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:

- Discharge the individual, unless he or she has criminal charges, in which case the individual must be transferred to the custody of the appropriate law enforcement officer; or
- 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
- Place an improved individual 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

Section 394.4599, Florida Statutes	Notice
Section 394.463(3), Florida Statutes	Notice of Release
Section 394.469(2), Florida Statutes	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 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 believe they are 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.

CHAPTER 12

SPECIAL POPULATIONS

I. Overview

II. Minors

III. Vulnerable Adults

IV. Substitute Decision-Makers and Advance Directives

V. Veterans



Chapter 12: Special Populations

I. Overview

The Baker Act contains specific criteria and procedures related to special populations including minors, individuals who reside in a long-term care facility, veterans, and individuals who are in custody of the Department of Corrections. These individuals often have different needs and considerations for care. 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.

The Department sponsors training courses related to the Baker Act and these special populations located on the Florida Alcohol and Drug Abuse Association's Learning Management System for Behavioral Health at www.FloridaLearner.org.

II. Minors

Section 394.455(29), Florida Statutes	Minors – Definition
Chapter 743, Florida Statutes	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 to make certain legal decisions. For more information about minors who are married, unmarried pregnant, or emancipated please refer to Chapter 743, F.S.

For purposes of this guide:

- The term minor is 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 DJJ, who currently has custody of the minor.

A minor whose disability of nonage has been removed is treated as an adult when determining legal status, including voluntariness and competence. The individual must receive services at a designated receiving facility that serves their age group.

Providing behavioral health care to minors requires specialized knowledge, experience, and developmentally appropriate skills. Children and adolescents are continuing to grow cognitively, emotionally, and socially and often rely on trusted adults to meet their needs. Effective care builds upon each minor's developmental capacity while providing safeguards that promote safety and well-being. The manner in which mental health care is delivered and the protections afforded to minors, depends on both of the following factors²⁵:

²⁵ Florida Court Education Council (2016). *Baker Act Benchguide*, Page 116. Retrieved from <http://www.flcourts.org/core/fileparse.php/539/urlt/Baker-Act-Benchguide.pdf>.

- 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

It is estimated that approximately 20 percent of minors in the U.S. experience a diagnoseable mental health condition.²⁶ This rate is even higher for minors who are removed from their home for their safety due to suspected abuse or neglect.²⁷ Mental health conditions often present themselves as crises leading to over 32,000 involuntary examinations of minors in Florida during the 2024- 2025 fiscal year.²⁸

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 J, Notifications, for more information regarding notifications requirements for minors.

B. Voluntary Admission for Minors

Section 394.4625(1), Florida Statutes	Authority to Receive Patients
Section 744.102, Florida Statutes	Guardianship Definitions
Section 39.01, Florida Statutes	Definitions for Proceedings Related to Children

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

- The minor's parent or legal guardian must provide express and informed consent to the voluntary admission.
- 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.

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

C. Treatment for Minors

Section 394.491, Florida Statutes	Guiding Principles for the Child and Adolescent Mental Health
Section 394.495, Florida Statutes	Child and Adolescent Mental Health Systems of Care

Mental health services have 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, namely, a clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist must include specific elements for minors including both of the following.

²⁶ Center for Disease Control. Children's Mental Health (2025, June 5). Data and Statistics on Children's Mental Health <https://www.cdc.gov/children-mental-health/data-research/index.html#:~:text=Childhood%20mental%20health%20conditions%20affect,2>.

²⁹ Turney, K. and Wildeman, C. (2016). Mental and Physical Health of Children in Foster Care. *Pediatrics*, 138(5), e20161118. Retrieved from <https://pediatrics.aappublications.org/content/pediatrics/138/5/e20161118.full.pdf>.

³⁰ Florida Department of Children and Families, Office of Substance Abuse and Mental Health. (2025). *The Baker Act Florida Mental Health Act Fiscal Year 2024/2025 Annual Report*. Retrieved from https://www.myflfamilies.com/crisis-services/baker-act-training/_and_Florida_Department_of_Children_and_Families_Baker_Act_Dashboard:_Baker_Act_Dashboard_|_Florida_DCF

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

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

- Right to consent.
- Parental rights.
- Treatment planning.
- Behavioral management needs.
- Minors right to education.
- Minors in CSUs.
- Minors in residential treatment centers.
- Minors under the protective supervision of the Department, including:
 - Foster Home
 - Relative/Nonrelative care
 - Parental (in-home judicial)
- Minors with legal charges.
- Minors in the custody of Department of Juvenile Justice.

Consent for Treatment

Section 394.4784, Florida Statutes	Minors; Access to Outpatient Crisis Intervention Services
Section 743.064, Florida Statutes	Emergency Medical Care of Minors Without Parental Consent
Section 743.0645, Florida Statutes	Other Persons Who May Consent to Treatment of a Minor

Minors can't access treatment without consent from a parent or legal guardian, including consenting to most medical and mental health services. In most cases, the parent or legal guardian must provide express and informed consent. Efforts made to locate and engage the minor's parent or legal guardian must be documented in the clinical record. When a minor is not under the protective supervision of the Department or DJJ and their parent or legal guardian cannot be reached, these people may be contacted to provide consent, in the following order.

- A person holding Power of Attorney.
- Stepparent.
- Grandparent.
- Adult sibling.
- Adult aunt or uncle.

These individuals 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 consent of a parent or legal guardian to sign in voluntarily to a designated receiving facility, some other types of services can be accessed by a minor without parental consent under certain circumstances. 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 any one (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. It is recommended to obtain the parent or legal guardians' consent prior to placing a minor in a room with an adult.
- 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 civilly committed to a State Mental Health Treatment Facility for involuntary inpatient placement. Minors who are ordered to an involuntary inpatient placement must continue receiving treatment services in a designated receiving facility. The administrator of the designated 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 ([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 EMTALA, and in the online course entitled Emergency Medical Treatment: Florida's Baker Act and Marchman Act which can be found at the Department's website <https://www.myflfamilies.com/crisis-services/baker-act-training/baker-act-online-training-courses>.

Treatment Planning

Section 394.496, Florida Statutes

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.

Behavioral Management with Minors

Chapter 65E-9.013, Florida Administrative Code

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.

Minors may act impulsively or take risks because their brains are still developing, making them more sensitive to rewards, emotions and peer influence while their decision making and impulse control systems are not fully mature. According to 2024 Florida-specific estimates from the National Survey on Children's Health – which uses parent-reported information about noninstitutionalized children – about 20 percent of children ages 0-17 in

Florida experienced one adverse childhood experience (ACE), and about 20 percent experienced two or more ACEs.²⁹ According to the most recently available 2025 estimates from the Florida Youth Substance Abuse Survey, about 22 percent of Florida high school youth experienced one ACE, and about 13 percent had two ACEs. Research shows that exposure to ACEs is significantly associated with increased odds of suicide ideation and suicide attempts among Florida youth.³⁰ For example, the likelihood of having suicidal thoughts compared to youth with no ACEs was 38 percent higher for those with one ACE, 78 percent higher for those with two ACEs, and 97 percent higher for three ACEs.³¹

Traumatic experiences and behavioral health conditions can disrupt normal adolescent brain development by affecting areas responsible for emotion regulation, impulse control, and decision-making. These experiences heighten stress responses, make teens more reactive and less able to self-regulate, and can intensify risk-taking or impulsive behavior. When left unaddressed, traumatic events may interfere with healthy brain development and lead to ongoing problems with emotional regulation, impulse control and increased risk for future crisis.

When mild anxiety or subtle increases in agitation are not de-escalated early, the youth may not know how to regulate these emotions effectively and may verbally or physically act out. 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 the potential to create a more intense adverse reaction.³⁶

There are several approaches that help prevent the use of seclusion or restraint. Trauma-responsive care is one important approach. Trauma-responsive 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 safety planning to better understand triggers and coping strategies. It is 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.

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. The creation and development of a service plan is tailored to the individual's current needs. The clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist must be included in the development of the services plan. 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

²⁹ Child and Adolescent Health Measurement Initiative. (2026). 2024 National Survey of Children's Health (NSCH) Interactive Data Query. Retrieved 9/3/2026 from <https://www.childhealthdata.org/>.

³⁰ Florida Department of Children and Families. (2026). Florida Youth Substance Abuse Survey 2025 State Report. Retrieved on 9/3/2026 from <https://www.myflfamilies.com/documents/FYSAS%202025%20State%20Report.pdf>.

³¹ Jensen, L. W. C., et al. (2025). Adverse Childhood Experiences, Race/Ethnicity, and Suicidality Among Florida High School Students. *Youth & Society*, 57(2), 233-257.

developing. A physical restraint should always be a last resort used only when all other options have been unsuccessful. More information on regulations for seclusion and restraint with minors is found in Chapter Nine.

Minors in the Custody of the Department

Section 39.407, Florida Statutes	Medical, Psychiatric, and Psychological Examination and Treatment
Chapter 65C-35, Florida Administrative Code	Psychotropic Medication for Children in Out-of-Home Care
Form CF-FSP 5339	Medical Report for Prescribing Psychotropic Medication to a Child in Out-of-Home Care

Recognizing the complex needs of this vulnerable population, the Department is committed to supporting family preservation when possible. When separation is necessary through an out of home placement, the Department works towards the goal of reunification, in accordance with the principles of trauma-informed care and least restrictive, family centered treatment. Parents often retain their parental rights during periods of dependency involvement, unless those rights are formally terminated by a court order. A parent's right to participate in decisions affecting their child's mental health treatment, including those related to Baker Act examinations, is not voided when the child is under the protective supervision of the Department.

When temporary custody through dependency or family court involvement is in effect, the facility staff must contact the dependency case manager to coordinate all aspects of care. It is important to keep the parents and the current caregivers involved as much as possible. The dependency case manager can assist facility staff to coordinate with parents and caregivers regarding medical and behavioral health appointments and to seek their opinion for treatment objectives, services and discharge planning. The dependency case manager can invite parents and caregivers to attend treatment team meetings to discuss the course of treatment, be given the opportunity to provide information, and ask questions. If transportation or scheduling conflicts arise, participation can occur over the phone or virtually if the parents do not have transportation or are working. Additionally, care teams should work with the parents to set up appointments with outpatient behavioral health services and provide referrals to caregiver support groups to promote a healthy family environment in anticipation of the minor returning home upon discharge. Discharge information should always include information about the Mobile Response Team if an urgent need arises before outpatient services begin or outside of regular business hours.

Parents retain the right to make informed decisions about psychotropic medication for their child, including declining consent, unless their parental rights have been terminated or a court has authorized the medication over their objection.

Protecting a minor's health, safety, and well-being may require treatment even when a parent declines or withdraws consent. When treatment is necessary, the Department may ask the court to authorize a medical or behavioral health examination or treatment. Parental consent or a court order is not required when the minor is experiencing an emergency medical condition; when the examination or treatment is directly related to suspected abuse or neglect by the parent or legal guardian; or when parental rights have been terminated and the child is in the permanent custody of the Department.

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, CSU, 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.

Minors Right to Education

Section 394.459(3)(a), Florida Statutes	Rights of Patients
Section 394.495, Florida Statutes	Child and Adolescent Mental Health Systems of Care
Chapter 2018-3, Florida Administrative Code	Public Safety

Collaboration with schools is essential. Schools have a responsibility to identify students who demonstrate a need for behavioral health services. Almost 9 percent of involuntary examinations of minors were initiated in the school setting during fiscal year 2025-26.⁴⁰ In 2018, Florida enacted the Marjory Stoneman Douglas High School Public Safety Act, creating and revising laws with additional safeguards to increase public safety in the community with a particular focus on schools. More importantly, students who experience an involuntary examination typically return to school and may need additional support in the school setting.

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. Poor academic performance may jeopardize future social, emotional, physical, and economic functioning. 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.

Specifically, sections 790.064 and 790.065, F.S. address firearm restrictions that may apply to certain individuals based on a mental health adjudication, commitment, or other qualifying circumstances. Section 790.064 addresses firearm possession and ownership disabilities, while section 790.065 addresses firearm purchase restrictions and includes specific requirements involving certain individuals who receive voluntary treatment following an involuntary examination.

⁴⁰ [Baker Act Dashboard | Florida DCF](#), retrieved August 19, 2026

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.

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

Section 415.102(28), Florida Statutes	Vulnerable Adult
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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 60 years of age or older, as defined by Chapter 825, F.S.
- 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.

Similar to minors, vulnerable adults 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

Mental Health conditions frequently manifest as crises, resulting in more than 12,000 involuntary examinations of adults aged 65 and older in Florida during the 2024-2025 fiscal year⁴⁴. There are few Baker Act provisions that apply specifically to older adults. For example, there are no designated receiving facilities exclusive to serving older adults. However, some psychiatric facilities 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. Section 394.4625(1)(b), F.S., provides additional requirements for assessing the ability of certain individuals age 60 or older to provide express and informed consent before voluntary admission.

⁴⁴ Florida Department of Children and Families Baker Act Dashboard: [Baker Act Dashboard](#) | [Florida DCF](#)

Transfer Trauma

Older adults, particularly those who need assistance with activities of daily living, may benefit from additional support when adjusting to changes in their environment or routine. A temporary or permanent move can affect a person's sense of familiarity, security, and connection. This experience, often called relocation stress or transfer trauma, may contribute to emotional distress, changes in behavior, or physical health concerns, including an increased risk of falls. Whenever clinically appropriate, long-term care facilities should provide on-site psychiatric and behavioral health support. Staff trained in compassionate communication and verbal de-escalation can help individuals regain a sense of calm and safety, maintain continuity of care, and avoid unnecessary transfers.

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 ETO 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 is found in chapter Nine.

Residents of Long-Term Care Facilities

Section 394.4625, Florida Statutes	Voluntary Admissions
Section 394.463, Florida Statutes	Involuntary Examination
Chapter 65E-5.180, Florida Administrative Code	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:

- Individuals that are residents of nursing homes and at least 60 years of age.
- Individuals 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.
- Individuals with developmental disabilities receiving services under Chapter 393, F.S.
- Individuals whose medical treatment decisions are currently made by a legally authorized health care surrogate or proxy.

A resident of a long-term care or residential facility may require admission to a designated receiving facility or State Mental Health Treatment Facility when they experience symptoms of a mental health condition that cannot be safely managed in their current setting. It must also be reasonably believed that the individual will benefit from the services provided by the designated receiving or treatment facility. Long-term care and residential facilities should be able to manage many of the symptoms experienced by residents; however, some individuals may require medical or psychiatric hospitalization.

Individuals living in these settings are not limited to older adults. Younger individuals with developmental disabilities who receive services through the APD may also reside in assisted living facilities, group homes, or

other residential settings. When Baker Act services are considered, the individual's mental health condition and circumstances should be evaluated separately from their developmental disability.

Having a developmental disability or living in an APD supported or other residential setting does not automatically mean that an individual is unable to make their own decisions or provide express and informed consent. Section 393.12, F.S., provides that a person with a developmental disability may not be presumed incapacitated solely because they receive nonresidential services or live in residential care.

A developmental disability or placement in a residential setting alone is not a basis for involuntary examination under the Baker act. 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 criteria for involuntary examination, 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.

Section 394.4625, Florida Statutes	Voluntary Admissions
Chapter 65E-5.280(6), Florida Administrative Code	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 through the Agency's Complaint Administration Unit 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 deciding on whether they will accept the resident back.

Additional information on transportation procedures for individuals on involuntary status is found in Chapter Seven, module two of the online course Law Enforcement and the Baker Act, and the transportation FAQs.

[Florida's Learning Management System for Behavioral Health](#) also offers a self-paced online course entitled Long-Term Care and the Baker Act. This course provides information regarding 1) how to appropriately respond to persons with mental health conditions who reside in long-term care facilities, 2) various conditions that often mimic a psychiatric condition and possible intervention; 3) the procedures for initiating an involuntary assessment with a resident of a long-term care facility; and 4) the types of substitute decision-making for health care choices.

Independent Expert Examination

Section 394.4625(1)(b), Florida Statutes	Authority to Receive Patients
Section 394.467(6)(a), Florida Statutes	Involuntary Inpatient Placement
Section 400.0255, Florida Statutes	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

Section 394.4598, Florida Statutes	Guardian Advocate
Chapter 65E-5.170, Florida Administrative Code	Right to Express and Informed Consent
Chapter 65E-5.230, Florida Administrative Code	Guardian Advocate
Chapter 65E-5.2301, Florida Administrative Code	Health Care Surrogate or Proxy

When providing medical and behavioral health services, hospitals are responsible for following written advance directives as well as notifying and consulting with substitute decision-makers. Hospitals are not always 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

Section 394.4672, Florida Statutes	Procedure for Placement of Veteran with Federal Agency
Chapter 296, Florida Statutes	Veteran’s Nursing Homes
Section 744.602, Florida Statutes	Veteran’s Guardianship Law
Section 744.637, Florida Statutes	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.^{46,47} Nationally, the incidence of military related suicides has risen approximately six percent from 2001 to 2023.⁴⁸ The 2023 suicide rate for Veterans was 35.2 per 100,000, while the non-Veteran suicide rate was 18.2 per 100,000.⁴⁹ Suicide was the 12th leading cause of death for Veterans, and the second leading cause of death for Veterans under age 45-years-old across the nation in 2023.⁵⁰ Suicide is the fourth-leading cause of premature mortality among Veterans in 2023, measured in terms of years of potential life lost (YPLL).⁵¹

Suicide risk is a heightened concern for individuals in the year following military separation. The suicide rate for transitioning service members was 41.2 per 100,000 in 2022.⁵² Transitioning service members with documented suicidal ideation, substance use disorders, or mental health conditions are at elevated risk of suicide in the year following separation and may require targeted interventions to ensure specialized support for their specific medical conditions.⁵³ There are approximately 1.4 million Veterans living in Florida, making Florida the second largest Veteran population in the nation.⁵⁴ There were 550 Veteran suicide deaths in Florida during 2023 (ten higher than 2022), of which 510 deaths were male and 39 were female.⁵⁵ The 2023 Florida Veteran Suicide Rate per 100,000 was 38.6, compared to the national Veteran suicide rate of 35.2.⁵⁶ 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.⁵⁷

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. Section 201 of the Act codified at

44 American Public Health Association (2014). *Removing Barriers to Mental Health Services for Veterans*. Retrieved from <https://www.apha.org/policy-and-advocacy/public-health-policy-briefs/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

45Schafer, K. M., Duffy, M., Kennedy, G., Stentz, L., Leon, J., Herrerias, G., & Joiner, T. E. (2022). Suicidal ideation, suicide attempts, and suicide death among Veterans and service members: A comprehensive meta-analysis of risk factors. *Military psychology*, 34, 129-146. Retrieved from <https://doi.org/10.1080/08995605.2021.1976544>

47 U.S. Department of Veterans Affairs (2026). *Florida Veteran Suicide Data Sheet, 2023*. Retrieved from https://www.mentalhealth.va.gov/docs/data-sheets/2025/State_Data_Sheets_2025_Florida_508.pdf

48 U.S. Department of Veterans Affairs, Office of Suicide Prevention. (2026). *2025 National Veteran Suicide Prevention Annual Report*. . Retrieved from https://www.mentalhealth.va.gov/docs/data-sheets/2025/2025_Annual_Report_Part_2_508.pdf

49 Ibid.

50 U.S. Department of Veterans Affairs, Office of Suicide Prevention. (2026). *2025 National Veteran Suicide Prevention Annual Report*. Retrieved from https://www.mentalhealth.va.gov/docs/data-sheets/2025/2025_Annual_Report_Part_2_508.pdf

53 Ibid.

54 Florida Department of Veterans' Affairs (2026). *Fast Facts*. Retrieved from <https://www.floridavets.org/our-veterans/profilefast-facts/>

55 U.S. Department of Veterans Affairs (2026). *Florida Veteran Suicide Data Sheet, 2023*. Retrieved from https://www.mentalhealth.va.gov/docs/data-sheets/2025/State_Data_Sheets_2025_Florida_508.pdf

56 Ibid.

55 U.S. Department of Veterans Affairs, Office of Suicide Prevention (2026). *Coping & Support* Retrieved from https://www.mentalhealth.va.gov/suicide_prevention/coping-support/index.asp

38 U.S.C. § 1720J 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.⁵⁸

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.

Veterans Crisis Line	Dial 988, then press 1
Florida Department of Veteran's Affairs (FDVA) Veterans Service Officers	727-319-7440
Florida Veterans Support Line	844-MyFLVet / (844-693-5838)
TTY Number	Use your preferred relay service or dial 711 then 988.
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	877-927-8387

For more information regarding mental health benefits available to active service members and veterans, please refer to the [U.S. Department of Veterans Affairs Health Care](#) webpage and [Suicide Prevention](#) webpage. To find local resources for Veterans, visit, the [Veterans Crisis Line](#) webpage

A. Veterans with Legal Charges

Section 394.47891, Florida Statutes	Military Veterans and Servicemembers Court Programs
Section 948.16(2)(a), Florida Statutes	Misdemeanor Pretrial Intervention and Mental Health Court
Section 948.21(2), Florida Statutes	Conditions of Probation or Community Control
Section 948.06(2)(j), Florida Statutes	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 the following conditions:

- Involvement is based on a non-violent felony conviction which occurred after June 30, 2016.
- Willingness to participate in mental health treatment.
- Agreeable to comply 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.

⁵⁶ H.R.8247 - 116th Congress (2019-2020): Veterans COMPACT Act of 2020, Congress.gov, Library of Congress

CHAPTER 13

DUTIES OF FACILITIES AND PROFESSIONALS

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- I. Overview
 - II. Designated Receiving Facilities
 - III. Licensure Requirements
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 - VIII. Rights and Responsibilities of Professionals
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 - XI. Transfers to Designated Receiving Facilities
 - XII. Warrants and Subpoenas
 - XIII. Weapons

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 be prepared to respond in the event of a medical emergency, 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

Section 394.462, Florida Statutes	Transportation
Chapter 65E-5.260, Florida Administrative Code	Transportation

Designated receiving facilities must accept all individuals 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 general hospital. If a designated receiving facility staff identifies signs or symptoms that may require medical evaluation or treatment, the appropriate medical professional should be notified to assess the individual and determine whether transferring the individual to a local general hospital or emergency department is necessary. 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 or
- 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 designated receiving facility, but it is determined that the individual needs an immediate transfer due to 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 911) to transfer the individual to a medical emergency department.

This is also true if the designated receiving facility does not have a bed available to admit a person. 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 designated 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-to-facility transfer should be arranged in accordance with the county's transportation plan and the needs of the individual. Law enforcement should not be routinely requested to conduct facility to facility transfers unless law enforcement transportation is authorized

or required under the county's transportation plan or by law. In addition, law enforcement is not required to remain on or return to the premises for security purposes after the individual and the required documentation have been transferred to a responsible individual at the designated receiving facility. or Once an individual arrives at a designated receiving facility, either under voluntary or involuntary status, and meets the criteria for admission, there are specific requirements that staff must complete.

III. Licensure Requirements

Section 394.4572, Florida Statutes	Screening of Mental Health Personnel
Chapter 65E-5.351, Florida Administrative Code	Minimum Standards for Designated Receiving Facilities

Designated receiving facilities have requirements 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 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 general hospital. An individual receiving services voluntarily who leaves the facility without authorization may also be administratively discharged if the individual does not meet the criteria for involuntary examination. Some of the other responsibilities of facility administrators include:

- 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.

V. Abuse Reports

Section 39.201, Florida Statutes	Mandatory Reports of Child Abuse or Neglect
Section 39.202, Florida Statutes	Confidentiality of Reports in Cases of Child Abuse
Section 415.1034, Florida Statutes	Mandatory Reports of Abuse of Vulnerable Adults
Section 415.107, Florida Statutes	Confidentiality of Reports and Records

A. Mandatory Reporting Requirements

Florida law requires any person who knows, or has reasonable cause to suspect abuse, abandonment, or neglect of a child, or abuse, neglect, or exploitation of a vulnerable adult, to report the concern to the [Florida Abuse Hotline](#). Certain professionals, including physicians, nurses, hospital personnel, mental health professionals, social workers, and residential or institutional staff, are specifically identified as mandatory professional reporters. 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. Failure to report known or suspected abuse, neglect, or exploitation may result in criminal penalties and, for licensed or certified professionals, may also result in professional disciplinary actions.

B. 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.

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.

The abuse hotline accepts reports 24 hours per day, seven (7) days per week. Reports can be made online, by phone or fax.

Reporting Method	Contact Information
Toll-Free Abuse Hotline	https://www.myflfamilies.com/services/abuse/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	711 or
TTY for Deaf or hard of hearing, English, Spanish, and Creole Speaking	800-955-8771 800-453-5145
Fax	800-914-0004

VI. Accommodation

Facilities must provide individuals with reasonable accommodation for conditions and circumstances that, if untreated, would substantially limit one or more major life activities. Reasonable accommodation 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

Section 394.459, Florida Statutes	Rights of Patients
Section 395.003, Florida Statutes	Licensure; Denial, Suspension, and Revocation
Chapter 65E-5.140, Florida Administrative Code	Rights of Persons

Hospitals provide services such as observation, evaluation, diagnosis, and treatment. Facilities that are licensed as hospitals under Chapter 395, F.S. 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 a voluntary or involuntary basis. They also apply to general hospitals that provide services to individuals receiving involuntary services under the Baker Act, even if the general 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.

A. Conditions of Participation

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

Emergency Services and Emergency Examination and Treatment of Incapacitated Persons

42 U.S. Code 1395dd	Examination and Treatment for Emergency Conditions
Section 395.1041, Florida Statutes	Access to Emergency Services and Care
Section 401.445, Florida Statutes	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 or

- 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 general 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 public access to emergency services to individuals requesting evaluation of a medical condition regardless of 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 psychiatric conditions as they do for medical conditions. CSUs and other facilities not licensed as hospitals do not have to comply with federal EMTALA regulations or Florida's hospital regulations. CSUs 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.

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.

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 destination 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 they are 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.

Medical Clearance

A general 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 general 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](https://www.myflfamilies.com/crisis-services/baker-act-training/baker-act-online-training-courses) found on the Department's website: <https://www.myflfamilies.com/crisis-services/baker-act-training/baker-act-online-training-courses>.

VIII. Rights and Responsibilities of Professionals

Section 394.460, Florida Statutes	Rights of Professionals
Section 456.059, Florida Statutes	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 to protect the person from danger.

A. Good Faith

Section 394.459(10), Florida Statutes

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 must 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 dismiss the firearms restriction.

IX. The Clinical Record and Documentation

Chapter 59A-3.254, Florida Administrative Code	Patient Rights and Care
Chapter 65E-5.160(j), Florida Administrative Code	Right to Treatment
Chapter 65E-5.840, Florida Administrative Code	Rights to Quality Treatment

Facilities must keep updated demographic and clinical records for everyone served. The clinical record is an important collection of documents, frequently maintained in an electronic health record, 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, progress notes, 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.

X. Safety Precautions

Facilities have a responsibility to keep individuals safe. While psychiatric hospitals and CSUs are designed for psychiatric emergencies, general hospitals are not. There are several precautions that general 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, for example:

- 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 must 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

Section 394.467(8), Florida Statutes	Involuntary Inpatient Placement
Section 394.463(2), Florida Statutes	Involuntary Examination
Chapter 65E-5.280(4), Florida Administrative Code	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 are authorized to initiate a search for the individual and 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 admitted on a voluntary basis 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.
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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 general 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

Section 394.463, Florida Statutes

Involuntary Examination

Individuals who are at a general hospital and an involuntary examination has been initiated will be referred to a designated receiving facility for further services. Once an individual is medically cleared, a general 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.

Effective July 2025 section 394.463, F.S. clarified that if the transferring facility does not complete a transfer within the 12-hour timeframe or does not provide the required notification within two hours after stabilization, the designated receiving facility retains the authority to keep the individual for the remainder of the 72-hour examination period. This retention is permissible provided that the individual continues to meet the criteria for involuntary examination and ensures that there is no interruption in the continuum of care.

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.

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 information including laboratory results and tests to ensure that they have the capability to care for the individual. All the required laboratory results needed to determine 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 laboratory 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 designated 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. Firearms and Weapons

Section 394.458(1)(a)3, Florida Statutes

Introduction or Removal of Certain Articles Unlawful

Weapons, including firearms and other weapons being carried by law enforcement officers, are prohibited in designated receiving facilities and hospitals providing mental health services unless specifically authorized by the facility administrator. If the designated receiving facility or hospital does not authorize weapons within the facility, it is recommended that officers leave weapons locked in their vehicle or the facility may provide 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 transport 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

II. Consent

III. Individual's Access to Personal Health Information

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 different levels of confidentiality that generally apply to health information. Substance use disorder records typically receive the most stringent protections, followed by mental health records and other physical health information.

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:

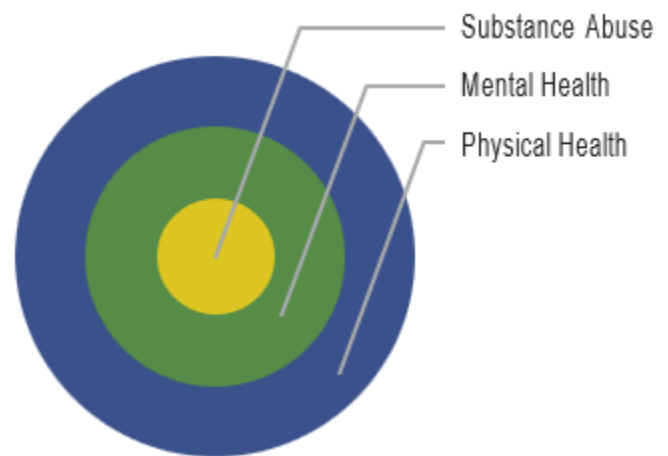
- Medication prescriptions and monitoring programs.
- The start and stop times of counseling or therapy sessions.
- The treatment method and frequency of treatment
- Results of clinical tests.
- Summaries of symptoms, diagnosis, treatment plans, progress in treatment, overall functioning, and prognosis.

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 consent to the release of information.

II. Consent

42 U.S. Code 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 of Objection
Section 394.4615, Florida Statutes	Clinical Records; Confidentiality
Chapter 65E-5.250, Florida Administrative Code	Clinical Records; Confidentiality

Most information that is shared with individuals 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 prohibit 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 provide additional confidentiality protections for minors receiving substance use disorder treatment. When Florida law allows a minor to independently consent to treatment, the minor may also have control over the disclosure of those treatment records. There are additional protections in court proceedings requiring a court order to permit the disclosure of information without the individual's consent.

Release of information forms must include distinct categories for psychotherapy notes, HIV, and substance use information because that information must be disclosed 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
Section 394.4615, Florida Statutes	Clinical Records; Confidentiality
Section 395.3025(4), Florida Statutes	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 establishes 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 object to treatment and has previously agreed to collateral contact with family members or friends.
- The individual is present and does not object to disclose 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 may be released to the appropriate agency when an individual is in the legal custody of the Department, the Department of Juvenile Justice, or the Department of Corrections, as authorized or required by law.
- 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 or other entity responsible for funding the individual's services, including the Department funded services administered through a Managing Entity, when applicable.

- 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.

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 signing a release of information consent form even though the professional may not be able to verify or comment on what is being said to them. This is a way to effectively collect collateral information about a crisis event or an individual’s history and allow the family member to feel engaged in their loved ones care.

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 designated 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 of an adult that the individual is being sent to a designated receiving facility for an involuntary examination and must tell a parent where their child is being transported for an involuntary examination.

Emergency Situations

42 C.F.R. 489	Emergency Medical Treatment and Labor Act
Section 401.445, Florida Statutes	Emergency Examination and Treatment of Incapacitated Persons
Section 394.4615, Florida Statutes	Clinical Records; Confidentiality
Chapter 65E-5.250, Florida Administrative Code	Clinical Records; Confidentiality

There are certain conditions that allow protected health information to be disclosed, and treatment 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.

Emergency Medical Treatment and Labor Act (EMTALA)

The disclosure of information in emergency medical situations is governed by federal legislation under 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*](#).

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. Lack of engagement may occur for several reasons including transportation and financial constraints, stigma, or belief that 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.

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, it is standard practice to request that individuals referred to another provider for services after discharge be asked to sign a release of information. However,

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 designated 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. Access to Personal Health Information

45 C.F.R. 164.524	HIPAA Right of Access
Section 394.4615(10), Florida Statutes	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 records 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.

APPENDICES

APPENDIX A-J

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- A. Oversight Organizations
 - B. Links to Important Resources
 - C. Laws Related to the Baker Act
 - D. Baker Act and Marchman Act Comparison Overview
 - E. Regions and Districts
 - F. Criteria for Initiation of Services and Legal Status
 - G. Time Frames
 - H. Seclusion and Restraint
 - I. Notifications
 - J. Baker Act Forms

Appendices

Appendix A. Oversight Organizations

Agencies Providing Oversight Under the Baker Act

The following is a list of agencies and roles in providing oversight to the Baker Act process.

Table A.1 Baker Act

Oversight Organization	Description	Contact Information
The Department and the Office of Substance Abuse and Mental Health	As Florida's mental health authority, the Office of Substance Abuse and Mental Health (SAMH) is responsible for the oversight of a statewide system of care for the prevention, treatment, and recovery of children and adults with serious mental illnesses or substance use disorders. Specifically, SAMH provides information about the Baker Act including developing and updating administrative rules, current forms, information on designated receiving facilities, and free online training. Along with AHCA, the Department also monitors all mental health services throughout the state and investigates complaints regarding designated Baker Act receiving facilities.	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/substance-abuse-and-mental-health
SAMH Regional Offices	The Department's SAMH division has six regional offices. These offices, with assistance from the Managing Entities, handle various coordination and procedural issues, and perform several functions including oversight of 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 systems of care (ROSC). SAMH regional offices are responsible for monitoring Managing Entity operations and providing technical assistance. In 2024, SAMH regional offices launched Regional Collaborative Meetings creating unified partnership that bring stakeholders together to address opportunities for improvement within Florida's behavioral health system of care.	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/contact-us . https://www.myflfamilies.com/rbhic .
Managing Entities	The Department contracts for a network of behavioral health services with regional systems of care called Managing. In 2008, Florida enacted legislation that authorized Managing Entities to oversee the daily operations of regional systems of care through a network of behavioral health providers. Managing Entities contract with provider agencies that offer an array of services, including prevention, outpatient, recovery support, and residential services, emergency. Seven Managing Entities serve Florida and strive to organize the most effective and streamlined system of care throughout the counties they serve in their respective districts.	Please visit https://www.myflfamilies.com/services/samh/samh-providers/reports-region/ to locate contact information for your local Managing Entity.

Florida Division of Administrative Hearings	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/
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Table A.2 Confidentiality

Oversight Organization	Description	Contact Information
Office for Civil Rights at the U.S. Department of Health and Human Services	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 File a Patient Safety Confidentiality Complaint HHS.gov http://www.hhs.gov/ocr/privacy/psa/complaint/index.htmlhttps://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 people. This includes populations of children, older adults, and individuals with disabilities. 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/ Abuse Hotline Florida DCF

Disability Rights Florida	Works to ensure that individuals with a disability are being treated fairly. More information on <i>Disability Rights Florida</i> can be found in Chapter 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 https://disabilityrightsflorida.org/contact
Americans with Disabilities Act	A federal legislation that protects individuals from discrimination due to a disability. More information on the Americans with Disabilities Act can be found in Chapter 8.	Southeast ADA Center Atlanta Office: 404-541-9001 Federal Office: 800-514-0301 http://adasoutheast.org/

Table A.4 Oversight Agencies Including Licensure and Accreditation

Oversight Organization	Description	Contact Information
The Agency for Health Care Administration	The Agency for Health Care Administration (AHCA) licenses all hospitals, CSUs, and residential treatment centers throughout the state. AHCA monitors these facilities for compliance with procedures relating to the Baker Act statutes and rules such as individual rights, standards of care, and procedures governing admissions, examination, and transfers. AHCA ensures that hospitals comply with federal regulations under the CMS, such as EMTALA. In addition to EMTALA complaints, AHCA will investigate 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 the Department of Health to assist with investigations. If the complaint is not regarding a healthcare facility for which they provide oversight services, the complaint can be made to the Department of Health. 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: Complaint Administration Unit Florida Agency for Health Care Administration Online Complaint Form for Medicaid Fraud and Abuse: HCF Complaint Form AHCA - Health Care Facility Complaint Form
The Joint Commission	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 demonstrating their commitment to providing excellent care. The Joint Commission gives them an additional set of standards and surveys they must follow to maintain their accreditation.	The Joint Commission One Renaissance Blvd. Oakbrook Terrace, IL 60181 Customer Service: 630-792-5800 Fax: 630-792-5005

The Commission on Accreditation of Rehabilitation Facilities	A non-profit organization that provides accreditation to providers of health and human services. They provide 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	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 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.	Department of Health 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://complaint-portal.mqa.flhealthsource.gov/home http://www.floridahealth.gov/licensing-and-regulation/enforcement/documents/complaint-form-2015.pdf
Office of Medical Quality Assurance at Department of Health	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.	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://www.floridahealth.gov/licensing-regulations/medical-quality-assurance/
Oversight Organization	Description	Contact Information
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.	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	A state- recognized, non-profit organization that certifies professionals in the areas of child welfare, addiction, mental health, and health. 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/ethical-complaints-and-discipline/

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/
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Table A.5 Financial

Oversight Organization	Description	Contact Information
Florida Office of the Inspector General	Can be contacted with a request to investigate a concern for abuse, fraud, misconduct, waste, and mismanagement of government resources in the State of Florida. Perform 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 at U.S. Department of Health and Human Services	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://www.fdacs.gov/Contact-Us/File-a-Complaint

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	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 Street Tallahassee, FL 32399-0322 Phone: 877-MY-FL-CFO (877-693-5236) Out of State: 850-413-3089 Consumer.Services@myfloridacf.o.com https://apps.fldfs.com/ESERVICE/Default.aspx

Table A.6 Medicaid

Oversight Organization	Description	Contact Information
The Florida 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 Public Benefits and Medicaid eligibility, Child and Family Services, Licensing and Background Screening.	Florida Department of Children and Families Office SAMH 2415 N. Monroe Street, Suite 400 Tallahassee, FL 32303 Phone: 850-487-1111 https://www.myflfamilies.com/ https://www.myflfamilies.com/services/public-assistance
The Agency for Health Care Administration	In addition to other oversight duties, The Agency for Health Care Administration also handles complaints regarding Medicaid fraud and abuse.	The Agency for Health Care Administration 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: Florida Medicaid Complaints Florida Agency for Health Care Administration

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	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. Code 1395dd 42 C.F.R. 489.24 Section 395.1041(5), Florida Statutes	Monitors provider compliance with the 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 at U.S. Department of Health and Human Services 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	Section 394.463, Florida Statutes Section 395.1041, Florida Statutes	Provides state protection for individuals with emergency medical conditions to receive care, particularly in those facilities that do not meet EMTALA requirements.
Interfacility Transfers	Section 395.1041, Florida Statutes Section 394.4685, Florida Statutes 42 U.S. Code 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 at U.S. Department of Health and Human Services 42 U.S. Code 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	The Agency for Health Care Administration	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	The Agency for Health Care Administration	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	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 Florida Department of Health	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	The Agency for Health Care Administration	Enforces the Centers for Medicare and Medicaid Federal Conditions of Participation for Behavioral Restraints and the Standards of The Joint Commission 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 Florida Department of Children and Families	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	The Agency for Health Care Administration, Chapter 395, Florida Statutes 59E, Florida Administrative Code	Provides licensure for all Florida hospitals, crisis stabilization units, and residential treatment centers.

Designated Receiving Facilities	The Florida Department of Children and Families	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	Managing Entities	Contracted through the Florida Department of Children and Families, Managing Entities provide direct oversight to public designated receiving facilities.
Licensure of Professionals	Office of Medical Quality Assurance at Florida Department of Health	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 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 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 Florida Department of Children and Families and The Agency for Health Care Administration.	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 centers.
Health Care Facility Complaints	AHCA or Florida Department of Health	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 and The Agency for Health Care Administration	Monitors providers compliance with federal regulations under the Centers for Medicare and Medicaid including the Conditions of Participation and the EMTALA.
Balanced Billing	Florida Department of Health	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	The Agency for Health Care Administration	Investigates denials for requests of refunds for payments.
Health Care Fraud	Office of the Inspector General	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	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	The Agency for Health Care Administration	Answers general inquiries and questions regarding eligibility and specific plan benefits. 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 Florida Department of Children and Families	The Department's SAMH office 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, Florida Administrative Code.
Baker Act Forms - Data Collection	The Florida Department of Children and Families Baker Act Data Collection System and the Baker Act Reporting Center at University of South Florida	The Baker Act Reporting Center receives forms from Baker Act Clerks of Court must 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	The Florida Department of Children and Families Office of Substance Abuse and Mental Health in partnership with the Managing Entities	Contracted through the Florida Department of Children and Families, Managing Entities oversee daily operations of mental health services provided at all levels of care. Managing Entities 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 Florida Department of Children and Families	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.
Oversight Provided for:	Oversight Organization and Legislation	Description
Funding	The Florida Department of Children and Families	Provides funding for public designated receiving facilities and other programs that support Baker Act services.
Serious Patient Injury Reports and Trends	The Agency for Health Care Administration	The Agency for Health Care Administration, 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	The Agency for Health Care Administration	Investigates complaints against providers of health care services.
Problem Resolution Programs	The Agency for Health Care Administration	Assists in finding solutions to complaints against AHCA licensed providers.
Medical Telecommunications and Transportation Violation Injunctive Relief and Civil Penalties	Florida Surgeon General Section 401.421, Florida Statutes	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 https://adasoutheast.org/states/florida/
Florida Department of Children and Families	
Abuse Reporting via the Florida Abuse Registry	https://www.myflfamilies.com/services/abuse/abuse-hotline https://reportabuse.myflfamilies.com/s/ Child: https://reportabuse.dcf.state.fl.us/Child/ChildForm.aspx Adult: https://reportabuse.dcf.state.fl.us/Adult/AdultForm.aspx
Regions of the Department	https://www.myflfamilies.com/rbhc http://www.myflfamilies.com/contact-us
Managing Entities	http://www.usf.edu/cbcs/baker-act/for-consumers/managingentities.aspx https://www.myflfamilies.com/services/samh/providers/managing-entities
Judicial Circuit Courts	http://edr.state.fl.us/Content/area-profiles/criminal-justice-circuit/circuits-map.png
The Department's Substance Abuse and Mental Health Website	https://www.myflfamilies.com/services/samh/samh-providers
Licensed Substance Abuse Providers	Substance Use Disorder Licensing and Regulation Florida DCF
Baker Act User Reference Guide	https://www.myflfamilies.com/crisis-services/baker-act-training/

Florida Department of Children and Families	
Baker Act Forms	https://www.myflfamilies.com/crisis-services/baker-act/baker-act-forms
Mental Health Advance Directive	Baker Act Frequently Asked Questions Florida DCF
Frequently Asked Questions (FAQs)	https://www.myflfamilies.com/sites/default/files/2023-09/Baker%20Act%20FAQs%20%28003%29.pdf
Online Courses	https://www.myflfamilies.com/crisis-services/baker-act-training/ https://www.floridalearner.org/
Florida Medicaid	https://www.myflfamilies.com/services/public-assistance
Baker Act Reporting Center	
Baker Act Reporting Center	https://www.usf.edu/cbcs/baker-act/
Louis de la Parte Florida Mental Health Institute	https://www.usf.edu/cbcs/fmhi/
The Agency for Health Care Administration	
The Agency for Health Care Administration	http://ahca.myflorida.com/
Complaint Administration Unit	https://ahca.myflorida.com/contact-ahca/file-a-complaint.html
Medicaid Fraud and Abuse Online Complaint Form	https://apps.ahca.myflorida.com/mpc-complaintform/
The Joint Commission	
Behavioral Health Care Accreditation	https://www.jointcommission.org/en-us/standards/standards-manuals
Commission on Accreditation of Rehabilitation Facilities	
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://mqa-internet.doh.state.fl.us/mqasearchservices/healthcareproviders
Florida Health Care Complaint Portal	https://complaint-portal.mqa.flhealthsource.gov/home
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://flcertificationboard.org/credentials/
Florida Certification Board	
File an Ethics Complaint	https://flcertificationboard.org/policy-procedure/
Online Education Platform Training Site	https://flcertificationboard.org/education-training/
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	https://www.floridahealth.gov/about-us/inspector-general/
Office of the Inspector General at U.S. Department of Health and Human Services	https://www.oig.hhs.gov/
Report Fraud to U.S. Department of Health and Human Services	https://www.oig.hhs.gov/fraud/report-fraud/index.asp
Florida Department of Agriculture and Consumer Services	
Division of Consumer Services	https://www.fdacs.gov/Divisions-Offices/Consumer-Services
File a Complaint	https://www.fdacs.gov/Contact-Us/File-a-Complaint
Consumer Complaint Form	https://forms.fdacs.gov/10000.pdf
Centers for Medicare and Medicaid	
Centers for Medicare and Medicaid	https://www.cms.gov/
Contact Information for Region 4	https://www.cms.gov/about-cms/where-we-are/regional-offices
Florida Medicaid	https://www.myflfamilies.com/food-cash-and-medical
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 Centers for Medicare and Medicaid Restraint Training Requirements Handbook	https://www.cms.gov/training-education/medicare-learning-networkr-mln/resources-training
Hospital Discharge Appeal Notices	https://www.cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices.html
U.S. Department of Health and Human Services	
U.S. Department of Health and Human Services	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	
Office for Civil Rights	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

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://floridacourtrules.com/probate/rule-5.900/ https://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0700-0799/0765/Sections/0765.105.html .

Table B.3 Florida Administrative Code

Chapter 65: The Department	https://www.flrules.org/gateway/departments.asp?id=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 Crisis Stabilization Units 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
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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://resourcelibrary.myflfamilies.com/cfop155/CFOP%20155-21,%20Use%20of%20Restraint%20in%20Mental%20Health%20Treatment%20Facilities.pdf
Joint Commission Standards on Restraint and Seclusion/Nonviolent Crisis Intervention Training Program	https://www.jointcommission.org/en-us/standards/r3-report/r3-report-44
National Patient Safety Goals	https://www.jointcommission.org/en-us/standards/national-patient-safety-goals

Table B.5 Federal Legislation: U.S. Code and C.F.R.

HIPAA	
42 U.S.C. 1320 Part C: Health Insurance Portability and Accountability Act (HIPAA)	https://uscode.house.gov/view.xhtml?path=/prelim@title42/chapter7/subchapter11/partC&edition=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://aspe.hhs.gov/reports/health-insurance-portability-accountability-act-1996
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)	https://www.congress.gov/crs-product/IF12355 https://uscode.house.gov/view.xhtml?req=granuleid:USC-1994-title42-section1395dd&num=0&edition=1994

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/training/what-protection-pupil-rights-amendment

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	https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section15001&num=0&edition=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
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=0400-0499/0400/0400PARTVContentsIndex.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=0400-0499/0429/0429PARTIIContentsIndex.html
Adult Day Care Centers	http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0429/0429PARTIIIContentsIndex.html

Table B.11 Department of Veteran's Affairs (VA)

U.S. Department of VA: How to Apply for Healthcare Benefits	https://www.vets.gov/health-care/apply/
U.S. Department of VA: Florida Locations	https://www.va.gov/directory/Guide/state.asp?dnum=ALL&STATE=FL
U.S. Department of VA: Health Care Benefits Eligibility	https://www.va.gov/health-care/eligibility/
VA Benefits Guide	https://department.va.gov/wp-content/uploads/2024/12/2025-Federal-Benefits-for-Veterans-Dependents-and-Survivors.pdf 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.va.gov/resources/getting-emergency-care-at-non-vafacilities/
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://flsheriffs.org/how-we-serve/training-program/crisis-intervention-team-training/
De-Escalation Tips	https://www.crisisprevention.com/blog/general/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	https://nursinghome411.org/wp-content/uploads/2017/05/ltccc-antipsychotic-drugs-oversight-ftags-mar2013.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/crisis-services/baker-act-training/
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
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
Students with Emotional/Behavioral Disabilities	http://www.sednetfl.info/ http://www.fldoe.org/academics/exceptional-student-edu/ese-eligibility/emotional-behavioral-disability-e-bd.shtml
Substance Abuse and Mental Health Services Administration	https://library.samhsa.gov/sites/default/files/advisory-model-standards-crisis-care-workers-pep25-07-017.pdf

Appendix C. Laws Related to the Baker Act

Florida Baker Act laws and rules are found in the Florida Statutes and Florida Administrative Code (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. 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	
Florida Statutes	Rule (F.A.C.)
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 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, Florida Statutes	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, Florida Statutes	Developmental Disabilities	
397, Florida Statutes	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 or 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 advanced 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.

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 - All individuals who have an involuntary examination initiated will go to a designated receiving facility or a general 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 CSUs.	- The Department licenses all substance use providers and this information is available on the Departments website. - 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 may 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	Minors may be voluntarily admitted to a Marchman Act facility without a court hearing or the permission of a parent.

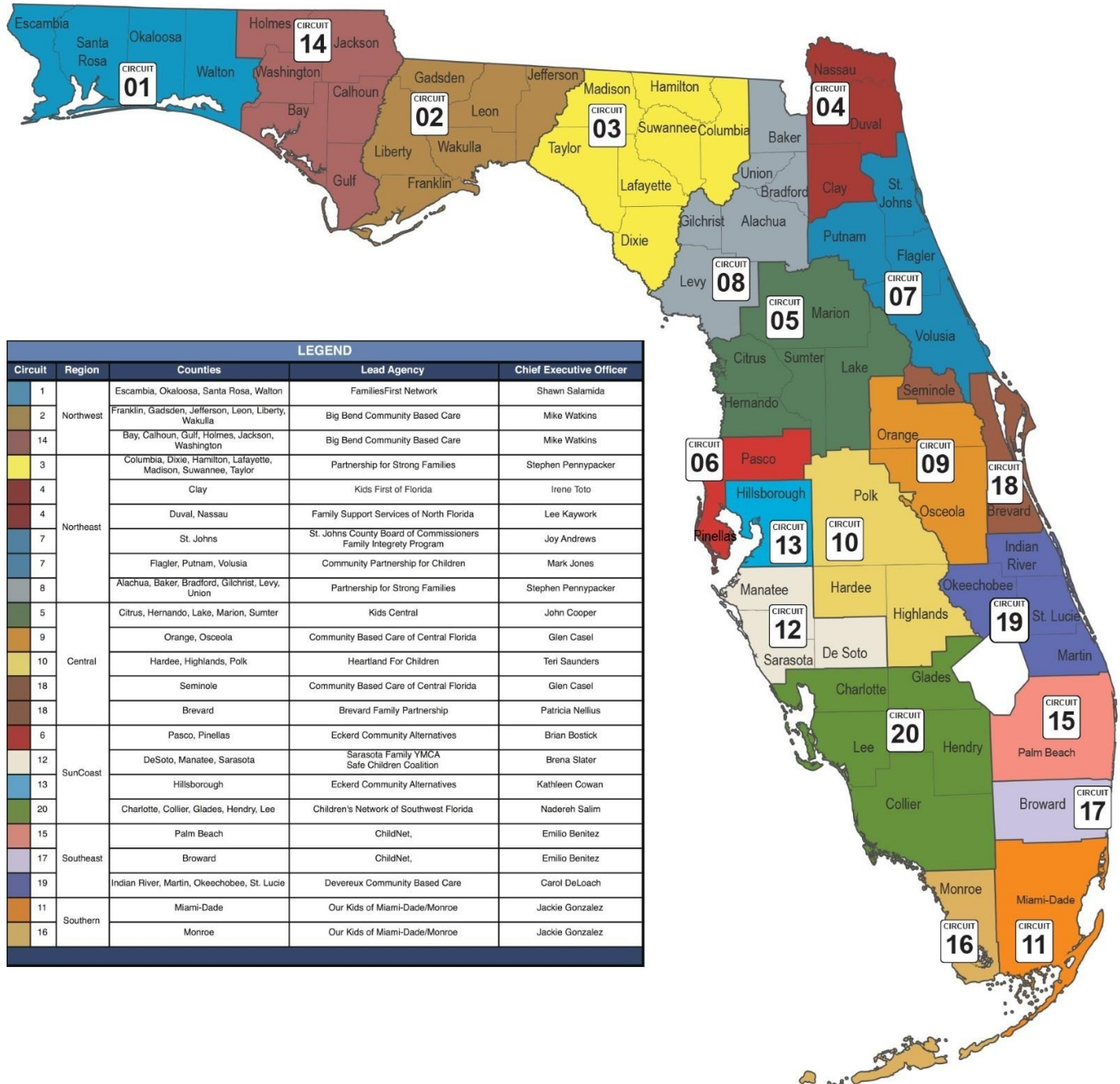
	willing to provide express and informed consent and a parent is also in agreement with the voluntary admission.	
Facility Security	All individuals receiving services in a designated receiving facility or state mental health treatment facility must be admitted to a locked unit regardless of whether they 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 continued involuntary outpatient treatment is supported by a social worker or case manager of a licensed service provider, 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 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. • General 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, Managing Entities, 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.



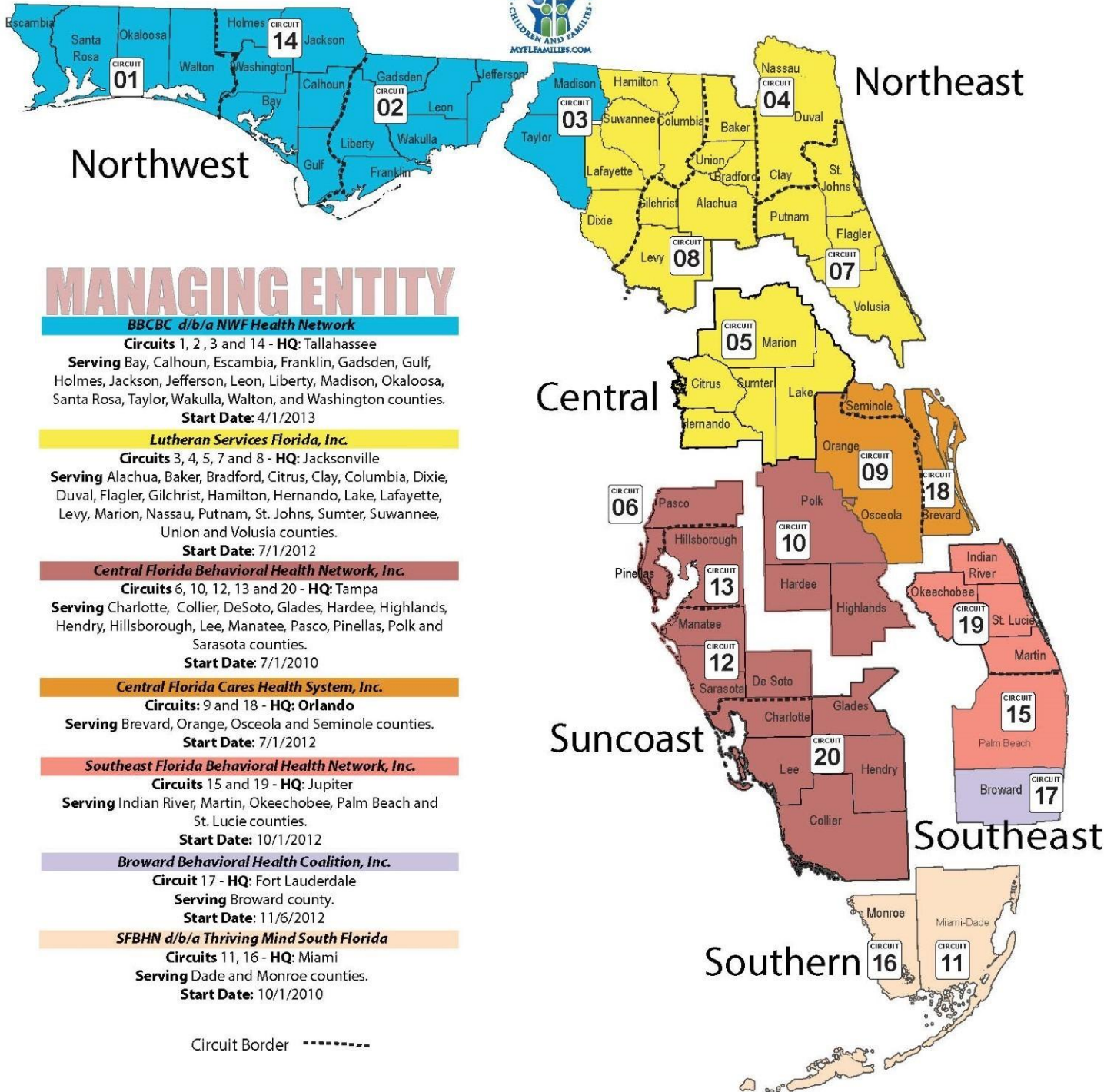


Table E.3 Managing Entities Contact Information

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.bbhcfloida.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 Health 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	People 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

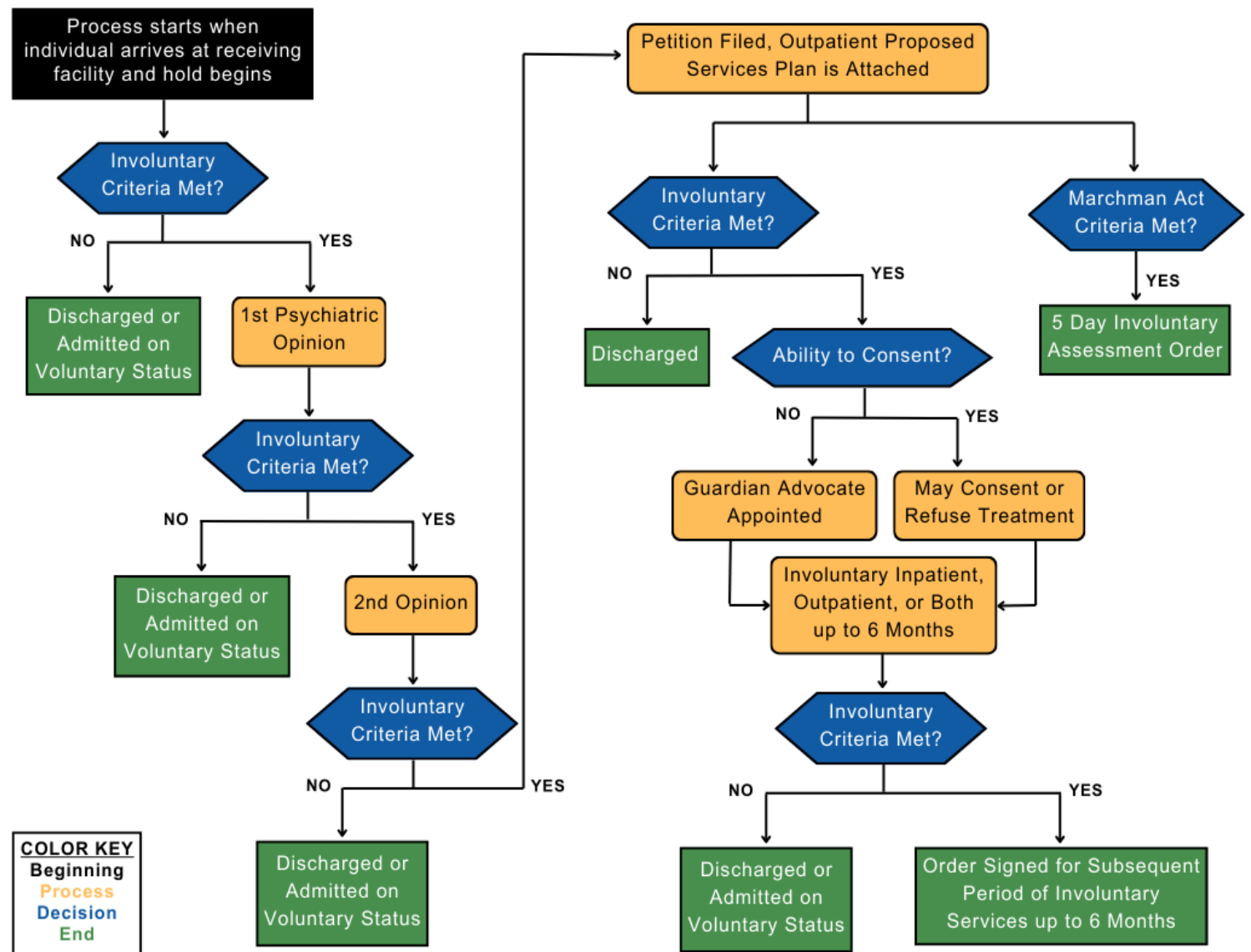
Minors and individuals who have a substitute decision-maker, such as those who reside in a long-term care facility or have a full-time caregiver at home, will almost uniformly be involuntary when receiving services at a Baker Act facility. The following table will help clarify some of the circumstances 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.

Individual Residing in Long-Term Care Facility	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.	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. 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.
Substitute Decision- Maker	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.	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.

Appendix G. Baker Act Flow Chart

This chart is intended to display the flow of a Baker Act of an individual– from the initial arrival, to evaluation, and to what happens afterwards.



Or

Involuntary Examinations, Inpatient Placement, and Outpatient Services

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graph TD
    Start([The process for involuntary services begins]) --> Step1{Appears to meet criteria for involuntary services}
    Step1 --> Box1[A 1st opinion is given by a psychiatrist that examined the individual, supporting the belief that involuntary services criteria reasonably appear to be met  
Section 394.467(3)(b), F.S.]
    Step1 --> Box2[Does not meet criteria for involuntary services]
    Box1 --> Step2{Appears to meet criteria for involuntary services}
    Box1 --> Box3[Does not meet criteria for involuntary services]
    Box2 --> Dis1([Discharged])
    Box2 --> Vol1([Admitted on a voluntary status])
    Box3 --> Step3{Does not meet criteria for involuntary services}
    Box3 --> Step4{Does not meet criteria for involuntary services}
    Step3 --> Dis2([Discharged])
    Step3 --> Vol2([Admitted on a voluntary status])
    Step4 --> Box4[The individual is examined by a psychologist or a 2nd psychiatrist, or other authorized professionals if prior are unavailable, who gives a 2nd opinion  
Section 394.467(3)(b), F.S. Section 394.467(3)(c), F.S.]
    Box4 --> Step5{Appears to meet criteria for involuntary services}
    Box4 --> Step6{Does not meet criteria for involuntary services}
    Step5 --> Box5[A petition for involuntary services is filed all all required criterion are substantiated. For outpatient, a proposed services plan is attached  
Section 394.467(4), F.S.]
    Step6 --> Dis3([Discharged])
    Step6 --> Vol3([Admitted on a voluntary status])
    Box5 --> Step7{The individual is appointed a public defender if eligible within 1 court working day after the petition is filed  
Section 394.267(5), F.S.}
    Step7 --> Step8[A hearing is held within 5 court working days after the filing of the petition, unless a continuance is granted  
Section 394.467(7)(a)(1), F.S.]
    Step8 --> Step9{Does not meet criteria for involuntary services  
Section 394.467(13), F.S.}
    Step8 --> Step10{Meets criteria for Marchman Act instead  
Section 394.467(8)(c), F.S.}
    Step8 --> Step11{Meets all criteria for involuntary services  
Section 394.467(8)(a), F.S.}
    Step9 --> Dis4([Discharged.])
    Step10 --> Box6[5 day involuntary assessment order.]
    Step11 --> Step12[The court determines the individual's ability to consent to treatment based on testimony and evidence  
Section 394.467(7)(c), F.S.]
    Step12 --> Step13{Found competent to consent to treatment}
    Step12 --> Step14{Found incompetent to consent to treatment}
    Step13 --> Box7[May consent or refuse to consent to treatment]
    Step14 --> Box8[Guardian advocate appointed]
    Box7 --> Step15[Ordered to involuntary inpatient placement, involuntary outpatient services, or a combination for up to six months  
Section 394.467(8)(a), F.S.]
    Box8 --> Step15
    Step15 --> Step16{The individual improved; involuntary services criteria are no longer met  
Section 394.467(13), F.S.}
    Step15 --> Step17{The individual continues to meet all criteria for involuntary services  
Section 394.467(11), F.S.}
    Step16 --> Dis5([Discharged])
    Step16 --> Vol4([Admitted on a voluntary status])
    Step17 --> Box9[Order is signed for a subsequent period of involuntary services for up to 6 months]
  
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The flowchart details the process for involuntary services in Florida. It begins with a decision on whether the individual appears to meet criteria. If not, they are either discharged or admitted on a voluntary status. If they do appear to meet criteria, a 1st opinion is given by a psychiatrist. If this opinion supports the belief that criteria are met, the process continues to a 2nd opinion by a psychologist or another psychiatrist. If the 2nd opinion also supports the belief, a petition for involuntary services is filed. If the 2nd opinion does not support the belief, the individual is either discharged or admitted on a voluntary status. The petition process includes appointing a public defender, holding a hearing within 5 court working days, and determining if the individual meets criteria for involuntary services, the Marchman Act, or all criteria. If they meet all criteria, the court determines their ability to consent to treatment. If found competent, they may consent or refuse; if found incompetent, a guardian advocate is appointed. The court then orders involuntary inpatient placement, outpatient services, or a combination for up to six months. If the individual improves and no longer meets criteria, they are discharged or admitted on a voluntary status. If they continue to meet criteria, an order is signed for a subsequent period of involuntary services for up to 6 months.

**Involuntary services refers to involuntary inpatient placement and involuntary outpatient services.

End

Appendix H. 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 H.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.	The Departments Baker Act Data Collection System 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 contact 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.	
<u>394.463(2)(g)</u>	Initial Mandatory Psychiatric Examination - Minors	Within 12 hours of facility arrival.	

Statutes & Administrative Rule	Occurrence	Follow-Up Action...	Reported to...
<u>394.4625(2)(b)</u>	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
<u>394.4625(5)</u>	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
<u>394.467(7)(a)1</u>	Hearing for Involuntary Placement	A hearing for involuntary services petition must occur within five (5) court working days from the time the petition is filed with the court. Continuance can be granted by the court, by a showing of good cause, for up to 21 calendar days.	Presiding court
<u>65E-5.2301(5)</u> <u>394.4598,F.S.</u> <u>65E-5.1703 (7)</u>	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
<u>65E-5.180(7)(d)2</u>	Face-to-Face Examination Following	A face-to-face examination must occur with the individual within one (1) hour of initiation. This is typically performed by the	

	Seclusion or Restraint	physician; however, responsibilities may be delegated to a trained APRN, Physician Assistant, or Registered Nurse.	
<u>65E-5.180(6)(d)</u>	Investigation of Complaint	Formal and informal complaints must be investigated and completed within seven (7) days from the date of entry.	
<u>65E-5.601(3)</u>	Response to Grievance	A written response to a grievance must be provided within 14 calendar days of receipt.	Individual
<u>65E-5.1303(2)(d)</u>	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
<u>65E-5.280(4)(c)</u>	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.	
<u>394.4625(2)(b)</u>	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
<u>394.4625(5)</u>	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

<u>394.467(7)(a)1</u>	Hearing for Involuntary Placement	A hearing for involuntary services petition must occur within five (5) court working days from the time the petition is filed with the court. Continuance can be granted by the court, by a showing of good cause, for up to 21 calendar days.	Presiding court
<u>65E-5.2301(5)</u> <u>394.4598,F.S.</u> <u>65E-5.1703(7)</u>	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
<u>65E-5.180(7)(d)2</u>	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.	
<u>65E-5.180(6)(d)</u>	Investigation of Complaint	Formal and informal complaints must be investigated and completed within seven (7) days from the date of entry.	

Table H.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 H.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.	Reports must be made by using AHCA's Complaint Administration's online form within one working day.
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 H.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 signed.	

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. 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 their professional scope of practice.
Orders may be called into 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 or 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 behavior 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 must 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 must 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 Florida Department of Children and Families via the Baker Act Data Collection System. Must 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 Florida Department of Children and Families via the Baker Act Data Collection System. Must 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 Florida Department of Children and Families via the Baker Act Data Collection System. Must submit within five (5) working days of individual's arrival at the designated receiving facility.	Involuntary
CF-MH 3100 Transportation to Receiving Facility s. 394.463(2)(a)2, F.S.	Notification is provided to the Florida Department of Children and Families via the Baker Act Data Collection System. Must 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. <i>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.</i>	Voluntary
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 • Legal Guardian 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.	Florida Department of Children and Families (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

Action	Notification	Legal Status
CF-MH 3049 Restriction of Communication or Visitors	A copy of the completed documentation must be provided immediately 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. A minor's parent or legal guardian must be notified immediately upon arrival at a designated receiving facility. If the parent cannot be reached, notification must be attempted hourly for the first 12 hours. Parental notification and the person completing the notification must be reported through the Baker Act Data Collection System CF-MH 3118	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. <i>Reports must be made by using AHCA's Complaint Administration's online form within one working day.</i>	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 <i>If transfer occurs prior to receiving admission orders this form does not need to be completed.</i>	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 Substance Abuse and Mental Health	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 • Florida Department of Children and Families	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 • Florida Department of Children and Families	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
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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 • Florida Department of Children and Families • Guardian • Guardian advocate • Representative • Individual's attorney • State attorney	Involuntary

Action	Notification	Legal Status
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 <i>*If determination to withdraw petition is made with less than 24 hours, notification must occur immediately.</i>	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. • Florida Department of Children and Families	Involuntary
CF-MH 3032 Petition for Involuntary Outpatient Services	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. • Florida Department of Children and Families	Involuntary

Action	Notification	Legal Status
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	Baker Act Data Collection Form

☐ Firearm Prohibition	Finding and Certification by an Examining Physician of Person's Imminent Dangerousness
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Table K.4 Involuntary Inpatient Placement

☐ CF-MH 3155	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 Services
☐ 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 Florida Department of Children and Families
☐ 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

TableK.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 Services
☐ CF-MH 3115	Order Requiring Evaluation for Involuntary Outpatient Placement
☐ CF-MH 3118	Cover Sheet to Florida Department of Children and Families
☐ CF-MH 3032	Petition for Involuntary Services
☐ 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 Services or Diminished Treatment Plan
☐ CF-MH 3155	Order for Involuntary Services
☐ 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 ServiceOrder
☐ CF-MH 3180	Petition Requesting Authorization for Continued Involuntary Outpatient Services

☐ CF-MH 3185	Notice to Court of Waiver for Continued Involuntary Outpatient Placement Hearing and Request for an Order
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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 Service 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 Services
☐ 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 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

Appendix L. Mental Health Resources

How to Get Help

Calling the 988 Florida Lifeline is a courageous step. When you call, you'll talk to a local crisis counselor who is here to support you find the support you need. If you're experiencing a mental health crisis, here's how to get help:

Table .1 – Free 24/7 Behavioral Health Support

Elder Helpline	Available 24/7 for information about services and support for older adults and their families	1-800-963-5337
Florida Veterans Support Line	Provides 24/7 support and resources specific to veterans	1-844-693-5838
First Responder Crisis Text Line	Offers 24/7 mental health support through text for first responders	Text “Start” to 741-741
Mobile Response Teams	Provides in-person crisis intervention for those experiencing a mental health crisis.	Visit MyFLFamilies.com , “Mobile Response Teams” Page
988 Florida Lifeline	Available 24/7 to offer support for suicidal thoughts, substance use disorder, mental health crises, or emotional distress.	Call, Text, or chat 988

1. Florida Department of Children and Families, Office of Substance Abuse and Mental Health (n.d.). Tallahassee, FL: Author. Retrieved from <https://www.myflfamilies.com/crisis-services/baker-act/baker-act-forms>

3. Baker Act Reporting Center. (2024, November). The Baker Act Fiscal Year 2023/2024 Annual Report. Tampa, FL: University of South Florida, Louis De La Parte Mental Health Institute, Department of Mental Health Law and Policy. Retrieved from https://www.usf.edu/cbcs/baker-act/documents/ba_usf_annual_report_2023_2024_v2.pdf Association for Children’s Mental Health. Problems at School. Retrieved from <http://www.acmh-mi.org/get-help/navigating/problems-at-school/>.