Baker Act Reporting Center

http://bakeract.fmhi.usf.edu/
Questions may be addressed to the Baker Act Reporting Center director, Annette Christy (achristy@usf.edu; 813-279-1923).

- This center receives Baker Act forms on behalf of the Agency for Health Care Administration, as F.S. 394 specifies Baker Act Receiving Facilities must submit to AHCA.
- Additional specifics of data submission, including forms, are contained in Florida Administrative Code, 65.E.5
- Forms may be found at http://www.myflfamilies.com/service-programs/mental-health/baker-act-forms. There is also a link to this website from the main page of the Baker Act Reporting Center website.
- More specifics of data reporting requirements and logistics are described on the Baker Act Reporting Center website.
- The center makes an effort to maintain a list of contacts at receiving facilities so that information can be shared about changes to/issue related to submission of forms.
- Please email Annette Christy with the name, email, and job title of the person(s) who is the best contact at your facility for these data issues so that we can keep you up to date on data submission and training issues.

Online Baker Act Training

http://bakeracttraining.org/
Over the past several years, the Florida Department of Children & Families (DCF) has funded the development of several online training modules. Following is a list of free, online training. CEUs/CLEs are available for these trainings. There is a fee to process the continuing education credits.

- Introduction to the Baker Act
- Emergency Medical Conditions
- Individual Rights
- Law Enforcement
- Long Term Care
- Minors
- Suicide Prevention

DCF also funded several web events. These have been put online. CEUs/CLEs are also available for the recorded version of these web events.

- Trauma Series
- Why People Die by Suicide
- Seclusion & Restraining
- Baker Act & Marchman Act & Co-Occurring Disorders

Guardian Advocate Training has also been developed by us with funding from DCF. This training may be found at http://flguardianadvocate.org/


- Bound copies may be ordered from ProCopy – see http://www.pro-copy.com/bakeract
Agenda

Morning: Getting into a Facility

1. History & Overview of Baker Act
2. Voluntary Admission
3. Involuntary Examination
4. Transportation
5. Emergency Medical Conditions
6. Older Adults & Long Term Care Facilities
7. Rights, Confidentiality, & Immunity

Afternoon: After Arrival at a Facility

7. Firearm Prohibitions
8. Involuntary Inpatient Placement
9. Involuntary Outpatient Placement
10. Rights of Persons & Substitute Decision-Makers
11. Admission / Discharge Issues

Alternatives to the Baker Act

Mental Illness Only
- Marchman Act, s.397, FS
- Developmental Disabilities, s.393, FS

Psychiatric – Not Medical
- Emergency Examination & Treatment of Incapacitated Persons, s.401, FS
- Federal EMTALA – Emergency Medical Treatment & Active Labor Act -- Access to Emergency Services & Care, s.395.1041, F.S.
- Medical Consent Act, s.766.103 FS

Intervention Alternatives
- Adult Protective Services, s.415, FS
- Guardianship, s.744, FS
- Advance Directives Act/Health Care Surrogate & Proxy, s.765, FS

Not a Discharge Destination
- Nursing Homes/Assisted Living Facilities
Who is Protected?

- Voluntary and Involuntary Status
- Inpatient and Outpatient Settings
- Children and Adults (including elders)
- Competent and Incapacitated Persons
- Persons in Publicly and Privately Funded Baker Act Facilities
- Persons held under the Baker Act in all hospitals, regardless of designation

Florida’s Mental Health Act – Nothing More & Nothing Less

History & Overview

- History
- Lack of due process
- Representative Maxine Baker / Intent
- 1971 passage -- 1972 implementation
- Frequently amended

Balances liberty interests against safety of individual and society

Receiving & Treatment Facilities

394.455(26) and (30), FS

Unless designated by DCF, facilities are not permitted to hold or treat individuals against their will or without their express and informed consent (involuntary status) for mental illness, except as required under federal EMTALA law.

- Receiving Facility: Any public or private facility designated by DCF to receive and hold individuals on involuntary status under emergency conditions for psychiatric evaluation and to provide short-term treatment (excludes jails)
- All areas on the premises of the facility are included in the designation.
- Treatment Facility: State Mental Health Facilities (state hospitals)

Receiving Facilities

Public & Private

- Public receiving facilities receive legislatively appropriated Baker Act funds
- Private receiving facilities do not.
- Both public & private receiving facilities serve indigent persons and have insurance contracts.
- Public & private receiving facilities have the same responsibilities under the Baker Act and people served have the same rights, other than individuals with felony charges on involuntary status who must be examined by a public receiving facility.
- Public receiving facilities must ensure the centralized provision and coordination of acute care services for eligible persons with acute mental illnesses, regardless of whether they can accept a transfer.
Receiving Facilities
394.461, FS and 65E-5.350 and 65E-5.180(5), FAC

Receiving facilities must:

- Provide onsite emergency reception, screening & inpatient treatment services 24 hours a day, 7 days a week, regardless of ability to pay
- Accept individuals of all ages
- Assess all individuals for clinical safety, co-occurring disorders, substance abuse, physical/sexual abuse or trauma
- Must comply with all EMTALA requirements, if a hospital, including free-standing psychiatric hospitals.

See the DCF website for a complete list of all designated public and private receiving facilities in each DCF Circuit, including the names and addresses of each receiving facility.

Voluntary Admission
Adults
394.4625, FS and 65E-5.270, FAC

- Have a mental illness
- Be suitable for treatment
- Be competent to provide express and informed consent
Voluntary Admission
Minors
394.4625, FS and 65E-5.270, FAC

- Have a mental illness (same definition as for adults)
- Be suitable for treatment
- Guardian must apply by express and informed consent for minor’s admission
- Minor agrees (assents) to the admission
- Judicial hearing to confirm the voluntariness of the admission
- Special provisions for dependent children in custody of DCF

Minors & the Baker Act
(continued)

Variety of state laws, case law, and court rules of juvenile procedures governing the admission and treatment of minors often are in conflict:

- Dependent or delinquent minors vs. those with their own parents or kinship care
- Inpatient vs. residential vs. outpatient
- Voluntary vs. involuntary
- Admission vs. treatment

Minority Defined:
A person under 18 whose disabilities haven’t been removed by marriage or emancipation.

Additional information on consent for minors in Appendix D of the 2014 Baker Act Handbook

Natural Guardianships
[744.301, FS]

- Mother/father jointly are guardians during minority
- Surviving parent is guardian even if remarried after other parent dies
- If marriage dissolved, guardianship goes to parent given parental responsibility
- If parents given shared responsibility, both continue as natural guardians
- If neither are given parental responsibility, neither is guardian
- A guardian can be appointed by the court
- Mother of child born out of wedlock is guardian unless court order states otherwise.

Dissolution of Marriage, Support & Time Sharing
Chapter 61, F.S.

- Parenting Plan: governs all circumstances among the parties including decision-making and time sharing
- Shared Parental Responsibility: court-ordered relationship in which both parents retain full parental rights/responsibilities and shared decision-making. Certain decisions may be assigned to one parent.
- Sole Parental Responsibility: court-ordered relationship in which one parent makes decisions (with or without visitation)
- Time Sharing Schedule: A time table included in Parenting Plan that specified the time the child will spend with each parent.
- Access to information/records available to either parent unless court specifically revokes this right.
Youth

- An **unaccompanied youth**, who is also a certified homeless youth, as defined in s. 382.002, and who is 16 years of age or older may petition the circuit court to have the disabilities of nonage removed. Certification can be done by the school district, emergency shelter director, or runaway youth center director. The court shall advance the cause on the calendar. (743.067, FS) - **cannot consent to admission or treatment under Baker Act**.

- An **unwed pregnant minor** may consent to the performance of medical or surgical care or services relating to her pregnancy or care of her child and such consent is valid and binding as if she had achieved her majority. Nothing in this act shall affect the provisions of s. 390.0111. (743.065, FS)

Consent to Medical Care/Treatment

s.743.065(1)and(2), FS

In absence of natural / adoptive parent or court-appointed guardian, the following have power to consent for minor’s medical care/treatment:
- Power of attorney
- Stepparent
- Grandparent
- Adult sibling
- Adult aunt or uncle

Medical care or treatment includes ordinary care but excludes surgery, general anesthesia, **psychotropic medications** or other extraordinary procedures that require a court order.

Emergency medical care or treatment can be provided by a physician or EMS for an acute condition when parental consent cannot be immediately obtained.

Dependent Children / Baker Act

39.402, FS 65C-35, F.A.C.

Revisions to chapter 39.402, FS pertaining to dependent children, effective 7/1/05, followed by rules promulgated in 2010:

- Parent remains only party to authorize admission/treatment of child (contingent on express & informed consent) except for court, unless parental rights severed.

- Removal from home – DCF takes possession of meds if currently prescribed and in original container and provides until shelter hearing.

- Court authorization requested at shelter hearing to continue to arraignment hearing (or 28 days whichever is sooner)

Dependent Children / Baker Act

(continued)

- Before filing dependency petition, physician evaluates need for medications & reports to court.

- Psychotropic medications can be administered in advance of a court order in only 2 circumstances:
  1. If prescribing physician certifies in writing that delay in providing the medication would more likely than not cause significant harm to the child, or
  2. In hospitals, CSU’s, or in psychiatric residential treatment programs

- Within 3 working days after the medication is begun in the above two circumstances, DCF must seek court authority for continuing the medications.
Outpatient Crisis Intervention Services & Treatment for Minors
394.4784, FS

Minors age 13 or older may consent to limited services, excluding psychotropic medications, by a licensed mental health professional or state licensed mental health facility up to 2 outpatient visits during any 1-week period, including:

- Diagnostic and evaluative services
- Crisis intervention services include individual/group counseling

Parent/guardian not liable for payment for services unless participating in the services

Mental Illness Means...
394.455(18), FS

- Impairment of the mental or emotional processes that exercise conscious control of one’s actions or of the ability to perceive or understand reality.
- Impairment substantially interferes with a person’s ability to meet the ordinary demands of living,
- Excluding developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

Co-occurring Disorders?

Express and Informed Consent Means...
394.455(9), FS

- Consent voluntarily given in writing by a competent person
- After sufficient explanation and disclosure of the subject matter involved
- To enable the person to make a knowing and willful decision
- Without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

Incompetent to Consent to Treatment Means...
394.455(15), FS

- That a person’s judgment is so affected by his or her mental illness
- That the person lacks the capacity
- To make a well-reasoned, willful and knowing decision
- Concerning his or her medical or mental health treatment.
Voluntary Admission
Selected Procedures
394.4625, FS and 65E-5.270, FAC

- Incapacitated or incompetent with a guardian – must be involuntary
- Incapacitated with health care surrogate / proxy making decisions -- must be involuntary
- Once on involuntary status, guardian or surrogate/proxy may generally give consent to treatment – not admission.
- Certification of competence by physician within 24 hours of arrival
- Special protections for selected elders – should not be sent from a nursing home or ALF to an ED for psychiatric assessment without first initiating Baker Act voluntary or involuntary status!

Special Protection for Elders on Voluntary Status
394.4625(1)(b) and (c), FS and 65E-5.270(3), FAC

An initial assessment of persons to give express and informed consent to treatment must be conducted before transport for voluntary examination:

- A person 60+ years of age for whom an emergency transfer is sought from a nursing home
- A person 60+ years of age diagnosed with dementia for whom transfer is sought from a nursing home, ALF, adult day care center, or adult family-care home
- A person for whom all decisions concerning medical treatment are currently being lawfully made by the health care surrogate or proxy designated under chapter 765.

Special Protection for Elders on Voluntary Status

The assessment must be performed by one of the 3 following services (each defined in law), pursuant to procedure approved by the DCF regional administrator:

- A mental health overlay program, or
- A mobile crisis response service, or
- A licensed professional authorized to initiate an involuntary examination and is employed by a CMHC

Assessment performed within 2 hours. If not, requesting facility may arrange an independent assessment by an authorized professional who is not employed by, under contract with, and does not have a financial interest in sending or destination facility.

Failure to comply a violation of chapters 400, 429, and Baker Act.

Discharge of Persons on Voluntary Status
394.4625(2), FS and 65E-5.270, FAC

- Notice of right to request release given at time of admission
- Request for discharge -- notice within 12 hours to physician or psychologist & release within 24 hours (3 working days from State Treatment Facility)
- Refusal or revocation of consent to treatment – discharge within 24 hours
- Petition for involuntary placement filed with the circuit court within 2 court working days after request for discharge is made

25 26 27 28
Initiating Involuntary Examinations
384.463(2), FS and 65E-5.280, FAC

Upon determination that person appears to meet criteria for involuntary examination, the exam may be initiated by any one of the following three means:

1. Court Order - the circuit court may enter an ex parte order; or

2. A law enforcement officer shall take into custody a person who appears to meet the criteria describing circumstances; or

3. A mental health professional may execute a certificate stating that s/he has examined the person within the preceding 48 hours and found the person met the criteria and stating the observations upon which that conclusion is based.

Involuntary Examination Criteria
394.463(1), FS

Reason to believe person has a mental illness and because of mental illness, person has refused or is unable to determine if examination is necessary, and either:

Without care or treatment, is likely to suffer from neglect or refuse to care for self, and such neglect or refusal poses a real and present threat of substantial harm to one’s well-being and it is not apparent that such harm may be avoided through the help of willing family members, friends, or the provision of other services; or

There is substantial likelihood that without treatment person will cause in the near future serious bodily harm to self or others, as evidenced by recent behavior.

Must meet all criteria

Involuntary Examinations Initiated by the Court
384.463(2)(a)1, FS and 65E-5.280(1), FAC

- Petition form (#3002)
- Filed with Clerk of the Court (Probate) – No fee charged
- Based on sworn testimony
- Time limit for execution of order
- When/how law enforcement can execute
- Transportation to nearest receiving facility – transfer later if appropriate – unless a Transportation Exception Plan has been approved by the Board of County Commissioners and the DCF Secretary.
Involuntary Examination Law Enforcement Officers
384.463(2)(a)(2), FS and 65E-5.280(2), FAC

- Law enforcement officer defined
- No need to be diagnosticians
- Observation or circumstances?
- Report of Law Enforcement Officer -- Form (3052a)
- Transportation to nearest receiving facility – transfer later by the facility if appropriate unless a Transportation Exception Plan has been approved by the Board of County Commissioners and the DCF Secretary.

Certificate of a Mental Health Professional
394.455(2), (4), (21), (23) and (24), FS

Mental Health Professional defined...

**Psychiatrist:** A medical practitioner licensed under chapter 458 or 459 who has primarily diagnosed/treated mental/nervous disorders for a period of not less than 3 years, inclusive of psychiatric residency.

**Physician:** A medical practitioner licensed under chapter 458 or 459 who has experience in the diagnosis/treatment of mental and nervous disorders or a physician employed by a facility operated by the U.S. Dept of Veterans Affairs which qualifies as a receiving or treatment facility.

Clinical Psychologist: A psychologist as defined in s. 490.003(7) with 3 years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure, or a psychologist employed by a facility operated by the United States Department of Veterans Affairs that qualifies as a receiving or treatment facility.

Psychiatric Nurse: A registered nurse licensed under chapter 464 who has a master's degree or a doctorate in psychiatric nursing and 2 years of post-master's clinical experience under the supervision of a physician.

Clinical Social Worker: A person licensed as a clinical social worker under chapter 491.

Licensed Mental Health Counselor: Means a mental health counselor licensed under chapter 491, F.S.

Licensed Marriage and Family Therapist: Means a marriage and family therapist licensed under chapter 491, F.S.

(Physician Assistants not eligible in statute, but recognized by Florida Attorney General in May 2008 Opinion to initiate involuntary exam, but not to perform other duties of a physician)
Mental Health Professionals

- When a general law and a specific law are in conflict, the specific law takes precedence.

- Specific Laws limit how the general law can be applied. Baker Act (specific law) takes precedent over licensure statutes (general laws).

- Only those professionals specifically referenced in the Baker Act may act. Cannot be delegated to other professionals such as Physician Assistants, ARNP’s or others.

Certificate of a MH Professional

384.463(2)(a)3, FS and 65E-5.280(3), FAC

- Examination within 48 hours prior
- By an authorized professional
- Citing observations of the professional on which his/her conclusion is based
- Observations must relate to the criteria
- Transportation to nearest receiving facility – transfer later if appropriate unless a Transportation Exception Plan has been approved by the Board of County Commissioners and the DCF Secretary.
- Certificate of a MH Professional (3052b)

Baker Act

Involuntary Examinations

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Rate/1,000:
- 7.8
- Court: 2%
- MHP: 49%
- LEO: 49%

Reporting to AHCA

394.459(9), 394.463(2)b, and 400.1021(c), FS

Any receiving facility accepting person for involuntary examination must send to BA Reporting Center cover sheet (#3118) and completed initiation form:
- Ex Parte Petition/Order
- Report of Law Enforcement Officer
- Certificate of a Professional

All court orders for Involuntary Placement must also be sent to the BA Reporting Center within 1 day:
- Involuntary Inpatient Placement Order
- Involuntary Outpatient Placement Order
- Continued Involuntary Outpatient Order

Receiving facilities must report to AHCA, by certified mail within one working day, long-term care facilities licensed under chapter 400 / 429, FS that do not fully comply with Baker Act provisions governing:
- Voluntary admission
- Involuntary examination
- Transportation
Transportation
394.462, FS and 65E-5.260, FAC

- Why law enforcement?
- Mandated duty for **all** Involuntary exams, regardless of how initiated (court, law enforcement or MH professional, except transfers from a hospital or between receiving facilities)
- Transportation to **nearest** receiving facility – transfer later if appropriate unless a Transportation Exception Plan has been approved by the Board of County Commissioners and the DCF Secretary.
- Which law enforcement agency?
- Exceptions/delegation of responsibility
- Divert Status? Must accept!

Return After Escape
from Receiving Facility 394.467(8), FS

- **Voluntary not meeting criteria** for involuntary placement, law enforcement not notified by facility.
- **Voluntary but meets criteria** for involuntary examination, 3052b initiated and law enforcement requested to take person into custody and deliver to nearest receiving facility. Transfer of person, if appropriate, arranged facility-to-facility.
- **Involuntary examination status**, within 72 hours of arrival at facility, meets criteria for involuntary placement, but prior to petition filed with court. Law enforcement given 3052 (a or b) or court order and requested to take person into custody and deliver to nearest receiving facility. Transfer of person, if needed, arranged facility-to-facility.

Transportation (continued)

- Nearest facility must accept (394, 395, and EMTALA)
  - Emergency medical conditions!
  - Medical clearance?
- Jail vs. Receiving Facility
- Facility at capacity?
- Security at facilities?
- Transfers from hospital ED’s?
- Medical or insurance screening at ER?
- Right to Individual Dignity -- procedures, facilities, vehicles, and restraining devices used for criminals may not be used with persons who have a mental illness, **except** for protection of the person or others.

Return of Persons After Escape (continued)

- **Petition for Involuntary Placement filed** with court, law enforcement provided copy of petition (3032) and requested to return person to facility from which the petition was filed.
- Under court’s **Order for Involuntary Placement** (#3008) and leaves facility without authorization, administrator authorizes search and return of person. Administrator of facility may request law enforcement to search for and return person and provide copy of order.
- If **escape is from an ED**, return to ED for appropriate transfer as required by EMTALA.
Law Enforcement Requirements
394.458, and 394.483(2),FS and 65E-5.280, FAC

**Weapons Prohibited:**
Except as authorized by law or as authorized by the hospital administrator, it is unlawful to bring any firearms or deadly weapons into a hospital providing mental health services.

**Paperwork Required:**
Initiation of Involuntary Exam:
- BA 52a (Law Enforcement) or
- BA 52b (MH Professional) or
- Ex Parte Order (Circuit Judge), and
- BA 3100 (transportation form)

Transportation Exception Plans
394.462(3), FS and 65E-5.2601, FAC
May be granted by DCF secretary (up to 5-years) after approval by Board of County Commissioners of any affected counties and the DCF regional administrator, for purposes of:
- Improving service coordination or
- Better meeting special needs of individuals

Proposal for exception must:
- Identify specific provision from which an exception is requested;
- Describe how proposal will be implemented by participating law enforcement agencies and transportation authorities; and
- Provide a plan for coordination of services such as case management

Transportation Exception Plans
The exception may be granted only for:
- Centralizing & improving provision of services within an area, which may include an exception to requirement for transporting to nearest receiving facility;
- Facility may provide an environment & services uniquely tailored to needs of an identified group of persons with special needs, such as hearing or visual impairments, or physical frailties; or
- Specialized transportation system providing an efficient & humane method of transporting persons to receiving facilities, among receiving facilities, and to treatment facilities.

Transfers
394.3685, FS and 65E-5.310
All transfers from hospitals to other facilities must comply with EMTALA. Otherwise:

**Public to Private Facilities**
- Requested by person or representative
- With approval by private facility
- At person’s expense

**Private to Public Facilities**
- Requested by person or representative and acceptance by public facility
- Requested by private facility and acceptance by public facility, at cost to transferring facility. 2 working days for public facility to respond (not from ED)

**Between Private Facilities**
- Requested by person or representative and acceptance by facility to which transfer is sought
Transfers in Legal Status
394.4625(4)and(5), FS and 65E-5.270(1)(b), FAC

Voluntary ➔ Involuntary
- File Petition for Involuntary Placement within 2 court working days.

Involuntary ➔ Voluntary
- All requirements of voluntary admission must be met
- Initial Mandatory Involuntary Examination completed by physician or clinical psychologist
- Certification of Competency to Consent to Treatment completed by physician.
- Only then can transfer to voluntary status be made.
- If imminently dangerous, firearm prohibition reporting to court must be made.

Involuntary Examination
394.463(2)(f)and 65E-5.2801(1), FAC

A “Baker Act” is not lifted, rescinded, overturned, reversed, or abrogated!

- Once an Involuntary Exam is initiated, the Initial Mandatory Involuntary Examination must be conducted without unnecessary delay by a physician or licensed clinical psychologist at a receiving facility or a hospital and documented in the clinical record
- Minimum standards for Initial Mandatory Involuntary Examination...

Minimum Standards for Initial Mandatory Involuntary Examination
394.463(2)(f), FS 65E-5.2801, FAC

- Thorough review of any observations of the person’s recent behavior; and
- Review “Transportation to Receiving Facility” form (#3100) and
- Review one of the following:
  - “Ex Parte Order for Involuntary Examination” or
  - “Report of Law Enforcement Officer Initiating involuntary Examination” or
  - “Certificate of Professional Initiating Involuntary Examination”
- Conduct brief psychiatric history; and
- Conduct face-to-face examination in a timely manner to determine if person meets criteria for release.

Involuntary Examination (continued)

- Disposition within 72 hours of arrival at first hospital or receiving facility
- “Approval” for release from receiving facility can only be done by a psychiatrist or a clinical psychologist or an emergency department physician (#3111)
- Notice of release or discharge (#3038)
Discharge or Release
Involuntary Examination
394.463(2)(I), FS

Within the 72-hour examination period:

- Person shall be released, unless charged with a crime. If so, returned to law enforcement, or

- Competent person, unless charged with a crime, shall be asked to give express and informed consent to voluntary placement, or

- Petition for involuntary placement filed with clerk of circuit court.

Emergency Medical Conditions &
the Baker Act
395, FS and EMTALA

An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any one of the following:

- Serious jeopardy to patient health
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ

Psychiatric and substance abuse emergencies are legally defined as emergency medical conditions!

EMTALA

- Federal EMTALA takes precedence over state statutes, when in conflict
- All hospitals must comply (not CSU’s, nursing homes or outpatient)

Appropriate transfer from ER based on:
1. Medical screening for emergency medical condition
2. Stabilize for transfer (mechanical, chemical or legal restraints?)
3. Consent of person/representative (receiving facilities) or certification by physician (non-receiving facilities)
4. Full disclosure / clinical records
5. Prior approval by transfer destination
6. Safe / appropriate method of transfer
7. Community / state approved plans?
8. Transfer based on paying status?
Hospital Licensing Statute

395.1041 Access to emergency services and care.—

(3)(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

Hospital Licensing Statute

s. 395.1041, F.S.

(3)(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred...

Emergency Medical Conditions

394.463(2)(g) and (h), F.S.

At hospital providing evaluation or treatment of an emergency medical condition:

- 72-hour clock starts at arrival, stops for emergency medical condition, starts again when person stabilized
- Examination can be conducted by a physician or clinical psychologist
- A physician or clinical psychologist can approve direct release (#3101) or
- Transfer to a designated receiving facility able to provide needed medical care:
  - Notice to receiving facility within 2 hours (#3102)
  - Transfer to or examination by receiving facility within 12 hours

Hospital Licensure


- Compliance with all rights by any hospital holding person on Baker Act voluntary or involuntary is a condition of hospital licensure
- Hospital emergency department compliance with Baker Act a condition of licensure.
- Hospital psychiatric records subject to Baker Act requirements and substance abuse records subject to Marchman Act.
- AHCA required to enforce provisions of Baker Act law/rules at all hospitals
Stabilize Pending Transfer
Prevent individuals from leaving the ER using the least restrictive method. Methods some hospitals use include:

- Examine, admit, transfer, or release for follow-up ASAP
- Place into a gown – remove shoes
- Locate person at back of ED, furthest from exit doors or in secured area or unit
- Use color-coded ID band or gown that identifies wandering risk
- Provide close observation
- Provide 1 on 1 by trained staff if necessary
- Provide video monitoring
- Use chemical or mechanical restraints if warranted under the federal Conditions of Participation behavioral restraint standards.

Inability to Transfer?

- Examination & release by ED physician if Mandatory Initial Involuntary Exam is conducted and person doesn’t meet a criteria for involuntary placement.
- Examination and release by contract psychologist or physician
- Have consult psychiatrist treat pending person’s transfer or release.
- Retain for medical treatment with psychiatric care by receiving facility.
- Transfer to “a” designated receiving facility able to manage the person’s medical condition – not the nearest facility.
- If unable to transfer within the 12 hour period, suggest report to DCF MH Program or Managing Entity staff and request assistance in transferring.

Elders with Psychiatric & Behavioral Needs

Mental illness occurs in all ages and circumstances and is treatable

Consequences of transfer for psychiatric purposes

- Ambulation and continence
- Confusion and disorientation
- Transfer trauma
- When can this be done on site?

Federal OBRA law requires specialized needs of nursing home residents be met:

- Assessment
- Consultation
- Intervention
- Treatment
**FHCA Best Practice Tool**

See FHCA best practice tool on Behavior Management / Aggression Control & Baker Act Guidelines (Appendix E)

- 1:1 oversight as possible
- Enlist staff familiar with resident & who have successfully redirected behaviors in past
- Gather behavioral data & document hourly
- Verbally redirect & assist resident to quiet area
- Review/revise current plan of care to calm: Toileting, food & fluids, warmth, repositioning, rest, music, reminiscence therapy, aroma therapy, safe outdoor activity, past successful diversions – document effectiveness of interventions.

(continued)

**Current Issues**

**Baker Act/Nursing Homes**

- Emergencies or just unaddressed problems?
- Admission of persons with behavioral issues to nursing homes without clinical consideration?
- In-place assessment of residents with aggressive or self-neglectful behavior
- Rule out non-psychiatric causes of behavioral problems, especially pain and medication interactions
- Provide therapeutic interventions by qualified staff to avoid Baker Act
- Appropriate initiation of involuntary examination (unlikely that voluntary admission will be appropriate)
Current Issues

- Involuntary exam by physician, psychologist, clinical social worker, LMHC, LMHT, or psychiatric nurse documenting observations that criteria is met – prior to transfer (not required to be independent professional)
- Reevaluate for readmission after exam & treatment -- not before
- Readmission to nursing home -- residents sent to another NH licensed and staffed the same as first NH that couldn’t manage resident’s behavior??
- Refused readmission for “dangerousness” ?? Federal case law!
- Residents discharged or transferred for one reason but refused for readmission for another?

Nursing Homes & Other Health Care Facilities

400.102(c); 429.71(2)(c); 429.911(2)(d); 394.463(2)(b), FS

- Failure to comply with Baker Act regarding the transportation, voluntary admission, and involuntary examination are grounds for action against facilities licensed under Chapter 400/429, F.S.
- Receiving facilities required to report to AHCA, by certified mail within one working day, facilities licensed under chapter 400/429, FS that do not fully comply with Baker Act provisions.
- Notice of emergency discharge or transfer to guardian or representative by phone or in person before transfer, if possible.

Rights of Persons

394.459, FS and 65E-5.140, FAC

- Individual dignity
- Treatment
- Participation in treatment & discharge planning
- Express and informed consent
- Quality of treatment
- Communication & abuse reporting
- Care and custody of personal affects
- Voting in public elections
- Habeas corpus
- Separation of children from adults
- Sexual misconduct prohibited
- Florida Patient’s Bill of Rights
- Confidentiality
Confidentiality

Variety of federal/state statutes and case law govern confidentiality:

- Baker Act Order after good cause hearing – subpoena insufficient
- Psychotherapist / patient privilege
- Substance Abuse
- HIPAA (treatment, operations and payment exempted)
- Substitute Decision-Makers
- Communicable Diseases
- Duty to report abuse, neglect & exploitation of children and vulnerable adults
- Foreign Nationals – Consular Notification & Access

Confidentiality (continued)

Unless person, guardian, guardian advocate, or surrogate/proxy waives by express and informed consent, confidentiality of record shall not be lost.

Information from record can be released:
- Court order after good cause hearing? **Yes**
- Declaration of intent to harm – **may** release sufficient information to adequately warn person threatened – **Yes**
- Tarasoff? **No**
- Inform guardians of minors? **Yes**
- Confessions of past crimes? **No**
- Testimony for criminal conviction? **No**
- Testimony for civil commitment? **Yes**
- Missing Persons?

Confidentiality

Person has right of reasonable access to own clinical record unless determined by physician to be harmful. If restricted:

- Recorded, with reasons, in clinical record
- Notice to person, attorney, and others
- Expires in 7 days but can be renewed

Facility policies should identify:

- What is reasonable access?
- Is this all “persons” – minors? incapacitated?
- Who will review for harmfulness?
- How, where & with whom actual review will take place?

Immunity

394.459 (10), 394.4615(8), and 394.460, FS

- Any person who acts in good faith in compliance with the Baker Act is immune from civil or criminal liability for his or her actions in connection with the admission, diagnosis, treatment, or discharge of a person to or from a facility. However, this section does not relieve any person from liability if such person commits negligence. (394.459)
Online Training Opportunities

www.bakeracttraining.org
On demand - at your convenience
Up-to-date material
No fee
Certificate of Achievement
CEC’s offered @ low cost

- Introduction to the Baker Act
- Emergency Medical Conditions & the Baker Act
- Law Enforcement & the Baker Act
- Long-term Care & the Baker Act
- Consent for Minors
- Rights of Persons in Mental Health Facilities
- Guardian Advocacy
- Seclusion & Restraint
- Suicide Prevention
- Why People Die by Suicide
- Trauma Series

Department of Children & Families Website

http://www.dcf.state.fl.us/mentalhealth/

Click on Baker Act. Contents include:
- Copy of Baker Act law (394, Part I, FS) and rules (65E-5, FAC)
- Baker Act forms – mandatory and recommended
- Selected forms in Spanish & Creole
- 2014 Baker Act Handbook
- Baker Act monitoring/survey instruments
- Frequently Asked Questions (FAQ’s) on 21 subject areas (see Appendix Q)
- List of all public and private receiving facilities throughout the state
- Mental Health Advance Directives
- Other relevant materials

Department of Children & Families Website

http://www.dcf.state.fl.us/mentalhealth/sa/

Click on Marchman Act. Contents include:
2003 Marchman Act User Reference Guide includes among other issues:
- Statute & Rules
- History & Overview
- Marchman Act Model Forms
- Law Enforcement and Protective Custody
- Flow Charts for Involuntary Provisions
- Admission & Treatment of Minors
- Where to Go for Help
- Marchman Act Pamphlet
- Substance Abuse Program Standards
- Common Licensing Standards
- Marchman Act PowerPoint Presentation
Afternoon Agenda

- Firearm Prohibition
- Involuntary Inpatient Placement
- Involuntary Outpatient Placement
- Rights of Persons
- Substitute Decision-makers
- Admission / Discharge Planning

Firearm Prohibition

Chapter 790, 065, FS

Florida’s weapon’s law (790, FS) has required since 2007 that certain individuals with mental illnesses or substance abuse impairment be reported by the court to FDLE for inclusion into state and national data bases to prohibit purchase of firearms or obtaining/retaining permits to carry concealed weapons. Among others adjudicated under forensic law (916), incapacitation (744), or convicted of many crimes, are individuals:

- Ordered to Involuntary Inpatient Placement (394.467(6), FS)
- Ordered to Involuntary Outpatient Placement (394.4655, FS)
- Ordered to Involuntarily Substance Abuse assessment (397.6818, FS)
- Ordered to Involuntary Substance Abuse Treatment (397.6957, FS)

Firearm Prohibition

Applicability

Effective 7/1/13, reporting to Clerks of Court must be made by Baker Act receiving & treatment facilities any individual who has been:

- Admitted for involuntary examination at a Baker Act receiving facility, and
- Certified by a physician to be of imminent danger to self or others and is competent to consent., and
- Allowed to transfer to voluntary status in lieu of court-ordered involuntary commitment

Such an individual may be prohibited from purchasing firearms or obtaining or retaining a license for a concealed weapon.
Firearm Prohibition
Applicability

The law does not apply to:

- Persons entering on voluntary status and remaining on voluntary status regardless of imminent dangerousness.
- Persons on involuntary status on the basis of self-neglect (unless imminently dangerous) instead of active danger.
- Persons on involuntary examination status who are discharged because they fail to meet any one of the involuntary placement criteria, without being converted to voluntary status.
- Persons whose potential for “dangerousness” is not considered by a physician as “imminent”.

(continued)

Firearm Prohibition
Applicability

The law doesn’t apply to (continued):

- Persons whose hearing on involuntary placement takes place and the petition is dismissed by the court.
- Persons on involuntary examination status who are first taken to hospitals not designated by DCF as receiving facilities for examination or treatment of medical conditions and are released directly by a physician or psychologist or are transferred by such hospitals to voluntary status before transfer to a designated receiving facility.

(continued)

Firearm Prohibition
Applicability

The law doesn’t apply to (continued):

- Persons subject to the involuntary provisions of the Marchman Act (397, FS) unless ordered by the court to undergo involuntary assessment and stabilization or involuntary treatment.

- The law doesn’t apply to guns currently owned by and in the possession of persons who have been reported as imminently dangerous due to mental illness – only future purchases (sale and delivery) or obtaining / retaining a concealed weapons permit.

Firearm Prohibition
Applicability

The law does apply to individuals on involuntary status found to be of imminent danger who request transfer to voluntary status in lieu of a petition for Involuntary Placement (BA 32) being filed with the court or requesting withdrawal of a petition already filed for Involuntary Placement. The individual must be competent to provide consent.

While a physician determines whether person is imminently dangerous, the Baker Act suggests “imminent danger” is:

Substantial likelihood that in the near future he or she will inflict serious bodily harm on self or others, as evidenced by recent behavior causing, attempting, or threatening such harm.
Firearm Prohibition
Receiving Facilities

Documentation Required:

- Mandatory Initial Involuntary Examination by physician/psychologist (not sent to court)
- “Finding and Certification by an Examining Physician of Person’s Imminent Dangerousness”, including certification of competence to consent.
- “Patient’s Notice and Acknowledgment form” signed by the patient.
- “Application for Voluntary Admission”
- “Notification to Court of Withdrawal of Petition” (if previously submitted)
- Cover Sheet

Firearm Prohibition
Courts

Within 24 hours after the person’s agreement to voluntary status, a record of the finding, certification, notice, and written acknowledgment must be filed by the administrator of the receiving facility with the Clerk of the Court.

No fee can be charged by the court for this filing.

Within 24 hours of receipt, the Clerk of Court will submit the petition and other related forms to a judge or magistrate for review.

Relief from Firearm Prohibition

Persons who have had their right to purchase a firearm removed may petition the court for relief of this firearm disability under s. 790.065(2)(d), F.S., as follows:

- A copy of the petition must be served on the state attorney who may object to and present evidence relevant to the relief sought.
- The hearing may be open or closed. The petitioner may present evidence and subpoena witnesses to appear. The petitioner may confront and cross-examine witnesses called by the state attorney. A record of the hearing shall be made. The court shall make written findings of fact and conclusions of law on the issues before it and issue a final order.
Relief from Firearm Prohibition

- The court shall grant the relief requested in the petition if the court finds, based on the evidence presented with respect to the petitioner’s reputation, the petitioner’s mental health record and, if applicable, criminal history record, the circumstances surrounding the firearm disability, and any other evidence in the record, that the petitioner will not be likely to act in a manner that is dangerous to public safety and that granting the relief would not be contrary to the public interest.

- If granted, FDLE will delete any mental health record of the person from the automated database of persons.

- If denied, the petitioner can't petition again until 1 year after the date of the final order, but may appeal the decision.

Involuntary Inpatient Placement Criteria

Finding of the court by clear and convincing evidence that:

- S/he has a mental illness and because of the mental illness:

- S/he refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or was unable to determine whether placement is necessary; and

  (continued)

Involuntary Inpatient Placement Criteria (continued)

- S/he is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for self, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or

- There is substantial likelihood that in the near future s/he will inflict serious bodily harm on self or others, as evidenced by recent behavior causing, attempting, or threatening such harm; and

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

All criteria must be met
Involuntary Inpatient Placement 394.467, FS
65E-5.290, FAC

- Petition may only be filed by the administrator of a receiving or treatment facility, after person’s admission and examination
- Recommend placement by psychiatrist and a psychologist or 2nd psychiatrist, both of whom examined the person within preceding 72 hours (2nd opinion may be electronic, maintaining visual & audio communication)
- Factual substantiation of each criteria alleged in the petition for involuntary inpatient placement – not just opinions, conclusions, or hearsay

Involuntary Inpatient Placement Petition
394.467(2)and (3), FS and 65E-5.290(1) and (2), FAC

- Petition (#3032) completed and filed within 72 hours of person’s arrival at facility or filed on next court working day if 72-hour period ended on weekend or legal holiday – no exception for weeknights
- No fee charged.
- Clerk of Court – provides required copies to person, DCF, guardian, or representative, state attorney and public defender

Notice of Filing Petition for Involuntary Placement
Initial/Continued – Inpatient/Outpatient
394.4599(2)(c), FS

Written notice of filing of petition for involuntary placement must contain:

- Petition filed with the circuit court in county where person is hospitalized.
- Office of public defender appointed to represent person if not otherwise represented by counsel.
- Date, time, and place of hearing, and name of each examining expert and every other person expected to testify in support of continued detention.

Initial & Continued
Involuntary Outpatient Placement
Notice of Hearings
(continued)

- Person entitled to independent expert examination and, if person cannot afford examination, court will provide for one; and
- Notice that person, guardian, representative or administrator may apply for change of venue for convenience of parties or witnesses or because of person’s condition.
**Involuntary Placement Process**

394.467(4), (5) (6)(a)2, FS and 65E-5.290(3) and (4), FAC

- Appointment and notification of Public Defender within 1 working day / role?
- State Attorney participation & role as “real party in interest”
- Access to person, witnesses and records by Public Defender
- **Person’s right** to at least 1 continuance, with concurrence of counsel, for up to 4 weeks
- Independent expert examination – provided by court (costs?). Confidential and not discoverable unless expert is called as person’s witness.

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**Involuntary Placement Hearing**

s.394.467(6), FS 65E-5-290(6), FAC

- Hearing held within 5 court working days unless continuance requested by person, with concurrence of counsel
- Held as convenient to person as consistent with orderly procedure and not likely to be injurious to person’s condition
- Judge or magistrate presides
- Video / telephonic hearings strongly discouraged by Florida Supreme Court Commission on Fairness.
- Person’s attendance at hearing -- any waiver of right to be personally present at hearing must be knowing, intelligent, and voluntary.

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**Involuntary Placement -- Hearing**

Testimony, under oath – proceedings recorded

**Burden of Proof by Clear and Convincing Evidence:**

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

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**Involuntary Placement Hearings**

Witnesses:
- 1 of the 2 examining professionals who executed placement certificate must testify
- Staff
- Family
- Case Manager
- Others?

No waiver of hearing permitted

Person may refuse to testify at the hearing

Consideration of competence to consent required – If incompetent, guardian advocate must be appointed.
Involuntary Inpatient Placement
Court Order
394. 463(6)(b), FS and 65E-5.290(7), FAC

If a court concludes person meets all criteria for involuntary inpatient placement, it shall order person, for a period of up to 6 months:

– Transferred to a treatment facility or, if the person is at a treatment facility, that the person be retained there, or
– Treated at any other appropriate receiving or treatment facility, or
– Receive services from a receiving or treatment facility

Transfer Evaluation to State Hospital
394.455(29), 394.461(2), FS and 65E-5.1301, FAC

No one may be transferred to a state hospital (voluntary or involuntary) without transfer evaluation

Criteria:
– Person meets the statutory criteria for admission to a state treatment facility; and
– Whether there are appropriate, more integrated, and less restrictive treatment resources available.

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

Admission to State Hospitals
65E-5.1302, FAC

– Transfer evaluation completed and submitted to court in advance of hearing
– Submission of State Mental Health Facility Admission Form (CF-MH 7000)
– Approval by state hospital personnel prior to transfer, after receipt of required documentation
– Physician-to-Physician Transfer form completed and submitted on day of transfer

Continued
Involuntary Inpatient Placement
394.467(7), FS and 65E-5.300, FAC

If person continues to meet criteria for involuntary inpatient placement, the administrator shall, 20 days prior to expiration of period during which treatment facility is authorized to retain person, file petition (#3035) requesting authorization for continued involuntary inpatient placement.

The request for continued involuntary placement must be accompanied by:
– A statement from person's physician or clinical psychologist justifying the request
– A brief description of person's treatment during the time he/she was involuntarily placed
– An individualized plan of continued treatment
Continued Involuntary Placement

- Waiver of person’s presence but no waiver of hearing.
- The testimony in the hearing must be under oath, and the proceedings must be recorded.
- If previously found incompetent to consent to treatment, testimony and evidence regarding the person’s competence shall be considered. If person is now competent to consent to treatment, administrative law judge may issue recommended order to court that found person incompetent to consent to treatment that person’s competence be restored and any guardian advocate previously appointed be discharged. (#3116)

Discharge or Release
Involuntary Inpatient Placement
394.469, FS and 65E-5.320, FAC

At any time a person is found to no longer meet the criteria for involuntary placement, the administrator shall:

- Discharge person, unless under a criminal charge, in which case the person shall be transferred to the custody of law enforcement; or
- Transfer person to voluntary status if willing and competent to provide express and informed consent, unless the person is under criminal charges or adjudicated incapacitated; or
- Place improved person, unless under a criminal charge, on convalescent status in the care of a community facility.
- Notice of discharge/transfer shall be given (#3038).

Continued Involuntary Placement (continued)

- If at hearing person continues to meet criteria for involuntary placement, administrative law judge will sign order (#3031) for continued involuntary inpatient placement for period not to exceed 6 months. Same procedure repeated prior to expiration of each additional period the person is retained.
- If person is found not to meet criteria for involuntary inpatient placement, release or transfer to voluntary status.
- Hearings are administrative, not judicial. Any order entered by Administrative Law Judge is final & subject to judicial review.
- Concurrent jurisdiction by circuit courts within first 6 months of involuntary placement.

Involuntary Outpatient Placement
Involuntary Outpatient Placement

A person may be ordered to Involuntary outpatient placement for period of up to 6 months upon a finding of the court that by clear and convincing evidence:

1. Person is 18 years of age or older (Proof required when age of person is in question).

2. Person has a mental illness consistent with DSM-IVR and as defined in Baker Act.

3. Person is unlikely to survive safely in the community without supervision, based on a clinical determination, based on a clinical determination (evidence of current/past behaviors substantiated);

4. Person has a history of non-compliance with treatment (evidence of previous specific incidents and timeframes of non-compliance substantiated).

5. Person has either:
   - At least twice within last 36 months been involuntarily admitted to receiving or treatment facility or received MH services in a forensic or correctional facility; or
   - Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to self or others, within the preceding 36 months.

6. Person is as a result of mental illness, unlikely to voluntarily participate in the recommended treatment plan and has either refused voluntary placement or is unable to determine whether placement is necessary (evidence of specific behaviors, events & statements by person substantiated).

7. In view of person’s treatment history and current behavior, the person is in need of involuntary outpatient placement in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to self or others, or a substantial harm to his/her well-being (evidence of treatment history, including time frames and current behavior must be substantiated).

8. It is likely the person will benefit from involuntary outpatient placement (evidence of how the person will benefit must be substantiated); and

9. All available less restrictive alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate or unavailable (evidence of each alternative examined must be substantiated).

Must meet all criteria

Petition

Petition (#3130) filed by administrator of a receiving or treatment facility must include:

- Substantiation of each criteria
- Certificate recommending placement by psychiatrist and psychologist or 2nd psychiatrist, both of whom have examined the person within the preceding 72 hours, that criteria for involuntary outpatient placement met (2nd opinion may be electronic, maintaining visual & audio communication)
- Copy of proposed treatment plan
Petition
(continued)

- Person may be retained pending hearing, unless stabilized and no longer meets involuntary exam criteria. In such case, person must be released while awaiting hearing for IOP.
- Prior to filing petition, administrator or DCF will identify service provider (#3140) that will have primary responsibility for court ordered services, unless
- Person currently participating in outpatient treatment and not in need of public financing for treatment. If so person, may be ordered to treatment with existing psychiatric provider. Proposed treatment plan attached to petition still required.

Treatment Plan

Service provider must prepare proposed treatment plan (#3145) in consult with person or guardian or GA for court’s consideration.

Treatment Plan must specify:
- Nature and extent of person’s mental illness
- Reduction of symptoms that necessitate Involuntary Outpatient Placement
- Include measurable service/treatment goals/objectives to:
  - Treat the person’s mental illness
  - Assist person to live and function in the community
  - Prevent relapse or deterioration

Petition by Receiving Facility administrator must be filed in circuit court where facility is located. Authorizes retention of person pending a hearing. If the person has been stabilized and no longer meets the criteria for involuntary examination, he/she must be released from the receiving facility pending the hearing on involuntary outpatient placement.

Petition by Treatment Facility administrator must be filed with circuit court in county where person will be living. Copy of petition, state MH discharge form, and treatment plan must be filed, with copy given to DCF in circuit where person is to reside.

Service Provider: Any public or private receiving facility, an entity under contract with DCF to provide mental health services, clinical psychologist, clinical social worker, mental health counselor, marriage & family therapist, physician, psychiatric nurse (each as defined in Baker Act), or a community MH center/clinic.

- Service Provider may select and provide supervision to other individuals to implement specific aspects of the treatment plan.
- Services must be deemed clinically appropriate by physician, psychologist, clinical social worker, LMHC, LMFT, or psychiatric nurse who is employed by, under contract with, or consults with the service provider.
### Treatment Plan

Provider must certify to court that:
- Sufficient services for improvement and stabilization are currently available in the local community,
- There is space available for the person;
- Funding is available for the program or service;
- Services are clinically appropriate; and
- Service provider agrees to provide them.

Petition may not be filed with court unless each above certification is made.

Service provider must provide copy of proposed treatment plan to the person and the Receiving Facility administrator.

### Non-Filing of Petition

**65E-5.285(1)(b), FAC**

- Notice to DCF of Non-Filing of Petition for Involuntary Outpatient Placement or Diminished Treatment Plan Due to Non-Availability of Services or Funding (#3150)

- Notice form to be filed by receiving facility or service provider upon determination that petition cannot be filed or will not reflect person’s service needs (#3150).

- Can be sent individually or bundled.

- Will serve as needs assessment for DCF planning and budgeting.

### Petition Filed by State Hospital

**394.4655(2)(b), FS 65E-5.285(1)(c), FAC**

- If person in involuntary inpatient placement meets criteria for IOP, treatment facility administrator may, before expiration of period authorized in existing court order, file petition and retain person pending hearing (#3130).

- Petition must have state MH discharge form (#7001) & proposed treatment plan attached.

- Copies must be provided to DCF representative in county where person will reside.

- Petition and attachments must be filed in county where person will reside.

### Involuntary Outpatient Placement Hearing Procedures

**394.4655(4) and (5), FS 65E-5.285(2), FAC**

- All procedures prescribed for Involuntary Inpatient Placement apply to Involuntary Outpatient Placement except as noted.

- Court must allow testimony from individuals deemed relevant regarding person’s prior history and how it relates to current condition.

- Hearing held in county where petition is filed in setting as convenient to person as consistent with orderly procedure and not likely to be harmful to person
  - Receiving Facility -- county where facility is located
  - Treatment Facility -- county where person will reside
**Hearing (Continued)**

- At any time prior to conclusion of hearing on involuntary outpatient placement, it appears to court that person instead meets criteria for involuntary inpatient placement, court can order admission for involuntary examination (#3101).
- If the person instead meets criteria for Marchman Act involuntary assessment, protective custody, or involuntary admission, court may order for admission up to 5 days (#3114).
- At any time prior to conclusion of hearing on involuntary inpatient placement, it appears to the court that the person instead meets criteria for involuntary outpatient placement, the court may order the person evaluated for involuntary outpatient placement (#3115). Release pending hearing?

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**Court Order**

394.6655(6)(b), FS 65E-5.285(3), FAC

- Upon a finding of the court by clear and convincing evidence that person meets all criteria, it shall enter an order (#3155) for a period of up to 6 months.
- Administrator of receiving facility or designated DCF representative must provide copy of court order and adequate documentation of person’s mental illness to service provider, including any advance directives, a psychiatric evaluation, and other evaluations performed.
- Copy of court order must be sent by service provider to AHCA within one working day after received from the court.

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**Continued Involuntary Outpatient Placement**

394.6655(7), FS 65E-5.285(4), FAC

- If person continues to meet criteria for involuntary outpatient placement, service provider shall, prior to end of order, file in circuit court petition for continued involuntary outpatient placement (#3180).
- Existing order remains in effect until continued placement petition disposed of.
- Petition/Certificate must include:
  - Statement from person’s physician or clinical psychologist justifying the request;
  - Brief description of person’s treatment during placement; and
  - Individualized plan of continued treatment, developed in consult with person or guardian/guardian advocate, if appointed

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**Continued Involuntary Outpatient Placement - Criteria**

Criteria for continued involuntary outpatient placement same as for initial order, except:

The 36-month time period included in criteria not applicable in determining appropriateness of additional periods of involuntary outpatient placement. These include:

- At least twice been involuntarily admitted to a receiving/treatment facility or received MH services in a forensic or correctional facility; or
- Engaged in one or more acts of serious violent behavior toward self/others, or attempts at serious bodily harm to self/others.
Continued Involuntary Outpatient Placement - Hearing

- Clerk of court must provide copies of petition/treatment plan to person, DCF, guardian/GA, State Attorney, and PD.

- Waiver of Hearing: Person and his/her attorney may agree to a period of continued outpatient placement without a court hearing (#3185).

- However, if person previously found incompetent to treatment, court is required to consider testimony and evidence regarding the person’s competence. Guardian advocate dismissed if person found competent.

Non-Compliance with Court Order

- If in clinical judgment of a physician, person has failed or refused to comply with treatment ordered by court and efforts were made to solicit compliance, and person meets criteria for involuntary examination (394.463), person may be brought to receiving facility (#3052b).

- If person doesn’t meet criteria for involuntary inpatient placement (394.467), person must be discharged from receiving facility.

- Service provider must determine if modifications should be made to existing treatment plan and try to continue to engage person in treatment.

Modification to Court Order

- After order is entered, the provider and person may modify provisions of the treatment plan.

- Any material modifications where parties agree, require provider to send notification of modification to the court.

- If material modification are contested, the court must approve or disapprove the modification (#3160).

“Material”: Important; more or less necessary, having influence or effect; going to the merits; having to do with matter rather than form (Black’s Law Dictionary)

Non-Compliance with Court Order (continued)

- The involuntary outpatient treatment order remains in effect unless service provider determines that person no longer meets criteria for involuntary outpatient placement or order expires

- Service Provider must determine whether modifications should be made to existing treatment plan and must attempt to continue to engage the person in treatment.
Discharge From Involuntary Outpatient Placement
394.4655(2)(a)2, 394.4655(6)(b)3 FS

- Service provider must discharge person when initial or continued order expires or at any time the person no longer meets the criteria for involuntary placement.
- If person has stabilized on inpatient setting and no longer meets criteria for involuntary exam, must be released pending hearing on involuntary outpatient placement.
- If person who is non-compliant with court order for involuntary outpatient placement doesn’t meet criteria for involuntary inpatient placement, must be discharged from receiving facility.

Rights of Persons
394.459, FS and 65E-5.140, FAC

- Individual dignity
- Treatment
- Participation in treatment & discharge planning
- Express and informed consent
- Quality of treatment
- Communication & abuse reporting
- Care and custody of personal affects
- Voting in public elections
- Habeas corpus
- Separation of children from adults
- Sexual misconduct prohibited
- Florida Patient’s Bill of Rights

Rights of Persons
(Continued)

Written copy of rights at admission
  - Signed by and provided to person
  - Copies provided to significant others

Discussion of rights during hospitalization

Posting of rights & phone numbers near phone:
  - Abuse Registry / Hotline
  - Disability Rights Florida, Inc. (previously known as the Advocacy Center for Persons with Disabilities)
  - Americans with Disabilities Act

Copy of Baker Act statute & rules on each unit
Right to Individual Dignity
349.459(1), FS and 65E-5.150, FAC

- Procedures, facilities, vehicles, and restraining devices used for criminals not be used with persons who have a mental illness, except for protection of the person or others

- Freedom of Movement – no restraint or seclusion except for safety of person or others (imminent danger)

- Outdoors & Exercise – at least ½ hour per day out of doors unless prohibited by physician’s order when suitable area is immediately adjacent to unit

- Special Clothing – prohibited for identification purposes

- All Constitutional Rights

Designated Representative
394.4597, FS

Voluntary: No notice except emergency

Involuntary:
- Name/address/phone # of guardian, guardian advocate & attorney in record
- If no guardian, person selects own representative
- Only if person unable/unwilling to select, facility must select from list, in order of listing:
  ✓ Health care surrogate
  ✓ Spouse
  ✓ Adult child
  ✓ Parent
  ✓ Adult next of kin
  ✓ Adult friend
  ✓ (FLAC no longer available)

Designated Representative
(continued)

The following shall not be designated:

- Licensed professional serving the person
- Employee of facility serving the person
- DCF employee
- Person in professional/business services
- Creditor of person

Role of Representatives

- Receive notice of individual’s admission
- Have immediate access to the individual unless documented to be detrimental
- Receive notice of any restriction of right to communicate or receive visitors
- Receive written notice of any restriction of the individual’s right to inspect his or her clinical record
- Petition on behalf of the individual for a writ of habeas corpus
- Receive copy of the inventory of personal effects
- Receive notice of proceedings
**Role of Representatives**

- Receive copy of petition for the individual’s involuntary placement filed with the court
- Apply for change of venue for the involuntary placement hearing for the convenience of the parties or the individual’s condition
- Be informed by the court of the individual’s right to an independent expert evaluation.
- Receive notice of individual’s release from a receiving facility
- Receive disposition of the individual’s clothing and personal effects, if not returned to the individual

**Admission Notices**

394.4599, FS

**Voluntary Admission** – No notice for adults except in emergencies

**Involuntary Admission**

- Prompt notice (within 24 hours) of arrival by phone or in person to:
  - Guardian or
  - Representative
- May waive notice of admission to designated representative only if person requests no notification
- No other required notices to representatives may be waived.

**Other Required Notices** (Continued)

394.4599, FS

Prompt notice to:
- Individual
- Representative
- Guardian Advocate
- Guardian
- Attorney

Notice to individuals in facilities must be provided:
- Orally and in writing
- Using language/terminology person can understand
- Using an interpreter if needed

To others by U.S. mail and by registered or certified mail, with receipts in chart or by hand delivery documented in chart

**Community Admission**

65E-5.130(1) and (2), FAC

- Advance directives?
- Identity of case manager
- Contact, with consent, of Case Management agency within 12 hours
- CM visit within 2 working days after notice to assist with discharge & aftercare planning
- If case manager out of circuit, telephone call may substitute
- If case managers don’t respond, call their supervisor or Managing Entity to report.
**Right to Treatment**
394.459(2), FS and 65E-5.160, FAC

- No denial or delay of treatment due to inability to pay – may collect appropriate reimbursement
- Least restrictive appropriate & available treatment required
- Physical examination within 24 hours by authorized health care practitioner
- Posted schedule of daily activities
- Individualized treatment plan within 5 days. Person must have had opportunity to assist in preparing and reviewing plan. Form must have space for person’s comments

**Treatment Plan**
394.459(2)(d), FS and 65E-5.160 (2), FAC

- Advance directives-person’s preferences for mental health care
- Diagnostic testing
- Person’s treatment goals
  - Housing
  - Social supports
  - Financial supports
  - Health, including mental health
- Observable, measurable & time-limited objectives
- Progress notes
- Periodic reviews
- Integrated approach to treatment
- Updates & physician summary every 30 days

**Express & Informed Consent**
394.459(3), FS and 65E-5.170, FAC

Competence is well reasoned, willful & knowing medical & MH decision-making

Prior to requesting consent to treatment, the following must be provided and explained in plain language:

- The reason for admission or treatment,
- Proposed treatment, including psychotherapeutic medications
- Purpose of treatment
- Alternative treatments
- Specific dosage range for medications
- Frequency and method of administration
- Common risks, benefits and short-term/long-term side effects
- Contraindications

(continued)

**Express & Informed Consent** (continued)

- Clinically significant interactive effects with other medications,
- Similar information on alternative medication which may have less severe or serious side effects.
- Potential effects of stopping treatment
- Approximate length of care
- How treatment will be monitored, and that
- Any consent for treatment may be revoked orally or in writing before or during the treatment period by the person legally authorized to make health care decisions for the person.
Express & Informed Consent (continued)

Full Disclosure must be given to:

- A competent adult, or
- The person’s guardian if adjudicated incapacitated, or
- The person’s guardian advocate if found by the court as incompetent to consent to treatment, or
- The minor and his/her guardian

Express and Informed Consent (continued)

- If competent to consent, person is competent to refuse or revoke consent!
- If incompetent to consent, person is incompetent to refuse or revoke consent!
- Treatment options:
  Provide, Refuse, Revoke, Negotiate
- Certification of competence to consent:
  ✓ Voluntary admission
  ✓ Transfer from involuntary to voluntary
  ✓ Each person allowed to consent to own treatment

Authorization for Treatment

65E-5.170(2), FAC

General Authorization for Treatment (#3042a)
- Routine medical care
- Psychiatric assessment
- Assessment/treatment other than medications

Specific Authorization for Psychotropic Medications (#3042b) --
- Disclosure by qualified personnel
  Completed prior to administration
- By authorized decision-maker
Incompetent to Consent to Treatment
65E-5.170(1)(d)2, FAC

- Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate
- Petition for Involuntary Placement
- Interim decision-maker (health care surrogate /proxy) where one exists

Guardian Advocate
394.4598, FS and 65E-5.230, FAC

Duties **begin** after appointment by court and completion of training

Duties **terminate** upon person’s discharge, transfer to voluntary status, restoration of competency, or expiration of involuntary placement order.

**Process:**
- Psychiatrist’s opinion that person is incompetent to consent to own treatment
- Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate (#3106)
- Petition for Involuntary Placement (#3032) to person, representative and prospective guardian advocate
- Right to an attorney, witnesses, & hearing

**Prior to appointment:**
- Receive information about duties/ethics of medical decision-making
- Agree to serve

**Prior to decision-making:**
- Full disclosure of treatment information
- Attend 4-hour training course approved by court (GA manual and/or DCF on-line course)
- Successfully pass test
- Meet and talk with individual and physician in person if possible; by telephone if not

**Authority:**
- Mental health decisions
- Court may authorize medical decisions

Guardian Advocate

Selection from list, in the order of priority, except for good cause documented in court record:
- Health care surrogate
- Spouse
- Adult child
- Parent
- Adult next of kin
- Adult friend
- Adult trained and willing to serve

**Prohibited From Serving:**
- Professional referred to in Baker Act
- Employee of facility providing services
- DCF employee
- Facility administrator

153
154
155
156
Guardian Advocate  
(continued)

Extraordinary decisions after separate hearing (#3108-3109) for the following:

– Electroconvulsive treatment
– Experimental treatments not approved by IRB
– Sterilization
– Abortion
– Psychosurgery

Decisions by guardian advocate may be reviewed by court, upon petition of person’s attorney, family or facility administrator

Replacement guardian advocate

Health Care Surrogate / Proxy

Advance Directive: instruction given by person expressing one’s desires about health care, and designation of a health care surrogate

Surrogate: Selected by the person, when competent, in an advance directive. Person can designate an alternative surrogate, or a separate surrogate for mental health than one for other medical care

Proxy: In the absence of an advance directive, selected in priority order from statutory list:

– Guardian
– Spouse
– Adult child
– Parent
– Adult sibling
– Adult relative
– Close friend*
– Clinical Social Worker*

Incapacity may not be inferred from the individual’s voluntary or involuntary hospitalization for mental illness or intellectual disability.

Policy: On interim basis, between time person is determined by a physician to be incapacitated to consent to treatment and time guardian advocate is appointed by court to provide express and informed consent to treatment, a health care surrogate or proxy may provide or refuse consent.

Authority: To make all health care decisions, including mental health, based on the decisions the individual would have made if competent to do so

“Substitute Judgment”
– Apply for benefits
– Access individual’s clinical record
– Authorize release of information and clinical records
– Authorize transfer to another facility.

Prohibited Procedures:

– Voluntary admission to MH facility
– Consent to treatment for individuals on voluntary status
– ECT
– Experimental treatment not approved by IRB
– Sterilization
– Abortion
– Psychosurgery
Health Care Surrogate and Proxy

Process:
– Attending physician documents incapacity of the individual
– Surrogate or proxy notified in writing that authority has commenced (#3122)
– Proxy signs Affidavit (#3123)
– Authority in effect until determination that individual has regained capacity

Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of Guardian Advocate (#3106) filed within 2 court working days of physician determination

Provide to surrogate or proxy same information required to be given to guardian advocate and make same training available

Consent Summary

- An individual who is competent to provide express and informed consent to admission or to treatment is competent to refuse or revoke consent
- Refusal / revocation of consent not evidence of incompetence
- Individuals found to be incapacitated or incompetent to consent to treatment is incapable of refusing or revoking consent to treatment authorized (by express and informed consent) by legally authorized substitute decision-maker

Health Care Surrogate/Proxy

- Ensure surrogate or proxy talks in-person with individual and physician if possible, if not, by telephone
- Surrogate or proxy given full disclosure prior to requesting his/her authorization for treatment
- Advance Directives can be revoked at any time by a competent individual
- Decisions of a health care surrogate or proxy may be reviewed by a judge at the request of the individual’s family, the facility, or physician, or other interested person

Quality of Treatment

Receiving and treatment facilities required to maintain in a form accessible to and readily understandable:
- Criteria, procedures & staff training required for use of & procedures for documenting, monitoring, and requiring clinical review of:
  - Close or elevated levels of supervision
  - Use of bodily control and physical management techniques
  - Restraint, seclusion or isolation
  - Emergency treatment orders
- Procedures for documenting and reviewing incidents resulting in injury.
- A system for investigating, tracking, managing, and responding to complaints by persons or others acting on their behalf.
Emergency Orders

Facilities must comply with the most stringent standards that apply to their facility, including ETO’s, restraints, seclusion, and other emergency interventions.

These may include:

- Joint Commission or CARF
- Federal Conditions of Participation (CMS)
- Facility policies and procedures

See Appendix I of 2014 Baker Act Handbook for extensive information on Florida’s requirements.

Emergency Treatment Orders

394.463(2)(f), 394.4625(5), FS and 65E-5.1703, FAC

- Document specific nature & extent of imminent danger to self or others (not just “agitated” or “disruptive”)
- Must attempt to contact guardian, guardian advocate or health care surrogate / proxy to obtain consent
- Medical review of person’s condition for causal medical factors
- Written order of a physician required-Initial order by phone
  - Written order signed within 24-hours
  - No PRN or standing orders
  - Each order valid not to exceed 24-hours; daily renewal by physician if dangerousness continued

Emergency Treatment Orders (continued)

Petition for guardian advocate:

- Petition must be initiated within 24 hours of ETO & submitted to court within 2 court working days thereafter

  Unless only single ETO is needed.

- If 2nd ETO written within 7 days, petition must be filed with court within 1 court working day thereafter requesting appointment of a guardian advocate.

Restraint and Seclusion

394.459(4), FS 65E-5.180(7), FAC

Restraint is a physical device, method, or drug used to control behavior.

Physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to individual’s body so he/she cannot easily remove the restraint and which restricts freedom of movement or normal access to one’s body. Physically holding a person during a procedure to forcibly administer psychotropic medication is a physical restraint.

Drug used as a restraint is medication to control person’s behavior or restrict freedom of movement & is not part of standard treatment regimen of a person with a diagnosed mental illness. (ETO not necessarily a chemical restraint)
Restraint and Seclusion

Restraint excludes physical devices or other physical holding when necessary for routine physical examinations and tests; or for purposes of medical treatment; used to provide support for body position or proper balance; or when used to protect a person from falling out of bed.

Seclusion means physical segregation of person in any fashion or involuntary isolation of person in an area person is prevented from leaving by physical barrier or by a staff member who is acting in a manner, or who is physically situated, so as to prevent person from leaving.

Prior to Seclusion or Restraint

- **Staff must be trained** as part of orientation and on annual basis. Specific required training itemized in rule.
- **Personal Safety Plan** (3124) addresses individual triggers leading to psychiatric crisis and preferred calming techniques (completed ASAP after admission and filed in the person’s record).
- **Plan reviewed** by team & updated as needed after each S/R. Specific intervention techniques from personal safety plan offered or used prior to S/R event documented in record.
- Each person must be **searched** for contraband before or immediately after being placed into seclusion or restraints.

Restraint/Seclusion Prohibitions

- Can’t be based on person’s history or on PRN or standing order
- Prone containment may be used only briefly to prevent imminent serious harm, and the person must be repositioned as quickly as possible.
- Objects impairing respiration can’t be placed over person’s face -- staff may wear protective gear when needed.
- Hands can’t be secured behind back except to prevent serious injury
- Walking restraints prohibited except for off-unit transportation under direct observation of staff
- Simultaneous S/R not used for minors
- Can’t locate restrained person in areas subject to view by anyone other than involved staff or where exposed to potential injury by other persons.
- Can’t be placed in S/R in nude or semi-nude state.

Initiating Restraint or Seclusion

- RN or highest level staff permitted by policy, immediately available & trained in S/R may initiate in emergency when danger is imminent. S/R order obtained from physician, ARNP, or PA, if permitted by the facility & stated within professional protocol. If treating physician didn’t order S/R, must be consulted ASAP.
- Examination conducted within 1 hour by physician or delegated to an ARNP, PA or RN, if authorized by facility & trained in S/R including:
  - Face-to-face assessment of person’s medical/behavioral condition
  - Review of record for pre-existing medical condition contraindicating use of S/R
  - Review of person’s medication orders including an assessment of the need to modify such orders during the period of S/R, and
  - Assessment of need or lack of need to elevate person’s head and torso during restraint.
Orders for Restraint or Seclusion

Each written order for S/R limited to:
- 4 hours for adults, age 18 and over
- 2 hours for minors age 9 - 17; or
- 1 hour for children under age 9

All orders signed within 24 hours of initiation. S/R order may be renewed up to total of 24 hours, after consultation/review by physician, ARNP, or PA in person, or by telephone with a RN who has physically observed/evaluated person.

When order has expired after 24 hours, physician, ARNP, or PA must see/assess person before S/R can be re-ordered. Results of assessment documented. Administrator notified of S/R use exceeding 24 hours.

Order shall include specific behavior prompting use of S/R, the time limits, & behavior necessary for release. Restraint orders must contain type of restraint ordered & positioning of person, considering age, physical fragility & physical disability.

During Restraint or Seclusion

Each person immediately informed of behavior resulting in S/R and criteria necessary for release.

Facility must notify guardian of minors in S/R ASAP, but no later than 24 hours and document notice in record, including date/time of notification & name of staff providing notification.

For each use of S/R, following information shall be documented in record:
- The emergency situation resulting in S/R;
- Alternatives/other less restrictive interventions attempted or clinical determination that less restrictive techniques could not be safely applied;
- Name/title of staff initiating S/R
- Date/time of initiation & release;
- Person’s response to S/R, including rationale for continued use of the intervention; and
- That the person was informed of behavior resulting in S/R & criteria necessary for release.

During Restraint and Seclusion

- When restraint initiated, nurse must assess person ASAP but no later than 15 minutes after initiation and at least every hour thereafter. Assessment includes person’s circulation/respiration, including vital signs
- Seclusion of persons over age 12 must be observed by trained staff every 15 minutes. At least one observation an hour conducted by nurse. Restrained persons must have continuous observation by trained staff. Secluded children age 12 and under must be monitored continuously by face-to-face observation or by direct observation through the seclusion window for first hour and at least every 15 minutes thereafter.
- Monitoring physical/psychological well-being of R/S person by trained staff must include: respiratory and circulatory status; signs of injury; vital signs; skin integrity & any special requirements specified in facility policies.
- During each period of S/R, person must be offered reasonable opportunities to drink & toilet as requested and restrained person must be offered opportunities for range of motion at least every 2 hours.
- Documentation of observations & staff’s name recorded at each observation.

Release from Restraint & Seclusion

- Release must occur as soon as person no longer an imminent danger to self/others, followed by debriefing to decrease risk of future S/R event & to provide support.
- Debrief individual, giving opportunity to process the S/R event ASAP – at least within 24 hours of release.
- Debrief involved staff and supervisors ASAP after the event and address:
  - Circumstances leading to the event,
  - Nature of de-escalation efforts and alternatives to seclusion and restraint attempted,
  - Staff response to the incident, ways to effectively support the person’s coping in the future and avoid the need for future S/R.
Release from Restraint & Seclusion
(continued)

- Staff debriefing review must be documented for continuous performance improvement/monitoring. Review findings forwarded to Oversight Committee.
- Within 2 working days, team meets to review circumstances preceding initiation, review the person’s treatment plan and Personal Safety Plan to determine if changes are needed to prevent the further use of R/S.
- Team will assess impact event had on person & provide counseling, services, or treatment needed as a result. Team must analyze person’s record for patterns relating to conditions, events, or presence of other persons immediately before or upon onset of behavior warranting S/R. Team must review effectiveness of emergency intervention & develop more appropriate therapeutic interventions.
- Seclusion and Restraint Oversight Committee must conduct timely reviews of each use of S/R and monitor patterns of use to assure least restrictive approaches are used to prevent/reduce frequency / duration of use.

Complaints and Grievances
394.459(4)(b)3, FS 65E-5.180 FAC

Policy/procedures required to receive, review, investigate, track, manage & respond to formal/informal complaints by person or others.

Process explained verbally at orientation and provided in writing:

- How complaints can be addressed informally and formally with staff
- Informed of Abuse Registry, Disability Rights Florida, Inc. or others to request assistance
- Process, including phone numbers for above posted next to phones.

Life-safety issues acted upon immediately

Complaints and Grievances
(continued)

Formal complaints:
- Person not named in complaint will assist.
- Will include date/time of complaint and detail issue/remedy sought
- Forward to staff assigned to track/monitor

All formal complaints must contain:
- Name of complainant
- Name of person receiving services
- Nature of complaint
- Date/time received by staff
- Date/time received by person who will track
- Name of person assigned to investigate
- Date person notified of who will investigate
- Due date for written response
- Written disposition of formal complaint.

Reporting Restraint & Seclusion

- All facilities must electronically report monthly S/R events to DCF,
- All facilities subject to federal CoP’s must report by telephone by next business day to CMS (written report to DCF) any death that occurs:
  - While a person is restrained or secluded;
  - Within 24 hours after release from R/S; or
  - Within one week after S/R, where it is reasonable to assume that use of the S/R contributed directly or indirectly to the person’s death.

177 178 179 180
Complaints and Grievances
(continued)

- Written response provided to person within 24 hours of disposition. If complainant other than patient, not given details of disposition without consent, unless having right to information.

- Disposition can be appealed to administrator who will review and make final decision within 5 working days and provide written response within 24 hours thereafter.

Communication, Abuse Reporting & Visitation
394.459(5), FS and 65E-5.190, FAC

Guaranteed regardless of age or development, but facility shall establish reasonable rules governing visitors and use of telephones

Visits: Immediate access by family, guardian, guardian advocate, representative, or attorney, unless found to be detrimental

Telephone:
- Free local calls / Access to long-distance
- Private and confidential communication
- Phone located near posters giving advocate phone numbers
- Unlimited telephone for abuse reporting, attorney, & Disability Rights Florida, Inc.

Communication, Abuse Reporting & Visitation
394.459(5), FS and 65E-5.190, FAC

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Correspondence
- Stationery/stamps/gifts
- Send / receive unopened correspondence without delay
- Reasonable examination of suspected contraband & disposal

Restriction of Communication (#3049)
- Written notice with reasons to person, attorney, guardian, guardian advocate, or representative
- Reviewed every 7 days

Waiver: Competent adults may waive the confidentiality of their presence in a receiving or treatment facility

Care & Custody of Personal Effects
394.459(6), FS and 65E-5.200, FAC

Right to possess clothing / personal effects except for medical and safety reasons

Receiving and treatment facilities must develop policies and procedures governing:
- What will be removed for reasons of personal or unit safety
- How it will be safely retained by the facility
- How/when it will be returned
- How contraband will be addressed when not returned

Inventory:
- Witnessed by person and two staff
- At time of admission & when amended
Voting in Public Elections
394.459(7), FS and 65E-5.210, FAC

- A person in a facility who is eligible to vote has the right to vote in the primary and general elections.

- Receiving and treatment facilities shall have voter registration forms and applications for absentee ballots readily available at the facility (or in accordance with the procedures established by the County supervisor of elections), and shall assure that each person who is eligible to vote and wishes to do so, may exercise his or her franchise.

- Each designated facility shall develop policies and procedures governing how persons will be assisted in exercising their right to vote.

Separation of Children from Adults
394.4785, FS and 65E-12, FAC

Hospitals:
- Age 0-13 no contact with adults
- Age 13-17 share common areas with adults but share bedroom with adult only if doctor documents medical or safety issues daily
- Children and adolescents can be mixed

CSUs:
- Age 0-13 can share common areas with adult when under direct visual observation by staff but cannot share bedroom with an adult
- Age 14-17 share common areas with adults but share bedroom with adult only if doctor daily documents medical or safety issues

Sexual Misconduct Prohibited
Reporting & Penalties
394.4593, FS

- Sexual Misconduct means any sexual activity between an employee and a patient, regardless of the consent of the patient.

- An employee engaging in sexual misconduct with patient in DCF custody or in a receiving/treatment facility commits a felony.

- An employee who witnesses, knows of, or has reasonable cause to suspect sexual misconduct must immediately report to the Abuse Registry and to law enforcement. Failure to do so is a misdemeanor.

- Employee must prepare, date, sign independent report describing nature of the sexual misconduct, location/time of incident, and persons involved. Report must be given to program director for submitting to DCF Inspector General who will immediately investigate.

Habeas Corpus
394.459(8), FA and 65E-5.220, FAC

Each person admitted to a receiving or treatment facility must have written notice of right to petition (#3036) for writ:
- Cause and legality of detention
- Unjustly denied a right or privilege
- Abuse of procedure authorized in law

Petition (#3090) filed any time / without notice by:
- Person Guardian Advocate
- Relative
- Friend
- Attorney
- Guardian
- DCF

Facility files petition (any form) with clerk of court on next working day. No fee charged.
Florida Patient’s Bill of Rights
381.026, FS
The Medical Practice Act states that failure to provide patients with information about their rights and how to file a complaint are grounds for disciplinary action against physicians. [458.331(1)(mm), FS]

Patients have the right to:
– Be treated with courtesy and respect, with appreciation of his/her individual dignity, & with protection of his or her need for privacy.
– Know who is providing medical services & who is responsible for his/her care.
– Be given information concerning diagnosis, planned course of treatment, alternatives, risks, & prognosis.
– A prompt & reasonable response to questions & requests.
– Refuse any treatment, except as otherwise provided by law.

Violation of Rights
394.459(9) and (10), FS
 Any person who violates or abuses any rights or privileges of persons provided by the Baker Act is liable for damages as determined by law.

 DCF required to report to AHCA any violation of the rights or privileges of persons, or of any procedures, by any facility or professional licensed or regulated by the agency.

 AHCA authorized to rely on DCF investigation/findings in lieu of conducting own investigation -- AHCA authorized to impose any sanction authorized for violations based solely on the investigation and findings of DCF.

Baker Act Oversight
 Department of Children & Families (DCF)
 Managing Entity for mental health and substance abuse services
 Agency for Health Care Administration (AHCA)
 Disability Rights Florida, Inc.
 Public Defender & State Attorney
 Circuit Court Judge
Discharge Planning  
394.459(11), FS and 65E-5.1303, FAC

- Notification of right upon discharge to seek treatment from the professional or agency of person’s choice.

- Discharge planning, beginning at admission, including:
  - Transportation resources
  - Access to stable living arrangements;
  - How assistance in securing needed living arrangements or shelter will be provided to individuals at risk of re-admission within the next 3 weeks due to homelessness or transient status and prior to discharge shall request a commitment from a shelter provider that assistance will be rendered;
  - Information about preparation and use of advance directives;

Discharge Planning  
(Continued)

- Education and written information about person’s mental illness and medications
- Information about & referral to community resources, including peer support
- Referral to substance abuse treatment programs, trauma services, or other self help programs if indicated
- Assistance in obtaining timely aftercare appointment requested within 7 days of discharge
- Access to psychotropic medications or prescriptions or combination of meds & prescriptions until first scheduled aftercare appointment or 21 calendar days whichever comes first.

Discharge from State Hospitals  
65E-5.1305, FAC

- Completion of State Mental Health Facility Discharge form (CF-MH 7001)
- 7 days prior notice to community case management agency
- On day of discharge, physician or charge nurse immediately notifies aftercare provider using the Physician-to-Physician Transfer form (#7002)
### Discharge / Transfer Policies & Procedures

**394.459(11), FS and 65E-5.1304, FAC**

- **Public receiving facilities** affiliated with community mental health centers must ensure the centralized provision and coordination of acute care services for eligible persons with acute mental illnesses.

- “**Discharge**” of persons from receiving or treatment facilities automatically discharges a guardian advocate. **“Transfer”**, rather than discharge, to a hospital for medical treatment retains competent authorized substitute decision-maker.

### Discharge Policies & Procedures

- Policy statements which reflect cooperation with local publicly-funded MH/SA providers and which will both facilitate access by publicly funded case managers & enhance continuity of services & access to necessary psychotropic medications.

- Protocols for assuring that current medical and legal information, including day of discharge medication administered, is transferred before or with the person to another facility.

- Agreements or protocols for transfer and transportation arrangements between facilities.

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### Baker Act Reporting Center

**http://bakeract.fmhi.usf.edu/**

Louis de la Parte Florida Mental Health Institute  
University of South Florida  
13301 Bruce B. Downs Blvd.  
MHC 2637  
Tampa, FL 33612

**Annette Christy, Ph.D.**  
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