

Voluntary Admissions – Adults

(See also Express & Informed Consent and separate FAQ's related to Minors)

Requirements for Voluntary Admission

Q. Is there such thing as Voluntary Baker Act status?

Yes, a person can be on voluntary or involuntary status under the Baker Act. However, to be on voluntary status, a person must not only be willing to consent, but competent to consent to admission and to treatment. If a person is “incompetent to consent to treatment”, he/she can't be held under the voluntary provisions of the law:

394.455(15)“Incompetent to consent to treatment” means that a person's judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.

A person on voluntary status is presumed to be able to exercise all of his/her rights under the law, including that of consenting or refusing consent to admission and/or treatment. If competent, they could go to any facility they chose, whenever they wished to go, and by whatever means. In such situations where a physician has certified the person's competence to consent (also competent to refuse consent), the individual can then choose whether or not to accept a transfer. If the circumstance isn't considered an emergency, EMTALA wouldn't apply and a destination hospital wouldn't have to accept a transfer even if it had the capacity and capability of managing the person's care.

An involuntary examination is for those persons who refuse or even if not refusing, are not able to make well-reasoned, willful, and knowing decisions. They are the individuals you believe have an emergency psychiatric condition but aren't necessarily able to follow-through on care on their own.

Q. What are the requirements for the screening of a voluntary adult who presents to a 395 licensed psych hospital? Are there any specific guidelines/requirements related to how voluntary patients who present and are determined not to meet admission criteria should be handled?

This answer is specific to Baker Act requirements not to any JCAHO or CMS requirements or to your own facility policies and procedures. Screening requirements in the Baker Act law and rules primarily address individuals on involuntary status.

However, the following are specifically required for all persons, regardless of legal status:

- Notification of individual's case manager within 12 hours of arrival, with the individual's consent
- Physical examination within 24 hours of arrival by a health practitioner authorized by law to give such examinations
- Within 24 hours after admission of a voluntary patient, the admitting physician must document in the clinical record that the individual is able to give express and informed consent for admission and treatment

The Baker Act rules also have the following requirements for all persons served:

65E-5.180 Right to Quality Treatment.

(5) Mental health services provided shall comply with the following standards:

- (a) In designated receiving facilities, the on-site provision of emergency psychiatric reception and treatment services shall be available 24-hours-a-day, seven-days-a-week, without regard to the person's financial situation.
- (b) Assessment standards shall include provision for determining the presence of a co-occurring mental illness and substance abuse, and clinically significant physical and sexual abuse or trauma.
- (c) A clinical safety assessment shall be accomplished at admission to determine the person's need for, and the facility's capability to provide, an environment and treatment setting that meets the person's need for a secure facility or close levels of staff observation.
- (d) The development and implementation of protocols or procedures for conducting and documenting the following shall be accomplished by each facility:
 - 1. Determination of a person's competency to consent to treatment within 24 hours after admission;
 - 2. Identification of a duly authorized decision-maker for the person upon any person being determined not to be competent to consent to treatment;
 - 3. Obtaining express and informed consent for treatment and medications before administration, except in an emergency...

There are other requirements for treatment and subsequent discharge of persons on voluntary status. If using public funding, the following provisions of the Florida Administrative Code apply to public receiving facilities:

65E-5.400 Baker Act Funded Services Standards.

(1) Applicability. Designation as a public receiving facility is required for any facility licensed under the authority of Chapter 395 or 394, F.S., to be eligible for payment from Baker Act appropriations. Designation does not in and of itself represent any agreement to pay for any services rendered pursuant to Chapter 394, Part I, F.S., or this chapter. Public receiving facilities, under contract with the department, serve as a local focal point for district or region public information dissemination and educational activities with other local Baker Act involved entities and public agencies.

(2) Baker Act Funding.

(a) Only public receiving facilities, pursuant to Section 394.455(25), F.S., and only the costs of eligible Baker Act services provided to diagnostically and financially eligible persons may be paid with Baker Act appropriations.

(b) Baker Act services shall first be provided to acutely ill persons who are most in need of mental health services and are least able to pay.

(c) Persons receiving Baker Act funded services must meet financial eligibility criteria as established by the federal poverty guidelines. Public receiving facilities may provide Baker Act funded services to acutely ill persons who are financially ineligible if the total number of days of service paid for with Baker Act funds for financially ineligible persons does not exceed 20 percent of the total number of days paid for with Baker Act funds.

(d) An individual's diagnostic and financial eligibility shall be documented on mandatory form CF-MH 3084, Feb. 05, "Baker Act Service Eligibility,"

which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter.

(3) This section applies to all Baker Act funded providers. All services including hospital inpatient facilities, crisis stabilization units, short-term residential treatment programs, and children's crisis stabilization units providing services purchased by the department under this chapter shall be consistent with licensure requirements and must comply with written facility policies and procedures.

(4) Training. The training required in Rule 65E-5.330, F.A.C., is required for all direct service staff employed by publicly funded Baker Act service providers.

(5) Emergency Reception and Screening.

Q. As a community Case Manager for the VA, would I fill the Application for Voluntary Admission in the field or would that be completed by the staff at the hospital where the client is being taken? Regarding documentation in my clinical record, are there any key words I should or should not use?

Since the application for voluntary admission is a "recommended" form, the receiving facility may use a different form than the one in the Baker Act series. In any case, it is better to wait until the individual arrives at the facility as the staff may need to assess the person's situation and even to have witnesses to the signatures. If the individual is on voluntary status, you would want to be sure he/she is documented as not only willing to go to a receiving facility, but is able to make well-reasoned, willing and knowing decisions about his own care. If the individual is on involuntary status, you would want the documentation to include the diagnosis of a mental illness as defined in the Baker Act as well as your observations of any active or passive danger.

Q. If a patient is on a voluntary status in the Baker Act unit, prior to psychiatrically discharging the patient, the patient develops a medical complication and is discharged from the psychiatric unit and admitted to a medical floor. Since we are a receiving facility, do the same rules apply on the medical floor as on the psychiatric unit? Can a patient be on a voluntary status (form 40) on a medical floor in a Baker Act receiving facility? If yes and if the patient wants to leave, does the same rule apply that the psychiatrist has 24 hours to evaluate and make a decision? Once medically clear, does the patient have to sign a new voluntary form since it is a new admission?

Your entire facility is considered the receiving facility. A "transfer" from one unit to another is not considered a "discharge" under the Baker Act. While it is recognized that some type of a back office type of financial or administrative discharge is going to occur for the purpose of billing, you have no authority to "discharge" a person who still meets involuntary criteria.

However, if the person who had been documented as both willing and able to be voluntary subsequently changes his/her mind, a discharge must be done within 24 hours unless the psychiatrist initiates a petition for involuntary placement (BA32) that must be filed with the Clerk of Court within 2 working days of the patient's request for discharge. A patient should generally not be made involuntary under such circumstances for simply

exercising his/her right to request discharge. There should be a documented change in condition that would warrant this change in legal status.

No new voluntary form has to be completed if the patient's willingness and competence to be at your hospital voluntarily has been continuous while at the medical unit. One presumes that his/her psychiatric care needs were met while at the medical unit with a psychiatric overlay.

Q. What kind of notice is required when a person is released or transferred from involuntary to voluntary status?

The law states that persons transferred from involuntary to voluntary status must have notice given the same as a person released from involuntary status, as follows:

394.4625 Voluntary admissions.--

(4) TRANSFER TO VOLUNTARY STATUS.--An involuntary patient who applies to be transferred to voluntary status shall be transferred to voluntary status immediately, unless the patient has been charged with a crime, or has been involuntarily placed for treatment by a court pursuant to s. 394.467 and continues to meet the criteria for involuntary placement. **When transfer to voluntary status occurs, notice shall be given as provided in s. 394.4599.**

394.463 Involuntary examination.--

(3) NOTICE OF RELEASE.--Notice of the release shall be given to the patient's guardian or representative, to any person who executed a certificate admitting the patient to the receiving facility, and to any court which ordered the patient's evaluation.

394.4599 Notice.--

(1) VOLUNTARY PATIENTS.--Notice of a voluntary patient's **admission** shall only be given at the request of the patient, except that in an emergency, notice shall be given as determined by the facility.

(2) INVOLUNTARY PATIENTS.--

(a) Whenever notice is required to be given under this part, such **notice shall be given to the patient and the patient's guardian, guardian advocate, attorney, and representative.**

Q. Is it illegal for a CSU to refuse to accept a person on voluntary status prior to screening? Perhaps the CSU is full so the family member that transported the person is told to go to the next nearest receiving facility or the person has insurance that is accepted at another hospital?

There is no requirement in the Baker Act for a CSU to accept voluntary admissions. There is a possibility of liability to the agency if the person does something dangerous to self or others subsequent to the refusal. Staff would generally want to at least interview the person and anyone with them to determine if they may be eligible for involuntary examination under the Baker Act, but this is not required. A person meeting voluntary criteria is presumed to be able to go anywhere by any means to seek the care they need.

However, a hospital would be required to perform the screening required by the federal EMTALA law, unless the person has refused the screening. This could be done only after qualified staff confirmed that the person was capable of making an informed consent about the refusal.

Competence to Provide Express & Informed Consent

Q. Just want to make sure I am interpreting correctly: Person for whom an involuntary examination has been initiated and has been examined by physician to confirm their ability to provide express and informed consent, is still considered involuntary. What is needed to transfer the person from involuntary to voluntary would require the completion of the Certificate of Ability to Provide Express and Informed? Consent for Voluntary Admission. A signed Consent to treatment would not transfer the patient from involuntary status to voluntary.

You're correct that a signed consent to treatment is not sufficient to convert a person from involuntary to voluntary status. It would require several things to happen, including:

1. Completion and documentation of the Initial Mandatory Involuntary Examination by a physician or a psychologist.
2. Certification of competence to consent by a physician (recommended 3004 form_
3. Application for Voluntary Admission

Only then can an adult be allowed to convert from involuntary to voluntary status. A minor wouldn't require the Certification of Competence. The major sections of law and rule governing these issues are as follows:

394.4625 Voluntary admissions.

(4)TRANSFER TO VOLUNTARY STATUS.—An involuntary patient who applies to be transferred to voluntary status shall be transferred to voluntary status immediately, unless the patient has been charged with a crime, or has been involuntarily placed for treatment by a court pursuant to s. 394.467 and continues to meet the criteria for involuntary placement. When transfer to voluntary status occurs, notice shall be given as provided in s. 394.4599.

65E-5.270 Voluntary Admission.

(1) Recommended form CF-MH 3040, “**Application for Voluntary Admission,**” as referenced in paragraph 65E-5.1302(1)(b), F.A.C., may be used to document an application of a competent adult for admission to a receiving facility. Recommended form CF-MH 3097, Feb. 05, “Application for Voluntary Admission – Minors,” which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, may be used to document a guardian’s application for admission of a minor to a receiving facility. Recommended form CF-MH 3098, Feb. 05, “Application for Voluntary Admission – State Treatment Facility,” which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, may be used to document an application of a competent adult for admission to a state treatment facility. Any application for voluntary admission shall be based on the person’s express and informed consent.

(b) Recommended form CF-MH 3104, “**Certification of Person’s Competence to Provide Express and Informed Consent,**” as referenced in paragraph 65E-5.170(1)(c), F.A.C., may be used to document a person applying for transfer from involuntary to voluntary status is competent to provide express and informed consent. The original of the completed form shall be filed in the person’s clinical record. A change in legal status must be followed by notice sent to individuals pursuant to Section 394.4599, F.S.

65E-5.2801 Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.

The involuntary examination is also known as the initial mandatory involuntary examination.

(1) Whenever an involuntary examination is initiated by a circuit court, a law enforcement officer, or a mental health professional as provided in Section 394.463(2), F.S., **an examination by a physician or clinical psychologist must be conducted and documented** in the person’s clinical record. The examination, conducted at a facility licensed under Chapter 394 or 395, F.S., must contain:

(a) A thorough review of any observations of the person’s recent behavior;
(b) A review of mandatory form CF-MH 3100, “Transportation to Receiving Facility,” as referenced in subsection 65E-5.260(2), F.A.C., and recommended form CF-MH 3001, “Ex Parte Order for Involuntary Examination,” as referenced in subsection 65E-5.260(1), F.A.C., or other form provided by the court, or mandatory form CF-MH 3052a, “Report of Law Enforcement Officer Initiating Involuntary Examination,” as referenced in subsection 65E-5.260(1), F.A.C., or mandatory form CF-MH 3052b, “Certificate of Professional Initiating Involuntary Examination,” as referenced in subsection 65E-5.260(1), F.A.C.

(c) A brief psychiatric history; and

(d) A face-to-face examination of the person in a timely manner to determine if the person meets criteria for release.

(2) If the physician or clinical psychologist conducting the initial mandatory involuntary examination determines that the person does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement, the person can be offered voluntary placement, if the person meets criteria for voluntary admission, or released directly from the hospital providing emergency medical services. Such determination must be documented in the person’s clinical record.

(3) If not released, recommended form CF-MH 3040, “Application for Voluntary Admission,” as referenced in paragraph 65E-5.1302(1)(b), F.A.C., or recommended form CF-MH 3097, “Application for Voluntary Admission – Minors,” as referenced in subsection 65E-5.270(1), F.A.C., may be used if the person wishes to apply for voluntary admission.

(4) If not released and the person wishes to transfer from involuntary to voluntary status, recommended form CF-MH 3104, “Certification of Person’s Competence to Provide Express and Informed Consent,” as referenced in paragraph 65E-5.170(1)(c), F.A.C., documenting the person is competent to provide express and informed consent, may be used for this purpose.

(5) All results and documentation of all elements of the initial mandatory involuntary examination shall be retained in the person’s clinical record.

The law and rule are also clear that if a person on voluntary status refuses or revokes consent for treatment or requests release, he/she must be released from the facility

within 24 hours unless converted to involuntary status and a petition filed with the court within 2 court working days. Of course, a person with a court appointed guardian or one with a health care surrogate/proxy making health /mental health decisions for the person can only be held on involuntary status.

Q. If a patient presents to be admitted to the hospital and the person having them sign the BA 40 feels the patient is not aware of what they are signing, is it still permissible to have them sign knowing that the psychiatrist is going to evaluate their competency within 24 hours? The second part of this question is if a patient presents to be admitted to the hospital and it is known for a fact that the patient has been declared incompetent can you have them sign a BA-40?

Regarding your specific questions:

- a) If the staff member assessing the person at intake believes the person is unable to make well-reasoned, willful and knowing decisions about his/her medical and mental health issues, no voluntary should take place. Your documentation would probably reflect the person's status as involuntary – not because the person was refusing admission, but because he/she was unable to determine the examination was necessary. If you have someone available who is eligible to formally initiate involuntary status, that would be best – starting the 72-hour clock. If not, try to have this done within 12 hours if possible (the time you have to notify a psychiatrist or psychologist after a person on “voluntary” status requests discharge or refuses treatment) and certainly no longer than 24 hours after the person's arrival. In any case, you wouldn't want to have the person treated without the express and informed consent of an authorized decision-maker, unless imminent danger was documented. Once the physician had either documented the patient's capacity to make his/her own decisions or documented the incapacity and notified a proxy and full disclosure had been provided, consent to treatment can be sought.
- b) It would not be permissible to have an individual who has been adjudicated as incapacitated with a guardian appointed admitted as on voluntary status. The voluntary provisions of the Baker Act requires that an adult be competent to provide express and informed consent. It further expressly prohibits the admission of an incapacitated person on voluntary status. Finally, it states that if such a person is incorrectly admitted, he/she must be discharged or converted to involuntary status.

394.4625 Voluntary admissions.

(1) AUTHORITY TO RECEIVE PATIENTS.—

(a) A facility may receive for observation, diagnosis, or treatment any person 18 years of age or older making application by express and informed consent for admission or any person age 17 or under for whom such application is made by his or her guardian. If found to show evidence of mental illness, to be **competent to provide express and informed consent**, and to be suitable for treatment, such person 18 years of age or older may be admitted to the facility. A person age 17 or under may be admitted only after a hearing to verify the voluntariness of the consent.

(d)A facility may not admit as a voluntary patient a person who has been adjudicated incapacitated, unless the condition of incapacity has been judicially removed. If a facility admits as a voluntary patient a person who is later determined to have been adjudicated incapacitated, and the condition of incapacity had not been removed by the time of the admission, the facility must either discharge the patient or transfer the patient to involuntary status.

(e)The health care surrogate or proxy of a voluntary patient may not consent to the provision of mental health treatment for the patient. A voluntary patient who is unwilling or unable to provide express and informed consent to mental health treatment must either be discharged or transferred to involuntary status.

(f)Within 24 hours after admission of a voluntary patient, the admitting physician shall document in the patient's clinical record that the patient is able to give express and informed consent for admission. If the patient is not able to give express and informed consent for admission, the facility shall either discharge the patient or transfer the patient to involuntary status pursuant to subsection (5).

Q. If a person doesn't express any reluctance to be admitted, can they be admitted on voluntary status?

NOT NECESSARILY. If the person is an adult requesting admission and is believed by the admission staff to be capable of providing well-reasoned, willful and knowing decisions about their health care, they may be admitted on voluntary status. Within 24 hours, a physician must confirm this capacity and certify it in the clinical record. However, regardless of the person's willingness to be admitted, they must be handled on an involuntary basis if they appear to be unable to make well-reasoned decisions.

Q. How does a facility document in the clinical record that a person is both willing and able to provide express and informed consent to admission and to treatment?

Completion and proper use of the recommended Voluntary Admission form (3040) and the Certification form (3104) is the best way to ensure compliance with the law. These forms track the law/rules and will provide required documentation, where notes in the chart may be inadequate or overlooked. However, the certification by the physician should parallel the notes in the chart by physicians and staff.

Q. Are persons who have an above legal blood alcohol level allowed to sign a request for voluntary admission into a receiving facility?

Yes, as long as staff believes (and documents) that the person is both willing to be there and is able to understand the nature of the admission and all required treatment disclosures, and can fully exercise all rights. At any point where the person refuses the admission or treatment or doesn't appear to making well-reasoned, willful, and knowing decisions about treatment, the status would have to change to involuntary.

Q. What happens if a facility finds out that a person is being “forced” by family or others to be in a facility on a voluntary basis?

The person must be released or a petition for involuntary placement filed by the facility administrator. The Baker Act states that the person’s admission on voluntary status and his/her consent to treatment must not be a result of force, fraud, deceit, duress, or other form of constraint or coercion.

Q. Can the required Certification of a Person’s Competence to Provide Express and Informed Consent be performed by a psychologist, an ARNP, or physician’s assistant?

NO. The Baker Act requires that this be performed by a physician. It cannot be delegated to other professionals.

Q. A psychiatrist at our hospital ordered that a patient on involuntary status be transferred to voluntary status. However, the patient is clearly incompetent to consent to treatment. What should we do?

Just because a person requests voluntary status doesn’t mean the facility or physician must grant it. First, the person must be determined to be competent to provide express and informed consent – that means he/she must be documented by a physician to be able to make well reasoned, willful and knowing decisions about medical and mental health care. In this case, the woman should have gone to her involuntary inpatient placement hearing and had the assistant state attorney elicit the evidence that she met the involuntary criteria, was incompetent to consent (or refuse consent) to admission & treatment, and had a guardian advocate appointed.

65E-5.170 Right to Express and Informed Consent.

(1) Establishment of Consent.

(e) Competence to provide express and informed consent shall be established and documented in the person’s clinical record prior to the approval of a person’s transfer from involuntary to voluntary status or prior

to permitting a person to consent to his or her own treatment if that person had been previously determined to be incompetent to consent to treatment.

Recommended form CF-MH 3104, “Certification of Person’s Competence to Provide Express and Informed Consent,” as referenced in paragraph 65E-5.170(1)(c), F.A.C., properly completed by a physician may be used for this purpose.

Q. One of our doctors wanted to have a “jail hold” individual sign in voluntarily. He felt the patient was competent and the legal problem is a “civil matter”.

The current Baker Act statute prohibits the transfer of a person from involuntary to voluntary status if the person has pending criminal charges of any kind. The law is silent as to such a person with charges initially coming to the facility on voluntary status. While your physician’s opinion on this issue may be a wise one, he is compelled to comply with the law. DCF has recommended a proposed bill for consideration by the Legislature that

will among other things, amend the statute to permit the transfer of persons with criminal charges from involuntary to voluntary status if the person wishes to be at the facility and a physician has documented that the person is consistently able to make well-reasoned, willful, and knowing decisions about his or her medical and mental health care. Upon release or discharge, any person with criminal charges on voluntary or involuntary status could only be released to law enforcement. However, this proposed change to the Baker Act hasn't passed the Legislature yet and until it does, the current law prevails even if one doesn't agree.

Q. Please clarify the term “suitable for treatment” in the context of voluntary admission to a receiving facility. I have been under the impression that voluntary admission criteria are the same as involuntary criteria except that the person requesting admission is willing and able to provide express and informed consent. When I reviewed the 2008 Baker Act Handbook I could find no definition of “suitable for treatment“. As an emergency services screener at a receiving facility what guidelines should I use in determining if a person requesting voluntary treatment is suitable for inpatient treatment at a receiving facility?

A receiving facility must “accept” any person brought on involuntary status and the initial mandatory involuntary examination must be performed by a physician or clinical psychologist. However, this same requirement does not apply to persons on voluntary status. If your facility isn't a hospital and doesn't have the capacity (space) or capability (programming) to meet the needs of the person on voluntary status, you don't need to accept the person. You're correct that “suitable for treatment” isn't defined in the law or rules, however your facility may wish to develop policies and procedures to guide assessment staff in determining which persons need and can benefit from inpatient examination and which can be better served in some type of outpatient setting.

Right to Request Release

Q. How long can a facility hold a person on voluntary status who has requested discharged?

The facility has to discharge any person within 24 hours after the person requests discharge unless the person freely revokes the request and is able to give well-reasoned decision-making about the stay in the hospital and psychiatric treatment. If the person is at a state hospital, the period can be extended to three working days.

Q. We are a voluntary treatment center for substance abuse and mental health, licensed by AHCA and DCF. My medical staff would like to use the form “notice of Voluntary clients' right to request discharge” at the facility vs. using a Baker Act or Marchman Act. Please note we are not a receiving facility. How long can we hold the patient and what authorities do we need to notify?

While you aren't designated as a receiving facility, as a licensed hospital you are still required to comply with all aspects of the Baker Act as they apply to persons on voluntary status. Voluntary status requires an adult to not only be willing to be at the facility and to consent to needed treatment, but have a sustained competence to provide

well-reasoned, willful and knowing decision-making about his/her medical and mental health care. For example, Florida's hospital licensing law includes the following provisions:

395.003(5)(a) governing licensure of all hospitals states "Adherence to patient rights, standards of care, and examination and placement procedures provided under part I of chapter 394 shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment".

(5)(b)"Any hospital that provides psychiatric treatment to persons under 18 years of age who have emotional disturbances shall comply with the procedures pertaining to the rights of patients prescribed in part I of chapter 394".

395.1041(6) Rights Of Persons Being Treated.--A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

395.1055(5) governing rules and enforcement states "The agency shall enforce the provisions of part I of chapter 394, and rules adopted thereunder, with respect to the rights, standards of care, and examination and placement procedures applicable to patients voluntarily or involuntarily admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment".

395.3025 Patient and personnel records; copies; examination.--

(1) Any licensed facility shall, upon written request, and only after discharge of the patient...

(2) This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by the provisions of s. 394.4615.

(3) This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.

Among the other Baker Act forms, it would be very appropriate for your staff to use the BA 3051a form as well. You may want to delete the phrase "from a receiving facility" from the title of the form – the remainder of the form appears fine for your circumstances. You may want to examine the remainder of the Baker Act forms and adopt/adapt them for use in your facility to ensure rights of persons on voluntary status are fully protected.

Your question of using the form vs. using a Baker Act or Marchman Act was a bit confusing. The form simply informs persons on voluntary status of their right to request release, to apply for release, and to withdraw that application. This doesn't substitute for initiating an involuntary examination or admission under the Baker Act or Marchman Act.

Should one of your patients be unwilling to stay at your facility, unwilling to consent to treatment, or be unable to make well-reasoned, willful and knowing treatment decisions and otherwise meet the criteria for involuntary examination/admission under the Baker Act or Marchman Act, you would need to initiate involuntary provisions of the law. Different forms would be used for this purpose.

A designated receiving facility would have up to 24 hours to discharge or transfer a person from voluntary to involuntary status after a refusal of treatment, request for discharge, or a determination the persons lacked competence to provide express and informed consent. Since you aren't designated as a receiving facility, for those persons not released or discharged, you would immediately initiate an involuntary examination under the Baker Act so the person could be moved to a facility authorized to hold a person on involuntary status. Generally law enforcement would then be called to transport the person to a receiving facility, but since you are a licensed hospital, you'd need to be sure that EMTALA requirements for arranging transfer wouldn't apply.

Q. Is a MD allowed to place a 23-24 hour hold on patients in a voluntary behavioral health facility? That is, say a patient wants to leave and the MD would like to assess them before they give approval.

The question you raise is addressed in the Baker Act as follows:

394.4625 Voluntary admissions.--

(2) DISCHARGE OF VOLUNTARY PATIENTS.--

(a) A facility shall discharge a voluntary patient:

2. Who revokes consent to admission or requests discharge. A voluntary patient or a relative, friend, or attorney of the patient may request discharge either orally or in writing at any time following admission to the facility. The patient must be discharged within 24 hours of the request,

unless the request is rescinded or the patient is transferred to involuntary status pursuant to this section. The 24-hour time period may be extended by a treatment facility when necessary for adequate discharge planning, but shall not exceed 3 days exclusive of weekends and holidays. If the patient, or another on the patient's behalf, makes an oral request for discharge to a staff member, **such request shall be immediately entered in the patient's clinical record.** If the request for discharge is made by a person other than the patient, the discharge may be conditioned upon the express and informed consent of the patient.

(b) A voluntary patient who has been admitted to a facility and who refuses to consent to or revokes consent to treatment shall be discharged within 24 hours after such refusal or revocation, unless transferred to involuntary status pursuant to this section or unless the refusal or revocation is freely and voluntarily rescinded by the patient.

(3) NOTICE OF RIGHT TO DISCHARGE.--At the time of admission and at least every 6 months thereafter, a voluntary patient shall be notified in writing of his or her right to apply for a discharge.

(5) TRANSFER TO INVOLUNTARY STATUS.--When a voluntary patient, or an authorized person on the patient's behalf, makes a request for discharge, the request for discharge, unless freely and voluntarily rescinded, must be communicated to a physician, clinical psychologist, or psychiatrist as quickly as possible, but not later than 12 hours after the

request is made. If the patient meets the criteria for involuntary placement, the administrator of the facility must file with the court a petition for involuntary placement, within 2 court working days after the request for discharge is made. If the petition is not filed within 2 court working days, the patient shall be discharged. Pending the filing of the petition, the patient may be held and emergency treatment rendered in the least restrictive manner, upon the written order of a physician, if it is determined that such treatment is necessary for the safety of the patient or others.

Your facility isn't a "treatment facility" as only state mental health facilities are so designated. Therefore, you have to have a physician, psychologist or psychiatrist notified within 12 hours after the request for discharge by a person on voluntary status and release the patient within 24 hours after discharge unless a petition is to be filed with the court within two working days. Should the patient revoke the request for discharge before the 24 hour period expires, you would just document this in the chart.

Most facilities find the Baker Act form #3051a titled "Notice of Right of Person on Voluntary status to Request Discharge" to be helpful. This form notifies the person of their right to request discharge, to apply for discharge, and to withdraw the application for discharge all on the same document.

Guardians and Other Substitute Decision-Makers

Q. We only take "voluntary competent patients". Does the law permit us to have family members sign in their spouse for a voluntary if they have power of attorney over them? Right now, we are declining this but I need this clarified.

You are correct that only individuals who are not only willing but documented as able to make well-reasoned, willful and knowing decisions about their medical and mental health care are authorized to be admitted or retained on a voluntary status. The Baker Act law prohibits any person with a guardian from being on voluntary status and prohibits any person serving as a health care surrogate or proxy from providing consent to treatment for a person on voluntary status.

394.4625 Voluntary admissions.

(1) AUTHORITY TO RECEIVE PATIENTS.—

(a) A facility may receive for observation, diagnosis, or treatment any person **18 years of age or older making application by express and informed consent for admission** or any person age 17 or under for whom such application is made by his or her guardian. If found to show evidence of mental illness, to be competent to provide express and informed consent, and to be suitable for treatment, such person 18 years of age or older may be admitted to the facility. A person age 17 or under may be admitted only after a hearing to verify the voluntariness of the consent.

(d) A facility may not admit as a voluntary patient a person who has been adjudicated incapacitated, unless the condition of incapacity has been judicially removed. If a facility admits as a voluntary patient a person who is later determined to have been adjudicated incapacitated, and the condition of incapacity had not been removed by the time of the admission, the facility must either discharge the patient or transfer the patient to involuntary status.

(e) The health care surrogate or proxy of a voluntary patient may not consent to the provision of mental health treatment for the patient. A voluntary patient who is unwilling or unable to provide express and informed consent to mental health treatment must either be discharged or transferred to involuntary status.

(f) Within 24 hours after admission of a voluntary patient, the admitting physician shall document in the patient's clinical record that the patient is able to give express and informed consent for admission. If the patient is not able to give express and informed consent for admission, the facility shall either discharge the patient or transfer the patient to involuntary status pursuant to subsection (5).

Two important definitions are found in 394.455, FS as follows:

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

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

A “power of attorney” is no longer valid once a person becomes incompetent to act of his/her own behalf. However, a “Durable Power of Attorney for Health Care” is a form of health care surrogacy that survives the person's incompetency and only takes effect once a person has been determined incompetent or incapacitated by a physician. In any case, a Power of Attorney of any kind only provides authority for the substitute decision-maker to act in the ways specifically enumerated in the document. However, The Baker Act specifically prohibits the voluntary status of an individual who isn't able and willing to provide his/her own express and informed consent; he/she must be discharged or transferred to a designated receiving facility.

Q. We had an involuntary placement hearing today for a person who has a legal guardian. Before the hearing begun, both the State Attorney and the Public defender reported that the Legal Guardian could sign for the client as a Voluntary admission and there was no need of a hearing. Our staff reported that this was not allowed, and the attorneys reported the law had changed. They did not have a hearing and considered the issue resolved by having the father sign as the legal guardian. Has the rule changed regarding "A facility may not admit a voluntary patient a person who has been adjudicated incapacitated unless the condition of incapacity had been judicially removed"?

The attorneys are not correct. Chapter 394 Part I governing voluntary admissions specifically prohibits persons who have been adjudicated as incapacitated from being on voluntary status -- there has been no change in this provision. It goes on to state that even a health care surrogate/proxy cannot give authorization for treatment for a person on voluntary status. In any circumstance where an adult cannot provide express and informed consent, he/she must be transferred to involuntary status. Even a provision in chapter 744 alluding to a guardian having certain extraordinary powers doesn't apply due to its conflict with the more specific provisions of 394.

Q. Are legal guardians allowed to provide consent for psychiatric treatment (and specifications in the legal paperwork state the guardians can provide consent for medical/psychological care) or should the patient be Baker Acted? If BA is not required, does the status change if the patient decides they don't want to stay, guardian says they're staying, and there is need for continued emergency treatment?

Plenary and Limited Guardians appointed by the court under Chapter 744 (Florida's Guardianship statute) may not consent to the ward's admission – any admission of a ward must be on involuntary status. The plenary guardian or a limited guardian with authority to make mental health treatment decisions for the ward, may consent to the ward's treatment. Admission status and treatment are considered two very different things.

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(e) The health care surrogate or proxy of a voluntary patient may not consent to the provision of mental health treatment for the patient. A voluntary patient who is unwilling or unable to provide express and informed consent to mental health treatment must either be discharged or transferred to involuntary status.

An adult must be able to provide express and informed consent. A person with a substitute decision maker such as a guardian or health care surrogate/proxy has been determined by a judge or a physician not to be able to make such decisions. The substitute decision maker can make treatment decisions on behalf of the person, but not admission decisions. Only a court, law enforcement officer, or mental health professional can initiate examination for a person lacking capacity – not a guardian or other substitute decision maker.

Q. Can a guardian appointed by a court or a health care surrogate have their ward/principal admitted to a psychiatric hospital on voluntary status?

NO. The Baker Act specifically prohibits a guardian appointed by the court to act for a person found to be incapacitated in some way from admitting the person on voluntary status, but the guardian does have the authority to make treatment decisions, if the court has granted this authority in the court order once the person is admitted on an involuntary status. The Baker Act also specifically prohibits a health care surrogate/proxy from consenting to treatment of a person held on voluntary status. The person must be on involuntary status, in which case the surrogate/proxy may provide consent until a guardian advocate is appointed by the court.

Q. Can a health care surrogate or proxy admit a person on a voluntary basis?

NO. Even if the person (principal) has consented in an advance directive for the surrogate to have this authority, the Baker Act prohibits the surrogate from providing consent for such a person's treatment. In such circumstances, the person must be discharged from the facility or transferred to involuntary status.

Q. Occasionally we have individuals come to our jail diversion program who are civilly committed to the state hospital. We recently had an individual in the process of the civil hearing who decided he would voluntarily go to the state hospital for treatment. This individual has a plenary guardian. The state hospital is informing me that individuals cannot be admitted voluntarily to the state hospital if they have a legal guardian despite if the guardian agrees. They are stating that these individuals must be committed involuntarily. Can an individual with a legal guardian be voluntarily admitted to the state hospital? Is there any wording in CH. 394 I can refer to for this type of situation?

The information you've received from the state hospital is correct. The voluntary admission provisions of the Baker Act require that any adult who is not able to provide express and informed consent (defined in the law as unable to make well-reasoned, willful and knowing decisions about one's mental health care) must be admitted and detained on an involuntary basis. This is to ensure that the person's due process rights are preserved. You can find this in the following provision:

394.4625(1) Voluntary admissions.--

(d) A facility may not admit as a voluntary patient a person who has been adjudicated incapacitated, unless the condition of incapacity has been judicially removed. If a facility admits as a voluntary patient a person who is later determined to have been adjudicated incapacitated, and the condition of incapacity had not been removed by the time of the admission, the facility must either discharge the patient or transfer the patient to involuntary status.

(e) The health care surrogate or proxy of a voluntary patient may not consent to the provision of mental health treatment for the patient. A voluntary patient who is unwilling or unable to provide express and informed consent to mental health treatment must either be discharged or transferred to involuntary status.

The appellate courts have also found that when there is a conflict between the rights of a guardian in Chapter 744 (guardianship law) and the ward under the Baker Act, the ward's rights under the Baker Act prevail.

Q. I need information about seniors who are voluntary admissions to our psychiatric unit and have questionable ability to provide express and informed consent. Some of these individuals have court-appointed guardians or have a health care surrogate or proxy providing consent.

There are several laws that touch on this issue -- some are general laws governing the subject while just one -- the Baker Act -- addresses how those general laws can be applied in a specific situation. When a general law and a specific law are in conflict, the specific law takes precedent.

Chapter 744, FS governing guardianship has a provision allowing for extraordinary procedures below:

744.3215 Rights of persons determined incapacitated.--

(4) Without first obtaining specific authority from the court, as described in s. 744.3725, a guardian may not:

(a) Commit the ward to a facility, institution, or licensed service provider without formal placement proceeding, pursuant to chapter 393, chapter 394, or chapter 397.

744.3725 Procedure for extraordinary authority.--Before the court may grant authority to a guardian to exercise any of the rights specified in s. 744.3215(4), the court must:

(1) Appoint an independent attorney to act on the incapacitated person's behalf, and the attorney must have the opportunity to meet with the person and to present evidence and cross-examine witnesses at any hearing on the petition for authority to act;

(2) Receive as evidence independent medical, psychological, and social evaluations with respect to the incapacitated person by competent professionals or appoint its own experts to assist in the evaluations;

(3) Personally meet with the incapacitated person to obtain its own impression of the person's capacity, so as to afford the incapacitated person the full opportunity to express his or her personal views or desires with respect to the judicial proceeding and issue before the court;

(4) Find by clear and convincing evidence that the person lacks the capacity to make a decision about the issue before the court and that the incapacitated person's capacity is not likely to change in the foreseeable future;

(5) Be persuaded by clear and convincing evidence that the authority being requested is in the best interests of the incapacitated person; and

(6) In the case of dissolution of marriage, find that the ward's spouse has consented to the dissolution.

The other procedures requiring extraordinary authority by the court would follow the above procedure. However, because the Baker Act specifically prohibits a person who has been adjudicated incapacitated from being on voluntary status, it would not apply to Baker Act situations. Chapter 765, FS, Florida's Advance Directive statute, permits a health care surrogate or proxy to make any and all health care decisions the person would have made if competent to do so. However, the Baker Act states:

394.4625 Voluntary admissions.--

(1) Authority To Receive Patients.--

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(e) The health care surrogate or proxy of a voluntary patient may not consent to the provision of mental health treatment for the patient. A voluntary patient who is

unwilling or unable to provide express and informed consent to mental health treatment must either be discharged or transferred to involuntary status.

(f) Within 24 hours after admission of a voluntary patient, the admitting physician shall document in the patient's clinical record that the patient is able to give express and informed consent for admission. If the patient is not able to give express and informed consent for admission, the facility shall either discharge the patient or transfer the patient to involuntary status pursuant to subsection (5).

Express and Informed consent can only be provided by a competent adult who is able to make well-reasoned, willful, and knowing decisions about his/her own medical or mental health treatment.

394.455 Definitions

(9) "Express and informed consent" means consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

(15) "Incompetent to consent to treatment" means that a person's judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.

Even if a health care surrogate or proxy was allowed to provide interim consent for a person's treatment, a petition for involuntary placement and appointment of a guardian advocate would have to be filed with the clerk of court by a receiving facility administrator.

While Probate Rule 5.900 governing Expedited Judicial Intervention Concerning Medical Treatment Procedures is available, it is unlikely a judge would intervene in such a way to be in direct conflict with statute and Florida Administrative Code. Further, this process can take a while, unless the court is willing to speed up the process beyond that required by the Probate Rule.

There isn't 72 hours from the person's arrival at the facility to resolve the situation. There is only 24 hours after a person arrives at a facility before a physician must certify his or her competence to consent to admission and to treatment. If not, the person must be released or converted to involuntary status. If on involuntary status, he/she must be transferred to a designated receiving facility.

Transfers in Legal Status

Q. Can a person be transferred from involuntary to voluntary status, after arrival at a receiving facility?

YES, but only after the person has received the Mandatory Initial Involuntary Examination by a physician or a clinical psychologist and a physician has certified that the person is competent to provide well-reasoned decision-making about his or her admission and treatment, can the person can be transferred to voluntary status.

Q. Can a person be transferred from voluntary to involuntary status, after arrival at a receiving facility?

YES. At any time a person meets the criteria for involuntary examination or placement, he or she must be converted to involuntary status to ensure that due process rights are protected.

Q. If we have a patient who is voluntary and the MD wants to initiate a BA-32 for involuntary placement, do they also need to do a BA-52 or is initiating the BA-32 sufficient and just send that in to the court with the notice of the petition?

No BA-52 is needed to transfer a person from voluntary to involuntary status. The BA-32 must be filed with the court within two court working days of the person's refusal of treatment, request for discharge, or determination by a physician that the person is incompetent to consent to treatment. It is the court's responsibility to prepare the notice of petition unless the hospital has some different understanding with the Clerk of Court.

Q. What happens if the clinical status of a person on voluntary status deteriorates and the chart documents the person is no longer able to give well-reasoned decision-making regarding his/her treatment?

The person must be transferred to involuntary status and a petition filed for the appointment of a guardian advocate.

Q. We need clarification on Statue 394.4625 (4) on "Transfer to Voluntary" and section 394.463 on "Involuntary examination." When a patient presents/transfer from the ER on a BA 52 to our intake office, can the patient be placed on voluntary status prior to the face to face psychiatrist evaluation to determine competence to provide express and informed consent?

No. A person can't be transferred from involuntary to voluntary status until after the Initial Mandatory Involuntary Examination is conducted by a physician or a clinical psychologist. This is provided for in rules as follows:

65E-5.2801 Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.

The involuntary examination is also known as the initial mandatory involuntary examination.

- (1) Whenever an involuntary examination is initiated by a circuit court, a law enforcement officer, or a mental health professional as provided in Section 394.463(2), F.S., an examination by a physician or clinical psychologist must be conducted and documented in the person's clinical record. The examination, conducted at a facility licensed under Chapter 394 or 395, F.S., must contain:
 - (a) A thorough review of any observations of the person's recent behavior;
 - (b) A review of mandatory form CF-MH 3100, "Transportation to Receiving Facility," as referenced in subsection 65E- 5.260(2), F.A.C., and recommended form CF-MH 3001, "Ex Parte Order for Involuntary Examination," as referenced

in subsection 65E-5.260(1), F.A.C., or other form provided by the court, or mandatory form CF-MH 3052a, "Report of Law Enforcement Officer Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or mandatory form CF-MH 3052b, "Certificate of Professional Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C.

(c) A brief psychiatric history; and

(d) A face-to-face examination of the person in a timely manner to determine if the person meets criteria for release.

(2) If the physician or clinical psychologist conducting the initial mandatory involuntary examination determines that the person does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement, the person can be offered voluntary placement, if the person meets criteria for voluntary admission, or released directly from the hospital providing emergency medical services. Such determination must be documented in the person's clinical record.

(3) If not released, recommended form CF-MH 3040, "Application for Voluntary Admission," as referenced in paragraph 65E- 5.1302(1)(b), F.A.C., or recommended form CF-MH 3097, "Application for Voluntary Admission – Minors," as referenced in subsection 65E-5.270(1), F.A.C., may be used if the person wishes to apply for voluntary admission.

(4) If not released and the person wishes to transfer from involuntary to voluntary status, recommended form CF-MH 3104, "Certification of Person's Competence to Provide Express and Informed Consent," as referenced in paragraph 65E- 5.170(1)(c), F.A.C., documenting the person is competent to provide express and informed consent, may be used for this purpose.

(5) All results and documentation of all elements of the initial mandatory involuntary examination shall be retained in the person's clinical record.

(6) If the person is not released or does not become voluntary as a result of giving express and informed consent to admission and treatment in the first part of the involuntary examination, the person shall be examined by a psychiatrist to determine if the criteria for involuntary inpatient or involuntary outpatient placement are met.

Two other rules also apply to the situation you cite. They are:

65E-5.270 Voluntary Admission.

(1) Recommended form CF-MH 3040, "Application for Voluntary Admission," as referenced in paragraph 65E-5.1302(1)(b), F.A.C., may be used to document an application of a competent adult for admission to a receiving facility.

Recommended form CF- MH 3097, Feb. 05, "Application for Voluntary Admission – Minors," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, may be used to document a guardian's application for admission of a minor to a receiving facility.

Recommended form CF-MH 3098, Feb. 05, "Application for Voluntary Admission – State Treatment Facility," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, may be used to document an application of a competent adult for admission to a state treatment facility. Any application for voluntary admission shall be based on the person's express and informed consent.

(a) Recommended form CF-MH 3104, "Certification of Person's Competence to Provide Express and Informed Consent," as referenced in paragraph 65E- 5.170(1)(c), F.A.C., may be used to document the competence of a person to

give express and informed consent to be on voluntary status. The original of the completed form shall be retained in the person's clinical record.

65E-5.170(1)(e) Competence to provide express and informed consent shall be established and documented in the person's clinical record prior to the approval of a person's transfer from involuntary to voluntary status or prior to permitting a person to consent to his or her own treatment if that person had been previously determined to be incompetent to consent to treatment. Recommended form CF-MH 3104, "Certification of Person's Competence to Provide Express and Informed Consent," as referenced in paragraph 65E- 5.170(1)(c), F.A.C., properly completed by a physician may be used for this purpose.

As noted above, the involuntary examination must be conducted by a physician or clinical psychologist, the certification of competence must be documented by a physician, and the willing/competent person must have completed the application for voluntary admission – all this before converting a person from involuntary to voluntary status.

Access to State Mental Health Facilities

Q. I am an Assistant State Attorney. Recently a patient met almost all of the criteria for Involuntary Commitment, except he was competent to determine for himself that state hospital placement was necessary. For this reason, the patient didn't meet the criteria for involuntary commitment to the state hospital, but the psychiatrist believed the state hospital was the most appropriate placement for the patient. Is there anyway to get the patient into the state hospital?

There is no legal reason why a person can't be admitted to a state hospital on a voluntary basis. It would still involve a "Transfer Evaluation" by the Community Mental Health Center to ensure he meets criteria for state hospital admission and that there is no less restrictive setting for him in the community.