

2014
Baker Act

The Florida Mental Health Act
User Reference Guide



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For more information

Baker Act Reporting Center Website:
<http://bakeract.fmhi.usf.edu/>

FMHI Baker Act Training Website:
<http://www.bakeracttraining.org/>

Florida Department of Children and Families Baker Act Site:
<http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml>

Copies of this Manual

This manual is available in electronic form at the Florida Department of Children and Families Baker Act Website (<http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml>).

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Instructions for how to download the manual and order hard copies of manuals can be found at our Baker Act Reporting Center Website: <http://bakeract.fmhi.usf.edu/>

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2014 Baker Act —Table of Contents

Introduction

Development and Use of Baker Act Handbook	v
Use of Handbook.....	v
Statutes Not Included in Handbook	v
Baker Act Reporting Center	v
Baker Act Website	v
Baker Act Training Online	v
Baker Act Technical Assistance	vi
Florida’s Judicial Circuits and DCF Regions Map	vi
Managing Entities	vii
DCF Regions and Managing Entities.....	vii
Baker Act History & Overview	ix
Continuity of Care - Relationships	xix
Baker Act Flow Chart	xx

Statutes and Rules

Short title.....	1
Legislative intent.....	1
Definitions.....	2
Operation and administration	7
Screening of mental health personnel	11
Continuity of care management system	12
Assisted living facility.....	18
Introduction or removal of certain articles.....	20
Rights of patients	21
Sexual misconduct	58
Florida statewide and local advocacy councils.....	60
Guardian advocate	62
Notice.....	65
Rights of professionals	67
Designation of receiving and treatment facilities.....	67
Integrated adult mental health receiving facilities	76
Clinical records; confidentiality.....	77
Transportation	80
Voluntary admissions.....	85
Involuntary examination.....	89
Involuntary outpatient placement.....	95
Involuntary inpatient placement	107
Rulemaking authority.....	113
Procedure for placement of veteran with federal agency.....	113
Admission and discharge procedures.....	115
Transfer of patients among facilities.....	115
Discharge of involuntary patients	117
Attorney’s fee; expert witness fee	117
Involuntary placement from out-of-state mental health authorities	118
Minors access to outpatient crisis intervention services.....	119
Children admission and placement in mental facilities.....	120
Military veterans and service members court programs	121

Appendices

A Baker Act and Related Laws	A1
Marchman Act	A1
Developmental Disabilities	A1
Emergency Examination and Treatment of Incapacitated Persons..	A1
EMTALA.....	A2
Access to Emergency Services and Care.....	A2
Adult Abuse, Neglect, and Exploitation	A3
Advance Directives	A3
Guardianship.....	A4
Quick Reference Guide to Related Statutes.....	A5
B Voluntary Admissions	B1
Selected Definitions.....	B1
Criteria	B1
Exclusions.....	B1
Right to Discharge	B2
Transfer from Involuntary to Voluntary Status	B2
Transfer from Voluntary to Involuntary Status	B2
Discharge of Persons on Voluntary Status	B2
Elopement of a Person on Voluntary Status.....	B3
FORM: Voluntary Admissions Quick Reference Guide for Receiving and Treatment Facilities	B4
FIGURE: Adult Seeking Voluntary Admission	B6
FIGURE: Request for Discharge of Person on Voluntary Status ...	B7
C Express and Informed Consent	C1
Documentation of Competence to Provide Express and Informed Consent.....	C1
Persons Determined Incompetent to Consent to Treatment	C2
Persons Adjudicated Incapacitated	C2
Persons with Health Care Surrogates / Proxies	C3
Summary of Consent Issues	C3
TABLE: Summary Reference on Substitute Decision Making.....	C4
FORM: Mental Health Advance Directive	C6
D Consent for Admission and Treatment for Minors	D1
Minority/Non-Age	D1
Consent to Mental Health Admission	D3
Admission	D3
Hospitals.....	D3
Children’s Crisis Stabilization Units	D3
Consent to Psychiatric Treatment.....	D3
Inpatient Treatment	D3
Residential Treatment Centers	D3
Outpatient Crisis Intervention Services	D4
Substance Abuse (Marchman Act) Admission and Treatment.....	D4
Criteria	D4
Initiation	D4
Disposition	D5
Parental Participation in Treatment.....	D5
Release of Information.....	D5
Parental Participation/Payment	D5
Consent for General Medical Care & Treatment.....	D5
Power to Consent	D5
Emergency Care.....	D5
Emergency Care of Youth in DCF or DJJ Custody	D6

Delinquent Youth	D6
Medical, psychiatric, psychological, substance abuse, and educational examination and treatment	D6
Dependent Youth	D7
Medical, psychiatric, and psychological examination and treatment of child in DCF Custody.....	D7
Psychotropic Medications.....	D7
Examination, Treatment, & Placement.....	D9

E Baker Act and Long-Term Care Facilities Licensed Under

Chapter 400 and 429 E1

Introduction.....	E1
Voluntary Admissions	E1
Involuntary Examinations	E2
Transportation.....	E2
Florida Health Care Association Recommendations	E3
Nursing Homes	E5
Psychotropic Medication Usage Issues.....	E5
FIGURE: Person Seeking Voluntary Admission.....	E6
Quality First Credentialing Program Best Practices Tools.....	E7

F Involuntary Examination F1

Criteria	F1
Initiation	F1
Definitions of Professionals	F2
Selected Procedures	F2
Examination.....	F2
Release.....	F3
Escape or Elopement of a Person from a Receiving or Treatment Facility	F3
Notice of Discharge or Release.....	F3
FORM: Baker Act Involuntary Examination	
Quick Reference Guide for Receiving Facilities.....	F4
FIGURE: Involuntary Examination.....	F7

G Law Enforcement and the Baker Act G1

Introduction.....	G1
Voluntary Admission.....	G1
Involuntary Examination	G1
Behaviors to Look For	G1
Transportation for Medical Emergencies	G5
Designation of Transportation Responsibility	G5
Nearest Receiving Facility	G5
Criminal Charges	G5
Use of Restraining Devices.....	G5
Procedures.....	G6
Escape or Elopement of Persons from a Baker Act Receiving Facility	G6
Confidentiality of Clinical Records.....	G7
Crisis Intervention Teams	G7
FIGURE: Law Enforcement Officer (LEO).....	G9
The Baker Act – A Quick Reference Guide for Law Enforcement Officers.....	G10
Family Interaction with Law Enforcement.....	G11

H Baker Act and Emergency Medical Conditions H1

Introduction.....	H1
Voluntary Admission.....	H1
Criteria for Involuntary Examination.....	H1
Initiation of Involuntary Examination	H2
Certificate of a Professional.....	H2
Baker Act Involuntary Examination	H3
Emergency Medical Conditions (EMC).....	H3
Duties of all Hospitals.....	H4
EMTALA and the Baker Act Emergency Medical Treatment and Active Labor Act.....	H4
Medical & Psychiatric Screening.....	H5
Medical Clearance	H5
Baker Act Exam/Release.....	H6
Transfers.....	H6
CSU's.....	H8
Law Enforcement.....	H8
Safety/Stabilization	H8
Informed Consent for Transfer	H9
Funding	H9
EMTALA Ceases	H10
Summary	H10
FIGURE: Emergency Medical Treatment of Persons for Whom Involuntary Examination has been or will be Initiated.....	H11

I Orders for Emergency Treatment Including Restraints and Seclusion I1

Introduction.....	I1
General Management of the Treatment Environment.....	I2
Individual Behavior Management Programs	I2
Emergency Treatment Orders.....	I2
Restraint and Seclusion	I3
Staff Training.....	I4
Prior to the Implementation of Seclusion or Restraint	I4
Implementation of Seclusion or Restraint	I4
During Seclusion or Restraint.....	I6
Release from Seclusion or Restraint and Post-Release Activities.....	I7
Oversight.....	I7
Reporting	I7
Emergency Orders for Psychiatric Medications	I8
Initiation of an Emergency Treatment Order For Psychiatric Medications.....	I9
Health Care Surrogate and Proxy.....	I10
Quick Reference Guide to Restraint and Seclusion	I12

J Involuntary Inpatient Placement J1

Criteria	J1
Initiation of Involuntary Inpatient Placement.....	J1
Petition for Involuntary Inpatient Placement	J1
Appointment of Counsel.....	J2
Continuance of Hearing.....	J2
Independent Expert Examination	J2
Hearing on Involuntary Inpatient Placement.....	J2
Admission to a Treatment Facility	J3
Release of Persons.....	J3
Return of Persons	J3
Procedure for Continued Involuntary Inpatient Placement	J4
FORM: Quick Reference Guide for Receiving and Treatment Facilities Involuntary Inpatient Placement	J5
FIGURE: Involuntary Inpatient Placement	J7

K	Involuntary Outpatient Placement	K1	O	Baker Act/Marchman Act Comparison	O1
	Introduction.....	K1		Introduction and History	O1
	Rights of Persons	K1		Definitions	O1
	Criteria	K1		Service Providers.....	O3
	Petition.....	K2		Voluntary Admissions	O3
	Service Provider.....	K2		Involuntary Examination/ Admission Criteria	O4
	Treatment Plan	K3		Procedure for Involuntary Examination/Assessments.....	O5
	County of Filing.....	K3		Transportation Requirements for Involuntary	
	Notice of Petition	K3		Examination / Admission	O9
	Hearing	K4		Examination or Assessment.....	O12
	Testimony.....	K4		Release or Discharge.....	O13
	Court Order.....	K5		Notice of Release from Involuntary Examination / Involuntary	
	Continued Involuntary Outpatient Placement.....	K5		Admission	O14
	Notice of Petition for Continued Involuntary Outpatient Placement..	K5		Involuntary Placement / Involuntary Treatment —	
	Hearing on Continued Involuntary Outpatient Placement.....	K6		Procedure for Filing Petitions	O15
	Order for Continued Involuntary Outpatient Placement	K6		Appointment of Counsel.....	O17
	Modification to Court Order for Involuntary Outpatient Placement..	K6		Hearings for Involuntary Placement / Treatment	O17
	Change of Service Provider.....	K7		Initial Order	O17
	Non-Compliance with Court Order	K7		Hearings on Continued Involuntary Placement / Treatment.....	O17
	Discharge from Involuntary Outpatient Placement	K7		Release from Involuntary Placement / Treatment & Notices.....	O19
	FIGURE: Involuntary Outpatient Placement	K8		Responsibilities of Providers	O20
	FIGURE: Non-Compliance with Treatment Order	K10		Rights: General.....	O21
	FIGURE: Modification to Treatment Plans	K10		Rights: Individual Dignity.....	O21
L	Qualifications of Professionals & Others to Perform			Rights: Treatment.....	O21
	Baker Act Related Functions	L1		Rights: Express and Informed Consent	O22
	Definitions	L1		Rights: Quality Treatment / Services	O24
	Credentials	L2		Rights: Confidentiality	O25
	FIGURE: Quick Reference Guide to Decision-Making			Rights: Communication, Abuse Reporting & Visitation.....	O26
	by Mental Health Professionals and Others.....	L3		Rights: Care & Custody of Personal Effects	O26
M	Baker Act Notices	M1		Rights: Non-Discrimination	O27
	Voluntary Admission	M1		Rights: Voting in Public Elections	O27
	Involuntary Examination	M1		Rights: Right to Counsel.....	O27
	CHART: Notices/Copies Quick Reference Guide Facilities.....	M3		Rights: Habeas Corpus.....	O27
N	Marchman Act History and Overview	N1		Rights: Separation of Children from Adults	O28
	History	N1		Rights: Education of Minors.....	O28
	Related Legislation	N1		Special Issues	O28
	Legislative Intent	N2			
	Selected Definitions.....	N2	P	Resources	P1
	Client Rights	N3		Department of Children & Family Services	P1
	Voluntary Admission	N4		Managing Entities	P1
	Involuntary Admissions.....	N4		Baker Act Website	P1
	Criteria	N4		Receiving Facility List.....	P1
	Protective Custody	N5		Baker Act Training Online	P1
	Emergency Admission	N5		Florida Abuse Registry.....	P1
	Alternative Involuntary Assessment for Minors.....	N5		Agency for Health Care Administration	P1
	Involuntary Assessment & Stabilization	N5		Professional Regulation	P1
	Involuntary Treatment.....	N5		Other State Agencies	P2
	Provider Responsibilities.....	N5		Federal Agencies	P2
	Oversight.....	N6		Advocacy Organizations.....	P3
	Quick Reference Guide to Involuntary Admissions under the			Family Support.....	P3
	Marchman Act	N7		Elders	P4
				Addictions	P4
				Other Resources	P5
				Baker Act Online Training	P5

Q Military Service Members and Veterans	Q1
DD-214	Q1
Identifying Veterans.....	Q1
Organizations	Q1
Specific Populations.....	Q2
Veterans Health Initiative	Q3
Veterans' Crisis Line	Q4
Key Phone Numbers	Q4
Veteran's Issues and the Baker Act	Q4

R Frequently Asked Baker Act Questions	R1
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Baker Act Forms

Development and Use of Baker Act Handbook

Use of Handbook

This Handbook is intended to be used for informational purposes only. The information presented herein is not legally binding and does not have any legal authority. Only Chapters 394, F.S. and 65E-5, F.A.C. have legal authority, as well as Chapter 65E-12, F.A.C. which governs crisis stabilization units and short-term residential treatment facilities. Information is provided for purposes of orientation on how the Baker Act interacts with other laws. The information is not authoritative in these related areas.

The creation of administrative rules to implement and clarify the statute is governed by Chapter 120, F.S. The state law prohibits the repetition of statute in administrative rules. Therefore, individuals must be familiar with and routinely reference *both* the statutes and the corresponding rules to ensure correct implementation of the Baker Act law.

For training purposes, the statute and the corresponding administrative rules concerning the same subjects have been displayed side-by-side; statutes are sequentially displayed in the left column of each page in numerical order. The corresponding administrative rules are sequentially displayed in the right column. However, five rules are intentionally listed out of numerical sequence to display them next to the statute to which they refer. These five rules are those governing rights of persons in and operation of state mental health treatment facilities (Chapters 65E-5.601 and 65E-5.602), training (Chapter 65E-5.330, F.A.C.), designation of facilities (Chapter 65E-5.350, F.A.C.) and funded Baker Act services (Chapter 65E-5.400, F.A.C.).

To the extent possible, the word “individual” or “person” is used (rather than “patient”) throughout this Handbook, except for direct quotes from the statutes and for the purpose of clarity. Person-first language works to reduce stigma and increases professional sensitivity to the dignity of persons served. Following the display of statutes and corresponding administrative rules are appendices. These appendices contain useful material on select complex subjects derived from the Baker Act law, administrative rules, forms, practices and other statutes/case law. All current Baker Act forms are located in the back of the handbook.

Statutes Not Included in Handbook

Plan and Report 394.4674; Residential care for psychotic and emotionally disturbed children 394.4781; Intent 394.4786; South Florida State Hospital Privatization 394.47865; Definitions 394.4787; Use of certain Public Medical Assistance Trust Fund (PMATF) funds for the purchase of acute care mental health services 394.4788; Establishment of referral process and eligibility determination 394.4789.

Baker Act Reporting Center

The Louis de la Parte Florida Mental Health Institute is designated by the Florida Agency for Health Care Administration to be the Baker Act Reporting Center. The purpose of the BA Reporting Center is to receive the Baker Act involuntary examination initiation forms, orders for involuntary inpatient/outpatient placement, and cover sheets submitted by every receiving facility to the Agency for Health Care Administration (as required by Florida Statutes Chapter 394), organize and enter the data from the forms into an electronic database, and provide reports on the data collected. It is the official repository for the Baker Act data. For more information on Baker Act Reports, please contact Dr. Annette Christy by email at achristy@usf.edu or by telephone at (813) 279-1923.

The address of the Reporting Center is:

BA Reporting Center
FMHI
13301 Bruce B. Downs Blvd. MHC 2637
Tampa, FL 33612-3807

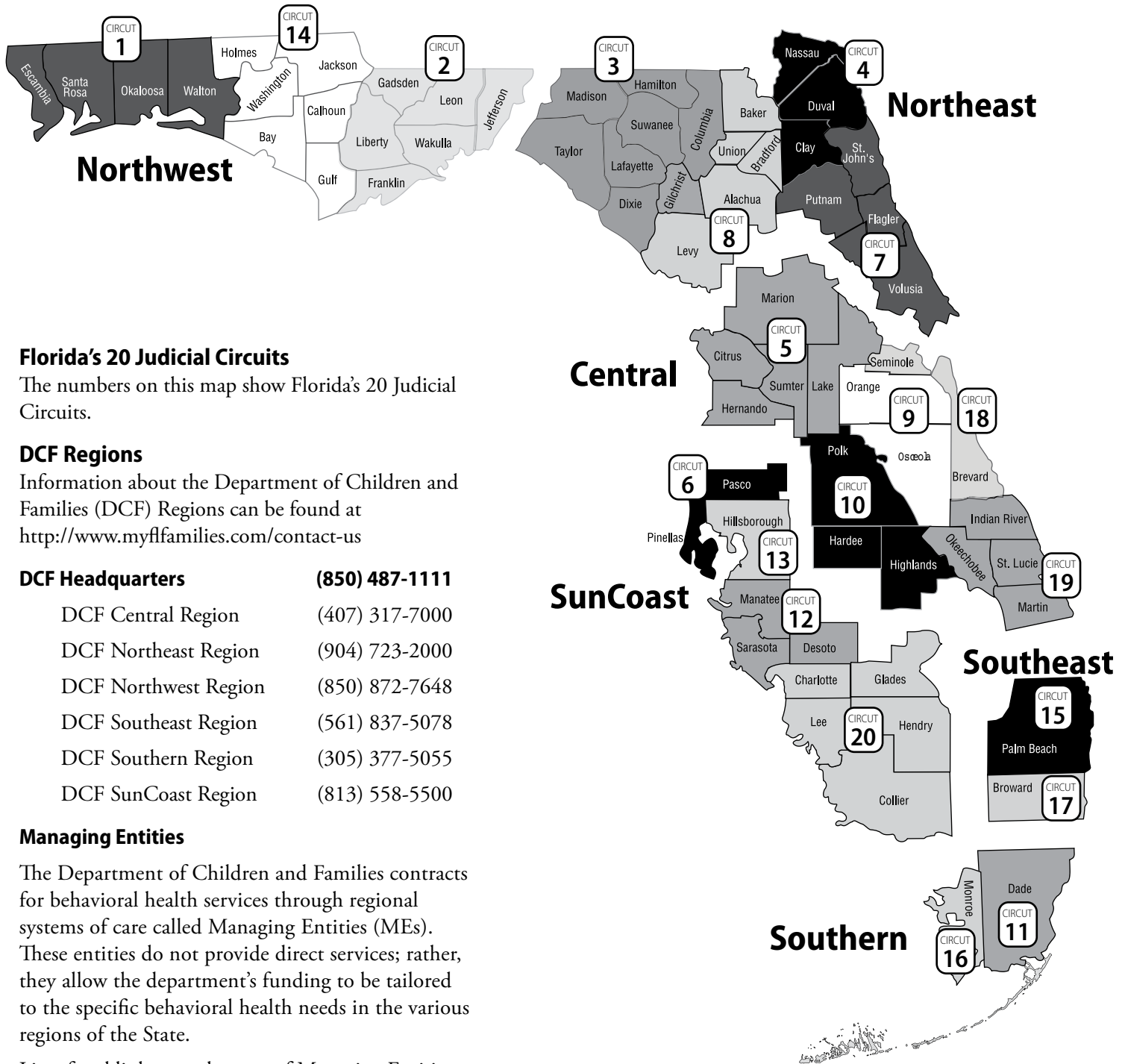
Baker Act Website

The state's Baker Act internet site is located at <http://www.dcf.state.fl.us/programs/samh/mentalhealth/laws/index.shtml>. Updated information about the Baker Act can also be found at the Baker Act Reporting Center website (<http://bakeract.fmhi.usf.edu>).

BAKER ACT TRAINING ONLINE **<http://www.bakeracttraining.org>**

Free online courses are available. They are approved for Continuing Education Credits (CEs) for a variety of professionals. There is a charge for the processing of the CEs

Florida's Judicial Circuits and DCF Regions



Florida's 20 Judicial Circuits

The numbers on this map show Florida's 20 Judicial Circuits.

DCF Regions

Information about the Department of Children and Families (DCF) Regions can be found at <http://www.myflfamilies.com/contact-us>

DCF Headquarters (850) 487-1111

DCF Central Region	(407) 317-7000
DCF Northeast Region	(904) 723-2000
DCF Northwest Region	(850) 872-7648
DCF Southeast Region	(561) 837-5078
DCF Southern Region	(305) 377-5055
DCF SunCoast Region	(813) 558-5500

Managing Entities

The Department of Children and Families contracts for behavioral health services through regional systems of care called Managing Entities (MEs). These entities do not provide direct services; rather, they allow the department's funding to be tailored to the specific behavioral health needs in the various regions of the State.

List of and links to web pages of Managing Entities (MEs) can be found at <http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities>

Two colorful maps that help clarify the DCF regions and Managing Entities can be found online at <http://bakeract.fmhi.usf.edu/>

DCF Regions and Managing Entities

County	DCF Region	Managing Entity	Judicial Circuit
Alachua	Northeast	Lutheran Services Florida	8th
Baker	Northeast	Lutheran Services Florida	8th
Bay	Northwest	Big Bend Community Based Care	14th
Bradford	Northeast	Lutheran Services Florida	8th
Brevard	Central	Central Florida Health System	18th
Broward	Southeast	Broward Behavioral Health Coalition	17th
Calhoun	Northwest	Big Bend Community Based Care	14th
Charlotte	SunCoast	Central Florida Behavioral Health Network	20th
Citrus	Central	Lutheran Services Florida	5th
Clay	Northeast	Lutheran Services Florida	4th
Collier	SunCoast	Central Florida Behavioral Health Network	20th
Columbia	Northeast	Lutheran Services Florida	3rd
Desoto	SunCoast	Central Florida Behavioral Health Network	12th
Dixie	Northeast	Lutheran Services Florida	3rd
Duval	Northeast	Lutheran Services Florida	4th
Escambia	Northwest	Big Bend Community Based Care	1st
Flagler	Northeast	Lutheran Services Florida	7th
Franklin	Northwest	Big Bend Community Based Care	2nd
Gadsden	Northwest	Big Bend Community Based Care	2nd
Gilchrist	Northeast	Lutheran Services Florida	8th
Glades	SunCoast	Central Florida Behavioral Health Network	20th
Gulf	Northwest	Big Bend Community Based Care	14th
Hamilton	Northeast	Lutheran Services Florida	3rd
Hardee	Central	Central Florida Behavioral Health Network	10th
Hendry	SunCoast	Central Florida Behavioral Health Network	20th
Hernando	Central	Lutheran Services Florida	5th
Highlands	Central	Central Florida Behavioral Health Network	10th
Hillsborough	SunCoast	Central Florida Behavioral Health Network	13th
Holmes	Northwest	Big Bend Community Based Care	14th
Indian River	Southeast	Southeast Florida Behavioral Health Network	19th
Jackson	Northwest	Big Bend Community Based Care	14th
Jefferson	Northwest	Big Bend Community Based Care	2nd
Lafayette	Northeast	Lutheran Services Florida	3rd
Lake	Central	Lutheran Services Florida	5th
Lee	SunCoast	Central Florida Behavioral Health Network	20th
Leon	Northwest	Big Bend Community Based Care	2nd
Levy	Northeast	Lutheran Services Florida	8th
Liberty	Northwest	Big Bend Community Based Care	2nd
Madison	Northeast	Big Bend Community Based Care	3rd

Managing Entities

Big Bend Community Based Care

525 North Martin Luther King Jr. Blvd.
Tallahassee, FL 32301
(850) 410-1020
<http://www.bigbendcbc.org>

Broward Behavioral Health Coalition

1715 SE 4th Avenue
Ft. Lauderdale, FL 33316
(954) 622-8121
<http://www.bbhcflorida.org>

Central Florida Behavioral Health Network

719 US Highway 301 South
Tampa, FL 33619
(813) 740-4811
<http://www.cfbhn.org>

Central Florida Cares Health System

707 Mendham Blvd., Suite 104
Orlando, FL 32825
(407) 985-3560
<http://centralfloridacares.org/>

Lutheran Services Florida

10450 San Jose Blvd., Unit A
Jacksonville, FL 33257
(904) 900-1075
<http://www.lsfnet.org>

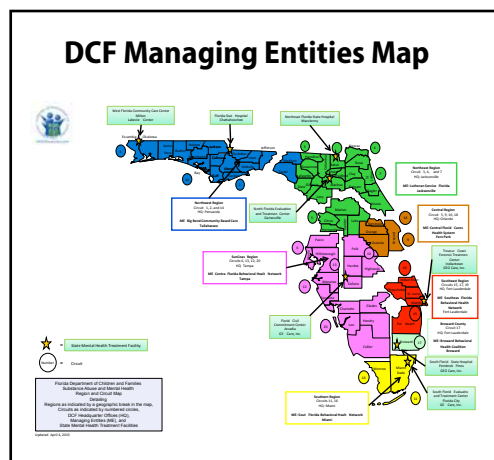
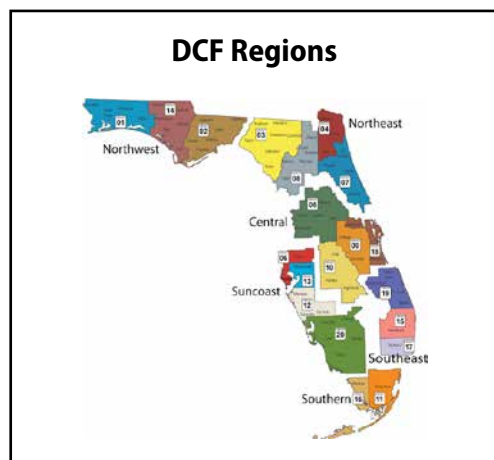
Southeast Florida Behavioral Health Network

140 Intracoastal Point Drive, Suite 211
Jupiter, FL 33477
(561) 203-2485
<http://web.sefbhn.org>

South Florida Behavioral Health Network

7205 Corporate Center Drive, Suite 200
Miami, FL 33126
(305) 858-3335
<http://sfbhn.org>

Two colorful maps that help clarify the DCF regions and Managing Entities can be found online at <http://bakeract.fmhi.usf.edu/>



DCF Regions and Managing Entities (Continued)

County	DCF Region	Managing Entity	Judicial Circuit
Manatee	SunCoast	Central Florida Behavioral Health Network	12th
Marion	Central	Lutheran Services Florida	5th
Martin	Southeast	Southeast Florida Behavioral Health Network	19th
Miami-Dade	Southern	South Florida Behavioral Health Network	11th
Monroe	Southern	South Florida Behavioral Health Network	16th
Nassau	Northeast	Lutheran Services Florida	4th
Okaloosa	Northwest	Big Bend Community Based Care	1st
Okeechobee	Southeast	Southeast Florida Behavioral Health Network	19th
Orange	Central	Central Florida Health System	9th
Osceola	Central	Central Florida Health System	9th
Palm Beach	Southeast	Southeast Florida Behavioral Health Network	15th
Pasco	SunCoast	Central Florida Behavioral Health Network	6th
Pinellas	SunCoast	Central Florida Behavioral Health Network	6th
Polk	Central	Central Florida Behavioral Health Network	10th
Putnam	Northeast	Lutheran Services Florida	7th
Saint Johns	Northeast	Lutheran Services Florida	7th
Saint Lucie	Southeast	Southeast Florida Behavioral Health Network	19th
Santa Rosa	Northwest	Big Bend Community Based Care	1st
Sarasota	SunCoast	Central Florida Behavioral Health Network	12th
Seminole	Central	Central Florida Health System	18th
Sumter	Central	Lutheran Services Florida	5th
Suwannee	Northeast	Lutheran Services Florida	3rd
Taylor	Northeast	Big Bend Community Based Care	3rd
Union	Northeast	Lutheran Services Florida	8th
Volusia	Northeast	Lutheran Services Florida	7th
Wakulla	Northwest	Big Bend Community Based Care	2nd
Walton	Northwest	Big Bend Community Based Care	1st
Washington	Northwest	Big Bend Community Based Care	14th

Baker Act

History & Overview

Statutes governing the treatment of mental illness in Florida date back to 1874. Amendments to the law were passed many times over the years but in 1971 the Legislature enacted the Florida Mental Health Act. This Act brought about a dramatic and comprehensive revision of Florida's 97-year old laws. It substantially strengthened the due process and civil rights of persons in mental health facilities.

The Act, usually referred to as the "Baker Act," was named after Maxine Baker, former State representative from Miami who sponsored the Act, while serving as chairperson of the House Committee on Mental Health. Referring to the treatment of persons with mental illness before the passage of her bill, Representative Baker stated "In the name of mental health, we deprive them of their most precious possession – liberty."

Since the Baker Act became effective in 1972, a number of legislative amendments have been enacted to protect persons' civil and due process rights. The most recent major revision was when Involuntary Outpatient Placement was added by the Legislature effective January 2005.

It is important that the Baker Act only be used in situations where the person has a mental illness and meets all remaining criteria for voluntary or involuntary admission. The Baker Act is the Florida Mental Health Act. It does not substitute for any other law that may permit the provision of medical or substance abuse care to persons who lack the capacity to request such care. For many persons, the use of other statutes may be more appropriate. Alternatives may include:

- Developmental Disabilities, Chapter 393, F.S.
- Marchman Act, (Substance Abuse Impairment), Chapter 397, F.S.
- Emergency Examination and Treatment of Incapacitated Persons, Chapter 401.445, F.S.
- Federal Emergency Medical Treatment and Active Labor Act (EMTALA) hospital "Anti-Dumping" law, 42 USC 1395dd.
- Hospital Access to Emergency Services and Care, Chapter 395.1041, F.S.
- Adult Abuse, Neglect, and Exploitation, Chapter 415.1051, F.S.
- Advance Directive, Chapter 765, F.S.
- Guardianship, Chapter 744, F.S.
- Expedited Judicial Intervention for Medical Procedures, Probate Rule 5.900

Rights of Persons with Mental Illnesses

s. 394.459, F.S. Ch. 65E-5.140, FAC

The Baker Act ensures many rights to persons who have mental illnesses. Some of these rights are as follows:

- **Individual Dignity:** Ensures all constitutional rights and requires that persons be treated in a humane way while being transported or treated for mental illness.
- **Treatment:** Prohibits the delay or denial of treatment due to a person's inability to pay and requires prompt physical examination after arrival; requires treatment planning to involve the person; and requires the least restrictive appropriate available treatment be based on the individual needs of each person.
- **Express and Informed Consent:** Encourages people to voluntarily apply for mental health services when they are competent to do so, to choose their own treatment, and to decide when they want to stop treatment. The law requires that consent be voluntarily given in writing by a competent person after sufficient explanation to enable the person to make well-reasoned, willful and knowing decisions without any coercion.
- **Quality of Treatment:** Requires medical, vocational, social, educational, and rehabilitative services suited to each person's needs to be administered skillfully, safely, and humanely. Use of restraint, seclusion, isolation, emergency treatment orders, physical management techniques, and elevated levels of supervision are regulated. Grievance procedures and complaint resolution is required.
- **Communication, Abuse Reporting, and Visits:** Guarantees persons in mental health facilities the right to communicate freely and privately with persons outside the facilities by phone, mail, or visitation. If communication is restricted, written notice must be provided. No restriction of calls to the Abuse Registry or to the person's attorney is permitted under any circumstances.
- **Care and Custody of Personal Effects:** Ensures that persons may keep their own clothing and personal effects, unless they are removed for safety or medical reasons. If removed, a witnessed inventory is required.
- **Voting in Public Elections:** Persons are guaranteed the right to register and to vote in any elections for which they are qualified voters.
- **Habeas Corpus:** Guarantees the right to ask the court to review the cause and legality of the person's detention or unjust denial of a legal right or privilege or an authorized procedure.
- **Treatment and Discharge Planning:** Guarantees the opportunity to participate in treatment and discharge

planning and to seek treatment from the professional or agency of person's choice upon discharge.

- **Sexual Misconduct Prohibited:** Any staff who engages in sexual activity with a person served by a receiving/treatment facility is guilty of a felony. Failure to report such misconduct is a misdemeanor.
- **Right to a Representative:** Selected by persons (or by facility when person can't/won't select their own) when admitted on an involuntary basis or transferred from voluntary to involuntary status. The representative must be promptly notified of the person's admission and all proceedings and restrictions of rights, receives copy of the inventory of the person's personal effects, has immediate access to the person, and is authorized to file a petition for a writ of habeas corpus on behalf of the person. The representative can't make any treatment decisions, can't access or release the person's clinical record without the person's consent, and can't request the transfer of the person to another facility.
- **Confidentiality:** Ensures that all information about a person in a mental health facility is maintained as confidential and only released with the consent of the person or a legally authorized representative. However, certain information may be released without consent to the person's attorney, in response to a court order (after a good cause hearing), after a threat of harm to others or other very limited circumstances. Persons in mental health facilities have the right to access their clinical records.
- **Violation of Rights:** Anyone who violates or abuses any rights or privileges of persons provided in the Baker Act is liable for damages as determined by law.

Voluntary Admissions

s. 394.4625, F.S. Chapter 65E-5.270, F.A.C.

The Baker Act encourages the voluntary admission of persons for psychiatric care, but only when they are able to understand the decision and its consequences and are able to fully exercise their rights for themselves. When this is not possible due to the severity of the person's condition, the law requires that the person be extended the due process rights assured for those under involuntary status.

Selected Definitions

s. 394.455, F.S.

Several definitions are important to understanding the criteria for voluntary admissions and consent to treatment.

Mental illness means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology. For the purposes of this part, the term does not include a developmental disability as defined in Chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment. (18)

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. (9)

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. (15)

Criteria for Voluntary Admissions

s. 394.4625(1)(a), F.S. s. 394.459(3)(a), F.S.

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 legal guardian. A person age 17 or under can be admitted only after a hearing to verify the voluntariness of the consent.

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. Each person entering a facility, regardless of age, must be asked to give express and informed consent for admission and treatment. If the person is a minor, express and informed consent for admission and treatment must also be requested from the person's guardian. Express and informed consent for admission and treatment of a person under 18 years of age is required from the minor's guardian.

Voluntary Admission Exclusions

s. 394.4625(1), F.S.

- A minor can only be admitted on a voluntary basis if willing and upon application by his/her legal guardian and after a judicial hearing to verify the voluntariness of the consent.
- A facility may not admit a person on a voluntary basis who has been adjudicated by a court as incapacitated.
- The health care surrogate or proxy of a person on voluntary status may not consent to mental health treatment for the person. Therefore, such a person would be discharged from the facility or involuntary procedures initiated.
- Certain individuals residing in or served by long-term facilities licensed under Chapter 400 and 429, F.S., may not be removed from their residence for voluntary examination unless previously screened by an independent authorized professional and found to be able to provide express and informed consent to treatment.
- A person on voluntary status who is unwilling or unable to provide express and informed consent to mental health treatment must either be discharged or transferred to involuntary status.

Consent to Admission/Treatment

Before giving consent to admission or treatment, the following information must be given to the person or his/her legally authorized substitute decision-maker:

- Reason for admission
- Proposed treatment, including proposed psychotropic medications
- Purpose of treatment
- Alternative treatments
- Specific dosage range for medications
- Frequency and method of administration
- Common risks, benefits and common short-term and long-term side effects
- Any contraindications which may exist
- 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

- Disclosure that any consent for treatment may be revoked orally or in writing before or during the treatment period if the person legally authorized to make health care decisions on behalf of the person.

Within 24 hours after a voluntary admission of an adult, the admitting physician must document in the person's clinical record that the person is able to give express and informed consent for admission and treatment. If the adult is not able to give express and informed consent, the facility must either discharge the adult or transfer the person to involuntary status.

Transfer to Voluntary Status

s. 394.4625(4), F.S.

A person on involuntary status who applies to be transferred to voluntary status must be transferred unless the person has been charged with a crime or has been involuntarily placed for treatment by a court and continues to meet the criteria for involuntary placement.

Before the transfer to voluntary status is processed, the mandatory initial involuntary examination must be performed by a physician or clinical psychologist and a certification of the person's competence to consent must be completed by a physician. In addition, the competent person must have formally applied for voluntary admission.

Transfer to Involuntary Status

s. 394.4625(5), F.S.

At any time a person on voluntary status is determined not to have the capacity to make well-reasoned, willful, and knowing decisions about mental health or medical care, he/she must be transferred to involuntary status.

When a person on voluntary status, or an authorized individual acting on the person's behalf, makes a request for his/her 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 person meets the criteria for involuntary placement, the administrator of the facility must file a petition for involuntary placement with the court within two court working days after the request for discharge is made. If the petition is not filed within two court working days, the person must be discharged.

Discharge of Persons on Voluntary Status

s.394.4625(2), F.S.

A facility must discharge a person on voluntary status:

1. Who has *sufficiently improved* so that retention in the facility is no longer clinically appropriate. A person may also be discharged to the care of a community facility.
2. Who *requests discharge*. A person on voluntary status or a relative, friend, or attorney of the person may request discharge either orally or in writing at any time following admission to the facility.

The person must be discharged within 24 hours of the request, unless the request is rescinded or the person is transferred to involuntary status. The 24-hour time period may be extended by a treatment facility (which generally is a state hospital) when necessary for adequate discharge planning, but must not exceed three days exclusive of weekends and holidays.

3. A person on voluntary status who has been admitted to a facility and who *refuses to consent to or revokes consent to treatment* must be discharged within 24 hours after such refusal or revocation unless transferred to involuntary status or unless the refusal or revocation is freely and voluntarily rescinded by the person.

Involuntary Examination

s. 394.463, F.S. Chapter 65E-5.280, F.A.C.

Criteria

s. 394.463(1), F.S.

A person may be taken to a receiving facility for involuntary examination if there is reason to believe that he or she has a mental illness (as defined in the Baker Act) and because of his or her mental illness:

1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or the person is unable to determine whether examination is necessary; and
- 2a) Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or
- b) There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to self or others in the near future, as evidenced by recent behavior.

Initiation of Involuntary Examination

s. 394.463(2), F.S.

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

1. A *court may* enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The ex parte order for involuntary examination must be *based on sworn testimony*, written or oral. No fee can be charged for the filing of a petition for an order for involuntary examination.

A law enforcement officer, or other designated agent of the court, must take the person into custody and deliver him or her to the nearest receiving facility for involuntary examination. A law enforcement officer acting in accordance with an ex parte order may serve and execute such order on any day of the week, at any time of the day or night. A law enforcement officer acting in accordance with an ex parte order may use such reasonable physical force as is necessary to gain entry to the premises, and any dwellings, buildings, or other structures located on the premises, and to take custody of the person who is the subject of the ex parte order.

The officer must execute a written report entitled "Transportation to a Receiving Facility" detailing the circumstances under which the person was taken into custody, and the report must be made a part of the person's clinical record. [65E-5.260, FAC]

The ex parte order is valid only until executed or, if not executed, for the period specified in the order itself. If no time limit is specified in the order, the order is valid for seven days after the date that the order was signed. Once a person is picked up on the order and taken to a receiving facility for involuntary examination and released, the same order cannot be used again during the time period. The order of the court must be made a part of the person's clinical record.

2. A *law enforcement officer must* take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to the nearest receiving facility for examination. The officer must execute a written report detailing the *circumstances* (doesn't require observations) under which the person was taken into custody, and the report must be made a part of the person's clinical record.
3. A *physician, clinical psychologist, clinical social worker, mental health counselor, marriage and family therapist, or psychiatric nurse* (each as defined in the Baker Act) may execute a certificate (CF-MH 3052b) stating that

he or she has examined the person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the *observations of the authorized professional* upon which that conclusion is based. A law enforcement officer must take the person named in the certificate into custody and deliver him or her to the nearest receiving facility for involuntary examination. The law enforcement officer must execute a written report detailing the circumstances under which the person was taken into custody. The report and certificate must be made a part of the person's clinical record. (While not authorized by statute, Florida's Attorney General wrote on May 28, 2008 that physician assistants could under specific circumstances initiate Baker Act involuntary examinations.)

Definitions of Professionals

s. 394.455, F.S.

Physician means a medical practitioner licensed under Chapter 458 or Chapter 459 who has experience in the diagnosis and treatment of mental and nervous disorders or a physician employed by a facility operated by the United States Department of Veterans Affairs which qualifies as a receiving or treatment facility under this part. (21)

Psychiatrist means a medical practitioner licensed under Chapter 458 or Chapter 459 who has primarily diagnosed and treated mental and nervous disorders for a period of not less than three years, inclusive of psychiatric residency. (24)

Clinical psychologist means a psychologist as defined in s. 490.003(3) 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 under this part. (2)

Clinical social worker means a person licensed as a clinical social worker under Chapter 491. (4)

Mental health counselor means a person licensed as a mental health counselor under Chapter 491. (37)

Marriage and family therapist means a person licensed as a marriage and family therapist under Chapter 491 (36)

Psychiatric nurse means a registered nurse licensed under Chapter 464 who has a master's degree or a doctorate in psychiatric nursing and two years of post-master's clinical experience under the supervision of a physician. (23)

Selected Procedures

s. 394.463(2), F.S.

Any receiving facility accepting a person based on a court's ex parte order, law enforcement officer's report or a professional's certificate must send a copy of the document with the required cover sheet to the Agency for Health Care Administration (via the Baker Act Reporting Center) on the next working day.

BA Reporting Center, FMHI

13301 Bruce B. Downs Blvd. MHC 2637

Tampa, FL 33612-3807

A person can't be removed from any long-term care program or residential placement licensed under Chapter 400/429, F.S. and transported to a receiving facility for involuntary examination unless an ex parte order, a Law Enforcement Officer's report, or a Professional's Certificate is first prepared. If the condition of the person is such that preparation of a law enforcement officer's report is not practicable before removal, the report must be completed as soon as possible after removal, but in any case before the person is transported to a receiving facility. A receiving facility admitting a person for involuntary examination who is not accompanied by the required ex parte order, professional certificate, or law enforcement officer's report must notify AHCA of the admission by certified mail no later than the next working day.

Involuntary Examination

s. 394.463(2)(f), F.S. Chapter 65E-5.2801, F.A.C.

A person must receive an initial mandatory examination by a physician or clinical psychologist at a receiving facility without unnecessary delay. This initial mandatory involuntary examination must include:

1. A thorough review of any observations of the person's recent behavior;
2. A review of the document initiating the involuntary examination and the transportation form;
3. A brief psychiatric history; and
4. A face-to-face examination of the person in a timely manner to determine if the person meets criteria for release.

The person can't be released by a receiving facility without the documented approval of a psychiatrist, clinical psychologist, or physician in the hospital's emergency department. However, a person may not be held in a receiving facility for involuntary examination longer than 72 hours. The person must be given prompt opportunity to notify others of his or her whereabouts.

Release

s. 394.463(2)(i), F.S.

Within the 72-hour examination period, one of the following three actions must be taken based on the individual needs of the person:

1. The person must be **released** unless he or she is charged with a crime, in which case the person must be returned to the custody of a law enforcement officer; or
2. The person, unless he or she is charged with a crime, must be asked to give express and informed consent to placement on **voluntary** status, and, if such consent is given, the person must be voluntarily admitted. Such transfer from involuntary to voluntary status must be conditioned on the certification by a physician that the person has the capacity to make well-reasoned, willful, and knowing decisions about mental health and medical issues; or
3. ***Apetition for involuntary placement*** must be completed within 72 hours and be filed with the circuit court within the 72 hours. If the 72 hours ends on a weekend or holiday, the filing must be no later than the next working day thereafter.

Notice of Discharge or Release

s. 394.463(3), F.S. s. 394.469(2), F.S.

Notice of discharge or transfer of a person must be given as provided in s. 394.4599, F.S. Notice of the release must be given to the person's guardian or representative, to any person who executed a certificate admitting the person to the receiving facility, and to any court that ordered the person's evaluation.

Reporting to AHCA

394.463(2)(a)

Any receiving facility accepting a person for involuntary examination must send the BA Reporting Center cover sheet (3118) and copy of completed initiating form:

- Ex Parte Petition/Order, or
- Report of Law Enforcement Officer, or
- Certificate of a Professional

All court orders for Involuntary Placement must also be sent to the BA Reporting Center within 1 day, including:

- Involuntary Inpatient Placement Order
- Involuntary Outpatient Placement Order
- Continued Involuntary Outpatient Order

Receiving facilities must report directly to AHCA by certified mail within one working day any long-term care facility licensed under chapter 400/429, F.S. that does not fully comply with Baker Act provisions governing voluntary admissions, involuntary examinations, or transportation.

Transportation of Persons for Involuntary Examination

394.462, F.S. 65E-5.260, FAC

Law enforcement has no responsibility to transport persons for voluntary admission. Neither is law enforcement responsible for transferring persons from a hospital ER where they may have been medically examined or treated to a Baker Act receiving facility. In the latter case, the person's transfer is the responsibility of the sending hospital, pursuant to the Federal EMTALA law.

Regardless of whether the involuntary examination is initiated by the courts, law enforcement, or an authorized mental health professional, law enforcement is responsible for transporting the person to the **nearest** receiving facility for the examination.

A law enforcement agency **may decline** to transport a person to a receiving facility **only if**:

1. The county has contracted for transportation at the sole cost to the county, and the law enforcement officer and medical transport service agree that the ***continued presence of law enforcement personnel*** is not expected to be necessary for the safety of the person to be transported or others. This statute requires the law enforcement officer to report to the scene, assess the risk circumstances, and, if appropriate, to "consign" the person to the care of the transport company. This includes nursing homes and ALF's, but not hospitals.

When a jurisdiction has entered into a county-funded contract with a transport service for transportation of persons to receiving facilities, such service must be given preference for transportation of persons from nursing homes, assisted living facilities, adult day care centers, or adult family care homes, unless the behavior of the person being transported is such that transportation by a law enforcement officer is necessary.

2. When a law enforcement officer takes custody of a person under the Baker Act, the officer may request assistance from emergency medical personnel if such assistance is needed for the safety of the officer or the person in custody.

If the law enforcement officer believes that a person has an emergency medical condition, the person may be first transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated receiving facility.

An emergency medical condition is defined in Chapter 395, F.S. as a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that absence of immediate medical attention could reasonably be expected to

result in serious jeopardy to patient health (including pregnant women and their fetus), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Once the person is delivered by law enforcement to a hospital for emergency medical examination or treatment and the person is placed in the hospital's care, the officer's responsibility for the person is over, assuming no criminal charges are pending.

Eventual transfer of the person from the hospital offering emergency medical treatment to the designated receiving facility for an involuntary examination under the Baker Act is the responsibility of the referring hospital, unless other appropriate arrangements have been made.

Other than when an emergency medical condition exists, the person must be delivered to the nearest designated receiving facility – not to an emergency room that might be more convenient to the law enforcement officer, unless a Transportation Exception Plan has been approved by the Board of County Commissioners and the Secretary of DCF. If the person requires transfer to a different facility for specialized care, the sending facility is responsible for arranging safe and appropriate transportation.

3. When a mental health professional member of a state funded mental health overlay program or mobile crisis response service (as defined in the statute) evaluates a person and determines that transportation to a receiving facility is needed, the service, at its discretion, may transport the person to the facility or may call law enforcement or make other transportation arrangements best suited to the needs of the person.
4. When a transportation exception plan meeting the criteria set out in s. 394.462 (4), F.S. has been approved by Board of County Commissioners and the Secretary of the Department of Children and Families.

The nearest receiving facility must accept persons brought by law enforcement officers for involuntary examination. [s. 394.462(1)(j), F.S.] This means that the law enforcement officer will never be legally obligated to further transport a person once presented to the nearest receiving facility or a hospital.

Persons with Criminal Charges

394.462, F.S. 65E-5.260, FAC

When an officer has custody of a person based on either non-criminal or minor criminal behavior that meets the statutory guidelines for involuntary examination under the Baker Act, the law enforcement officer must transport the person to the nearest receiving facility for examination.

When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under the Baker Act, such person must first be processed in the same manner as any other criminal suspect.

A receiving facility is not required to admit a person charged with felony charges for whom the facility determines and documents that it is unable to provide adequate security, but must provide mental health examination and treatment to the person where he or she is held. No person brought to a receiving facility on involuntary status who is charged with a crime can be released except back to the custody of a law enforcement officer.

The costs of transportation, evaluation, hospitalization, and treatment incurred by persons who have been arrested for violations of any state law or county or municipal ordinance may be recovered as provided in s. 901.35, F.S.

Weapons Prohibited on the Grounds of a Hospital Providing Mental Health Services

394.458, F.S.

Except as authorized by law or hospital administrator, firearms or deadly weapons cannot be brought into a hospital providing mental health services. Law enforcement officers may choose to lock their firearms in their vehicle prior to entering such a hospital or may place the firearms in a lock-box at the hospital, if one exists.

Paperwork Required by the Baker Act

394.462, F.S. 394.463, F.S. 65E-5.280, FAC

A law enforcement officer must execute a written report detailing the circumstances under which the person was taken into custody and the report must be made a part of the person's clinical record. A mandatory form entitled "Transportation to Receiving Facility" (form CF-MH 3100) has been developed to serve this purpose. An officer should not simply transport a person and leave him or her at a receiving facility for involuntary examination under the Baker Act unless the examination has been previously initiated by a court, an authorized mental health professional, or a law enforcement officer.

If the officer takes an individual to an ED due to a medical emergency after initiating the involuntary examination, the “Report of Law Enforcement Officer Initiating Involuntary Examination” must be submitted to hospital personnel to accompany the person to a receiving facility as well as the transport form.

If the officer was only transporting a person whose involuntary examination was initiated by a court or mental health professional, the officer must submit the court’s Ex Parte Order or the Certificate of Professional Initiating Involuntary Examination, along with the “Transportation to a Receiving Facility” form completed by the law enforcement officer which will be made a part of the person’s clinical record.

Involuntary Placement

s. 394.467 & .4655, F.S. s. 65E-5.290 & .285, FAC

A person may be ordered for ***Involuntary Inpatient Placement*** upon a finding of the court by clear and convincing evidence that he or she has a mental illness and because of his or her mental illness:

1. She/he has refused voluntary placement or is unable to determine whether placement is necessary; and
2. She/he is incapable of surviving alone or with the help of others and without treatment is likely to suffer from neglect which poses a real and present threat of substantial harm to his or her well-being; ***or***
3. There is substantial likelihood that in the near future she/he will inflict serious bodily harm on self or other person, as evidenced by recent behavior causing, attempting, or threatening such harm; ***and***
4. All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

An adult may be involuntarily ordered for ***Involuntary Outpatient Placement*** upon a finding of the court by clear and convincing evidence that he or she has a mental illness ***and*** because of his or her mental illness:

1. The person is unlikely to survive safely in the community without supervision, based on a clinical determination;
2. The person has a history of lack of compliance with treatment for mental illness;
3. The person has:
 - a. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving or treatment facility as defined in s. 394.455, or

has received mental health services in a forensic or correctional facility. The 36-month period does not include any period during which the person was admitted or incarcerated; or

- b. Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others, within the preceding 36 months;
4. The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary;
5. In view of the 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 himself or herself or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1);
6. It is likely that the person will benefit from involuntary outpatient placement; and
7. 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.

Within 72 hours of arrival at facility, or if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, a petition for involuntary inpatient placement ***must*** be filed by the receiving facility administrator (or petition for involuntary outpatient placement ***may*** be filed) and supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the person within the preceding 72 hours, that the criteria for involuntary placement are met (in certain rural counties the second opinion may be provided by a physician or psychiatric nurse, both with special training and experience as defined in the statute). The second opinion may be done by electronic means.

The public defender will be appointed by the court to represent the person unless otherwise represented by private counsel. The state attorney represents the state, rather than the petitioning facility administrator, as the real party in interest in the proceeding. The court will order an independent expert examination if requested by the person.

The court is required to hold the involuntary placement hearing within five (5) court working days unless a continuance is requested by the person with concurrence of counsel and granted by the court. The court may appoint a magistrate to preside at the hearing. One of the two professionals who executed the involuntary placement petition must testify at the hearing. The person's attendance at the hearing may be waived and the person may refuse to testify. All testimony must be given under oath and recorded. At the hearing, the court must consider testimony and evidence regarding the person's competence to consent to treatment. If the court finds that the person is incompetent to consent to treatment, it must appoint a guardian advocate.

If the court concludes that the person, by clear and convincing evidence, meets the criteria for involuntary inpatient placement, it must order the person to be retained at or transferred to, or be treated at or by an appropriate receiving or treatment facility on an involuntary basis, for a period of up to 6 months. The Florida Supreme Court has defined "clear and convincing evidence" as that which 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.

A petition for involuntary *outpatient* placement can only be filed by an administrator of a receiving or treatment facility -- if by a receiving facility it must be filed in the county where the facility is located -- if by a state hospital administrator, it must be filed in the county where the person will be living. In either case, a service provider must be designated to develop with the person a proposed treatment plan (that meets specific criteria) for the court's consideration and attach the proposed plan to the petition. The service provider cannot propose nor can the court order services unless they are readily available for the person in the community, funded, determined by an authorized mental health professional to be clinically appropriate, and for which the service provider agrees to deliver.

A person can be held at a receiving facility pending the court hearing on involuntary *outpatient* placement unless stabilized in which case the person must be released pending the hearing.

If material modifications later need to be made to the involuntary *outpatient* placement order or approved treatment plan and there are no objections, the court must be notified. If there are objections to proposed material changes, the court must consider whether or not to approve those changes.

If in the clinical judgment of a *physician*, the person has failed or refused to comply with involuntary *outpatient* treatment ordered by the court and efforts were made to solicit compliance, and the person meets criteria for involuntary examination, the person may be brought to a receiving facility. If the person doesn't meet the criteria for involuntary *inpatient* placement, the person must be discharged from the receiving facility. The service provider must then determine if modifications should be made to the existing treatment plan and try to continue to engage the person in treatment.

Continued Involuntary Placement

s. 394.4655(7), F.S. Ch. 65E-5.285(4), FAC

If a person continues to meet the criteria for involuntary placement, the administrator is required, prior to the expiration of the period during which the treatment facility is authorized to retain the person or a service provider is authorized to treat the person, to file a petition requesting authorization for continued involuntary placement. The request must be accompanied by a statement from the person's physician or clinical psychologist justifying the request, a brief description of the person's treatment during the time he/she was involuntarily placed, and an individualized plan of continued treatment.

Hearings on petitions for continued involuntary *inpatient* placement are administrative rather than judicial hearings and are conducted by an administrative law judge.

Hearings on petitions for continued involuntary *outpatient* placement are judicial and are conducted by the circuit court. Unless the person is otherwise represented by private counsel, he/she will be represented at the hearing by the public defender. If at a hearing it is shown that the person continues to meet the criteria for involuntary placement, the judge will sign the order for continued involuntary placement for a period not to exceed 6 months. The same procedure can be repeated prior to the expiration of each additional period the person is retained.

The 5DCA ruled that within the six month maximum period of an order for involuntary inpatient placement that the circuit court has concurrent jurisdiction over commitment proceedings. After the six month period expires, all placements must be handled through administrative hearings.

Discharge of Persons on Involuntary Status

s. 394.469, F.S. Ch. 65E-5.320, FAC

Receiving and treatment facilities, as well as service providers, are required to discharge a person at any time the person no longer meets the criteria for involuntary placement, unless the person has transferred, by express and informed consent, to voluntary status. If the person being discharged is under a criminal charge, he or she must be transferred to the custody of the appropriate law enforcement agency at the time of release.

Transfers

s. 394.4685, F.S. Ch. 65E-5.310, FAC

Transfers of persons with emergency medical conditions (including psychiatric and substance abuse emergencies) from hospital emergency departments are governed by the federal EMTALA “anti-dumping” law and Florida’s hospital licensing law. If a person requires transfer from a hospital emergency department that has provided the person evaluation or treatment for an emergency medical condition to a Baker Act receiving facility, the transfer must take place within 12 hours after the condition has stabilized. Otherwise, under provisions of the Baker Act governing transfers between designated receiving and treatment facilities, transfers may occur:

- Between public facilities, upon the request of the person or specified others or upon the discretion of the department to meet the medical or mental health treatment needs of the person or the availability of appropriate facility resources.
- From public to private facilities, upon request of the person, guardian or guardian advocate and upon acceptance of the person by the private facility.
- From private to public facilities upon request of the person, guardian, guardian advocate, or private facility, and upon acceptance of the person by the public facility. The public facility must respond to a request for the transfer within 2 working days after receiving the request. The cost of such transfer requested by a private facility is the responsibility of the sending facility.
- Between private facilities upon request of the person, guardian, or guardian advocate, and upon acceptance of the person by the facility to which transfer is sought.

Oversight

s. 394.457, F.S.

The Department of Children and Family Services (DCF) is designated the “Mental Health Authority” of Florida. The Department and the Agency for Health Care Administration (AHCA) exercise executive and administrative supervision over all mental health facilities, programs, and services.

DCF is required to report to AHCA any violation of the rights or privileges of persons, or of any procedure provided by any facility or professional licensed or regulated by AHCA.

DCF is required to adopt rules establishing forms and procedures relating to the rights and privileges of persons seeking mental health treatment from designated receiving and treatment facilities. Unless designated by DCF, facilities are not permitted to hold or treat persons on involuntary status.

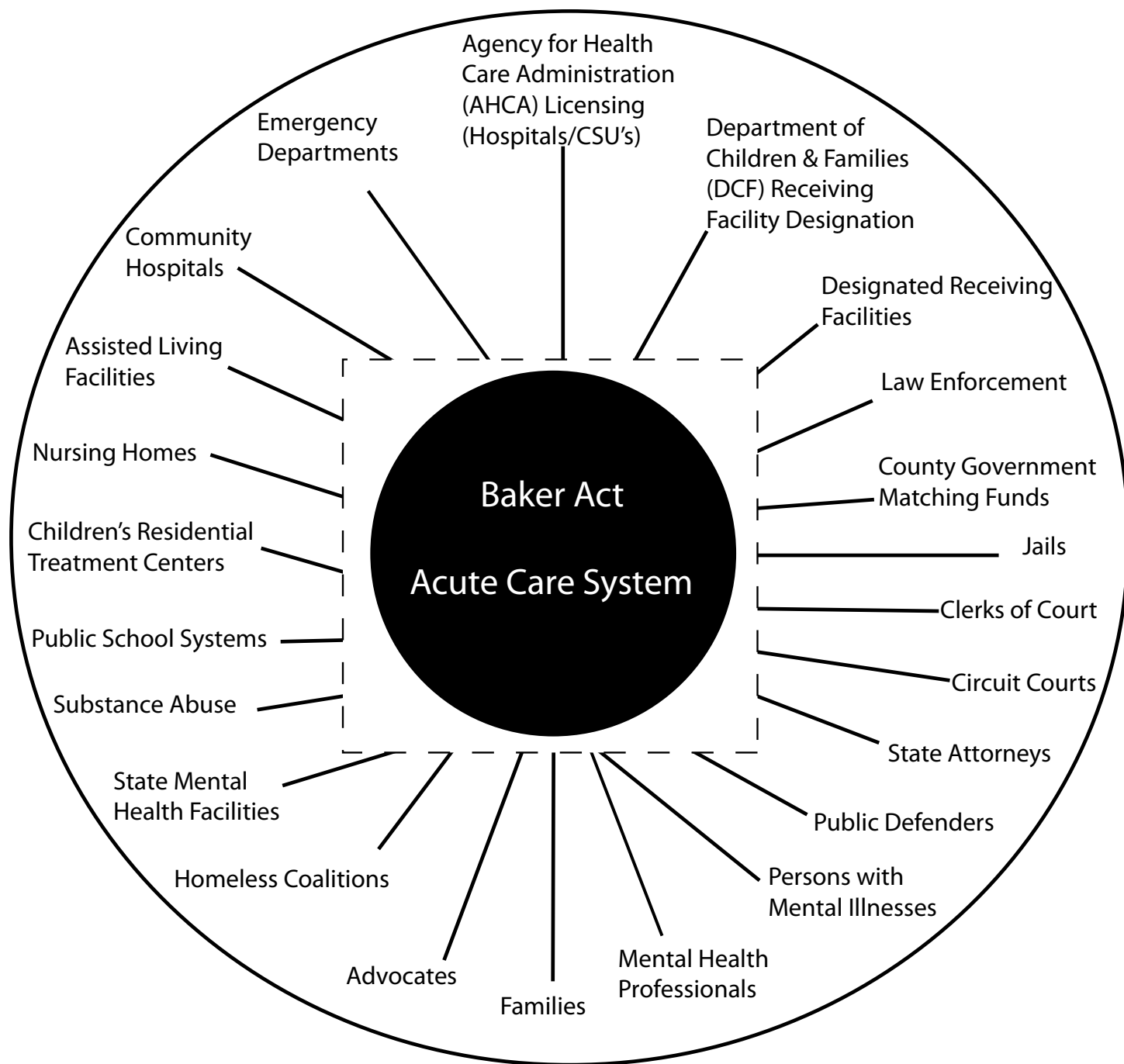
Disability Rights Florida (formerly known as the Advocacy Center for Persons with Disabilities) is a private nonprofit organization that receives federal funding to protect and advocate for the rights of persons who have disabilities. Disability Rights Florida prioritizes services to people with psychiatric disabilities in institutional inpatient and residential treatment settings. Some services are provided to those living independently as resources allow. Services to individuals include information and referrals, self advocacy support, technical assistance, investigations into complaints of abuse, neglect and rights violations, support in dispute resolution, negotiation and mediation, as well as advocacy services. Statewide initiatives include workshops and trainings, education of policymakers, systemic and legal advocacy, collaborative work on disability rights issues and the monitoring of public programs and facilities. Disability Rights Florida has offices in Tallahassee, Tampa, and Ft. Lauderdale, from which it serves the entire state of Florida. Contact can be made through www.disabilityrightsflorida.org or 1-800-342-0823. (1-800-346-4127 TDD).

Immunity

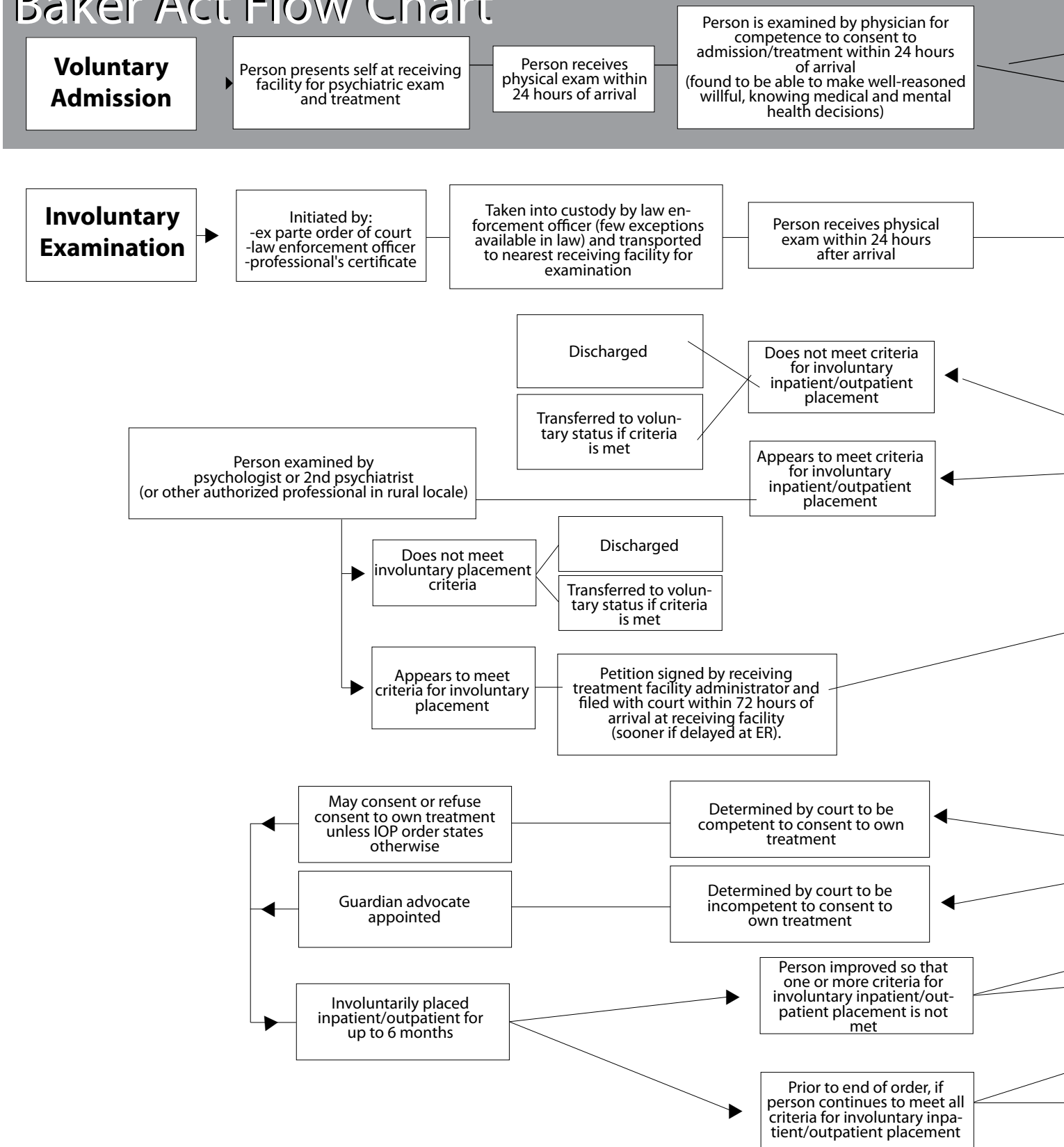
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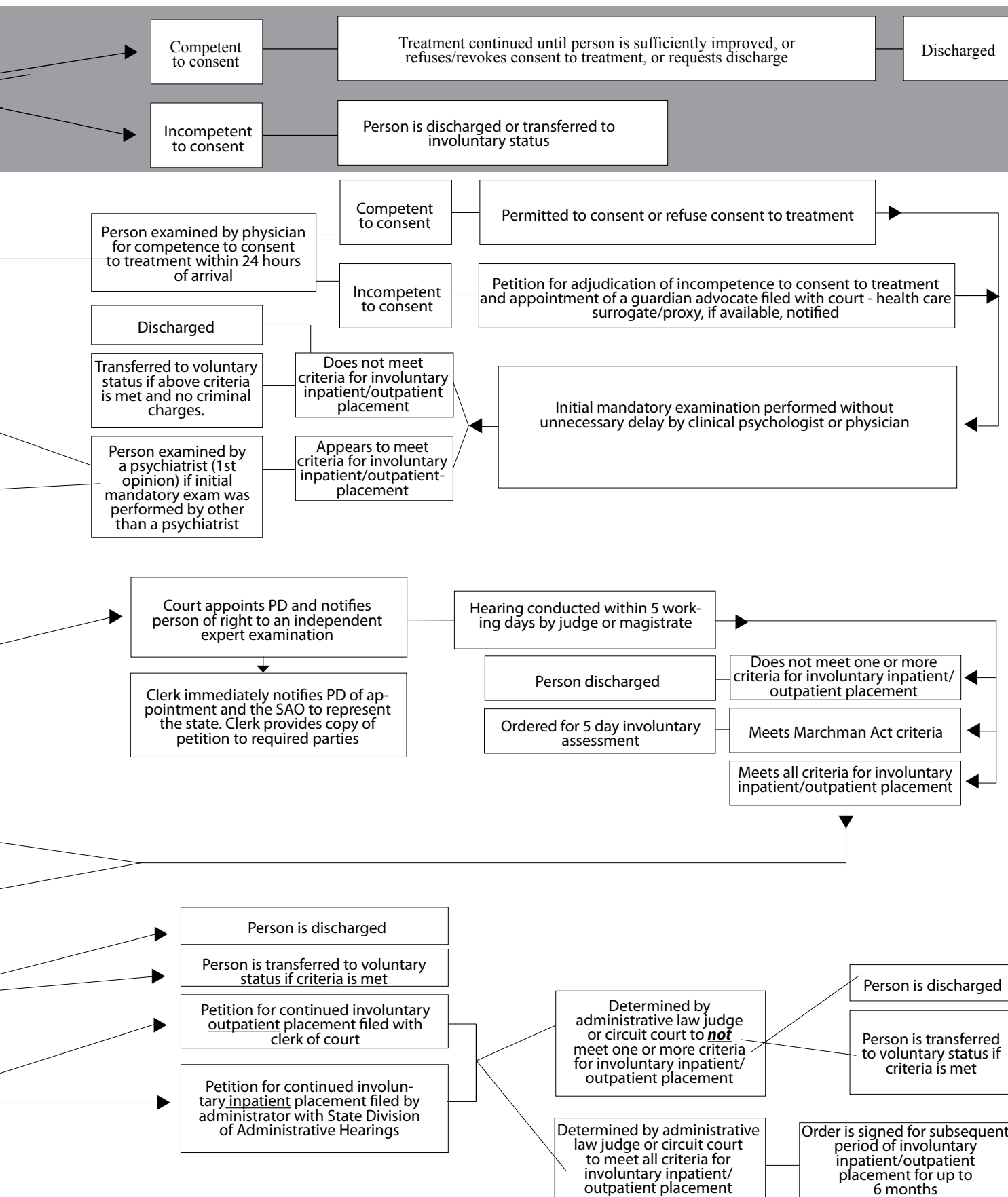
Any person who acts in good faith in compliance with the provisions of the Baker Act is immune from civil or criminal liability for his or her actions in connection with the admission, diagnosis, treatment, or discharge of a person to or from a facility. However, this section does not relieve any person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

Continuity of Care - Relationships



Baker Act Flow Chart





Statute & Rule Matrix — Florida Mental Health Act (Baker Act)

Statute Contents	Corresponding Rule Section	Page
394.451 Short title	N/A	1
394.453 Legislative intent	N/A	1
394.455 Definitions	65E-5.100 Definitions	2
394.457 Operation and administration	65E-5.110 Delegation of Authority	7
	65E-5.120 Forms	8
394.4572 Screening of mental health personnel	N/A	11
394.4573 Continuity of care management system; measures of performance; reports	65E-5.130 Continuity of Care Management System	12
	65E-5.1301 Transfer Evaluations for Admission to State Mental Health Treatment Facilities from Receiving Facilities	13
	65E-5.1302 Admissions to State Treatment Facilities	15
	65E-5.1303 Discharge from Receiving and Treatment Facilities	15
394.4574 Department responsibilities for a mental health resident who resides in an assisted living facility that holds a limited mental health license	N/A	18
394.458 Introduction or removal of certain articles unlawful; penalty	N/A	20
394.459 Rights of patients	65E-5.140 Rights of Persons.	21
	65E-5.150 Person's Right to Individual Dignity	22
	65E-5.160 Right to Treatment	23
	65E-5.1601 General Management of the Treatment Environment	24
	65E-5.1602 Individual Behavioral Management Programs	25
	65E-5.170 Right to Express and Informed Consent	26
	65E-5.1703 Emergency Treatment Orders	32
	65E-5.180 Right to Quality Treatment	35
	65E-5.1802 Maintenance of the Facility	50
	65E-5.190 Right to Communication and Visits	51
	65E-5.200 Right to Care and Custody of Personal Effects	53
	65E-5.210 Right to Vote in Public Elections	53
	65E-5.220 Right to Habeas Corpus	54
	65E-5.601 Operation and Administration of State Mental Health Treatment Facilities	54
	65E-5.602 Rights of Residents of State Mental Health Treatment Facilities	55
394.4593 Sexual misconduct prohibited; reporting required; penalties	N/A	58
394.4595 Florida statewide and local advocacy councils; access to patients and records (Defunded by 2010 Legislature)	N/A	60
394.4597 Persons to be notified; patient's representative		61
394.4598 Guardian advocate	65E-5.230 Guardian Advocate	62
	65E-5.2301 Health Care Surrogate or Proxy	64

Statute Contents	Corresponding Rule Section	Page
394.4599 Notice	N/A	65
394.460 Rights of professionals	N/A	67
394.461 Designation of receiving and treatment facilities	65E-5.350 Eligibility Criteria and Procedures for Designation of Baker Act Receiving Facilities	67
	65E-5.351 Minimum Standards for Designated Receiving Facilities	73
	65E-5.352 Procedures for Complaints and Investigations in Receiving Facilities	74
	65E-5.353 Criteria and Procedures for Suspension or Withdrawal of Designation of Receiving Facilities	75
394.4612 Integrated adult mental health crisis stabilization and addictions receiving facilities	N/A	76
394.4615 Clinical records; confidentiality	65E-5.250 Clinical Records; Confidentiality	77
394.462 Transportation	65E-5.260 Transportation	80
	65E-5.2601 Transportation Exception Plan	84
394.4625 Voluntary admissions	65E-5.270 Voluntary Admission	85
394.463 Involuntary examination	65E-5.280 Involuntary Examination	89
	65E-5.2801 Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S	91
394.4655 Involuntary outpatient placement	65E-5.285 Involuntary Outpatient Placement	95
394.467 Involuntary inpatient placement	65E-5.290 Involuntary Inpatient Placement	107
	65E-5.300 Continued Involuntary Inpatient Placement at Treatment Facilities	111
394.46715 Rulemaking authority	N/A	113
394.4672 Procedure for placement of veteran with federal agency	N/A	113
394.468 Admission and discharge procedures	N/A	115
394.4685 Transfer of patients among facilities	65E-5.310 Transfer of Persons Among Facilities	116
394.469 Discharge of involuntary patients	65E-5.320 Discharge of Persons on Involuntary Status	118
394.473 Attorney's fee; expert witness fee	N/A	117
394.475 Acceptance, examination, and involuntary placement of Florida residents from out-of-state mental health authorities	N/A	118
394.4784 Minors; access to outpatient crisis intervention services and treatment	N/A	119
394.4785 Children and adolescents; admission and placement in mental facilities	N/A	120
394.47891 Military veterans and service members court programs	N/A	121
	65E-5.330 Training	122
	65E-5.400 Baker Act Funded Services Standards	123

*The following sections of Chapter 394,FS (Baker Act) have been intentionally omitted from this matrix and the sections that follow: 394.4674 – Plan and report; 394.4781 – Residential care for psychotic and emotionally disturbed children; 394.4786 – Intent; 394.47865 – South Florida State Hospital; privatization; 394.4787 – Definitions; ss. 394.4786, 394.4787, 394.4788, and 394.4789; 394.4788 – Use of certain PMATF funds for the purchase of acute care mental health services; and 394.4789 – Establishment of referral process and eligibility determination.

394.451 Short title.

This part shall be known as “The Florida Mental Health Act” or “The Baker Act.”

394.453 Legislative intent.

It is the intent of the Legislature to authorize and direct the Department of Children and Family Services to evaluate, research, plan, and recommend to the Governor and the Legislature programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders. It is the intent of the Legislature that treatment programs for such disorders shall include, but not be limited to, comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment in order to encourage them to assume responsibility for their treatment and recovery. It is intended that such persons be provided with emergency service and temporary detention for evaluation when required; that they be admitted to treatment facilities on a voluntary basis when extended or continuing care is needed and unavailable in the community; that involuntary placement be provided only when expert evaluation determines that it is necessary; that any involuntary treatment or examination be accomplished in a setting which is clinically appropriate and most likely to facilitate the person's return to the community as soon as possible; and that individual dignity and human rights be guaranteed to all persons who are admitted to mental health facilities or who are being held under s. 394.463. It is the further intent of the Legislature that the least restrictive means of intervention be employed based on the individual needs of each person, within the scope of available services. It is the policy of this state that the use of restraint and seclusion on clients is justified only as an emergency safety measure to be used in response to imminent danger to the client or others. It is, therefore, the intent of the Legislature to achieve an ongoing reduction in the use of restraint and seclusion in programs and facilities serving persons with mental illness.

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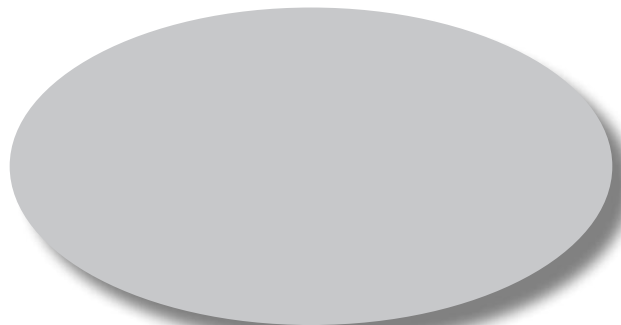
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N/A



Receiving facilities are governed by other federal and state laws or accreditation standards as well as their own policies and procedures. When in conflict, whichever applies to a facility and is most stringent and/or protective of the person's rights should be followed.

Statute

(Chapter 394.455 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.100 F.A.C.

394.455 Definitions.

As used in this part, unless the context clearly requires otherwise, the term:

- (1) “**Administrator**” means the chief administrative officer of a receiving or treatment facility or his or her designee.
- (2) “**Clinical psychologist**” means 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 under this part.
- (3) “**Clinical record**” means all parts of the record required to be maintained and includes all medical records, progress notes, charts, and admission and discharge data, and all other information recorded by a facility which pertains to the patient’s hospitalization or treatment.
- (4) “**Clinical social worker**” means a person licensed as a clinical social worker under chapter 491.
- (5) “**Community facility**” means any community service provider contracting with the department to furnish substance abuse or mental health services under part IV of this chapter.
- (6) “**Community mental health center or clinic**” means a publicly funded, not-for-profit center which contracts with the department for the provision of inpatient, outpatient, day treatment, or emergency services.
- (7) “**Court**,” unless otherwise specified, means the circuit court.
- (8) “**Department**” means the Department of Children and Family Services.
- (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.
- (10) “**Facility**” means any hospital, community facility, public or private facility, or receiving or

65E-5.100 Definitions.

As used in this chapter the following words and phrases have the following definitions:

- (1) **Advance directive** means a witnessed written document described in Section 765.101, F.S.
- (2) **Assessment** means the systematic collection and integrated review of individual-specific data. It is the process by which individual-specific information such as examinations and evaluations are gathered, analyzed, monitored and documented to develop the person’s individualized plan of treatment and to monitor recovery. Assessment specifically includes efforts to identify the person’s key medical and psychological needs, competency to consent to treatment, patterns of a co-occurring mental illness and substance abuse, as well as clinically significant neurological deficits, traumatic brain injury, organicity, physical disability, developmental disability, need for assistive devices, and physical or sexual abuse or trauma.
- (3) **Certified recovery specialist** means an individual credentialed by the Florida Certification Board as a Certified Recovery Peer Specialist, Certified Recovery Peer Specialist – Adult, Certified Recovery Peer Specialist – Family, Certified Recovery Peer Specialist – Veteran, or Certified Recovery Support Specialist.
- (4) **Discharge plan** means the plan developed with and by the person which sets forth how the person will meet his or her needs, including living arrangements, transportation, aftercare, physical health, and securing needed psychotropic medications for the post-discharge period of up to 21 days.
- (5) **Emergency treatment order (ETO)** means a written emergency order for psychotropic medications, as described in Rule 65E-5.1703, F.A.C.; or a written emergency order for seclusion or restraint, as described in subsection (7) of Rule 65E-5.180, F.A.C.
- (6) **Examination** means the integration of the physical examination required under Section 394.459(2), F.S., with other diagnostic activities to determine if the person is medically stable and to rule out abnormalities of thought, mood, or behavior that mimic psychiatric symptoms but are due to non-psychiatric medical causes such as disease, infection, injury, toxicity, or metabolic disturbances. Examination includes the identification of person-

Definitions

Statute

(Chapter 394.455 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.100 F.A.C.

treatment facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who appear to have a mental illness or have been diagnosed as having a mental illness. "Facility" does not include any program or entity licensed pursuant to chapter 400 or chapter 429.

- (11) "**Guardian**" means the natural guardian of a minor, or a person appointed by a court to act on behalf of a ward's person if the ward is a minor or has been adjudicated incapacitated.
- (12) "**Guardian advocate**" means a person appointed by a court to make decisions regarding mental health treatment on behalf of a patient who has been found incompetent to consent to treatment pursuant to this part. The guardian advocate may be granted specific additional powers by written order of the court, as provided in this part.
- (13) "**Hospital**" means a facility as defined in s. 395.002 and licensed under chapter 395 and part II of chapter 408.
- (14) "**Incapacitated**" means that a person has been adjudicated incapacitated pursuant to part V of chapter 744 and a guardian of the person has been appointed.
- (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.
- (16) "**Law enforcement officer**" means a law enforcement officer as defined in s. 943.10.
- (17) "**Mental health overlay program**" means a mobile service which provides an independent examination for voluntary admissions and a range of supplemental onsite services to persons with a mental illness in a residential setting such as a nursing home, assisted living facility, adult family-care home, or nonresidential setting such as an adult day care center. Independent examinations provided pursuant to this part through a mental health overlay program must only be provided under contract with

specific risk factors for treatment such as elevated blood pressure, organ dysfunction, substance abuse, or trauma.

- (7) "**Health care proxy**" means a competent adult who has not been expressly designated by an advance directive to make health care decisions for a particular incapacitated individual, but is authorized pursuant to Section 765.401, F.S., to make health care decisions for such individual.
- (8) "**Health care surrogate**" means any competent adult expressly designated by a principal's advance directive to make health care decisions on behalf of the principal upon the principal's incapacity.
- (9) "**Person**" means an individual of any age, unless statutorily restricted, with a mental illness served in or by a mental health facility or service provider.
- (10) "**Personal Safety Plan**" is a form used to document information regarding calming strategies that the person identifies as being helpful in avoiding a crisis. The plan also lists triggers that are identified that may signal or lead to agitation or distress.
- (11) "**Pro re nata** (PRN)" means an individualized order for the care of an individual person which is written after the person has been seen by the practitioner, which order sets parameters for attending staff to implement according to the circumstances set out in the order. A PRN order shall not be used as an emergency treatment order.
- (12) "**Protective medical devices**" mean a specific category of medical restraint that includes devices, or combinations of devices, to restrict movement for purposes of protection from falls or complications of physical care, such as geri-chairs, posey vests, mittens, belted wheelchairs, sheeting, and bed rails. The requirements for the use and documentation of use of these devices are for specific medical purposes rather than for behavioral control.
- (13) "**Recovery Plan**" may also be referred to as a "service plan" or "treatment plan." A recovery plan is a written plan developed by the person and his or her recovery team to facilitate achievement of the person's recovery goals. This plan is based on assessment data, identifying the person's clinical, rehabilitative and activity service needs, the strategy for meeting those needs, documented treatment goals and objectives, and documented progress in meeting specified goals and objectives.
- (14) "**Recovery Team**" may also be referred to as "service team" or "treatment team." A recovery team is

Definitions

- the department for this service or be attached to a public receiving facility that is also a community mental health center.
- (18) **“Mental illness”** means an impairment of the mental or emotional processes that exercise conscious control of one’s actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person’s ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.
- (19) **“Mobile crisis response service”** means a nonresidential crisis service attached to a public receiving facility and available 24 hours a day, 7 days a week, through which immediate intensive assessments and interventions, including screening for admission into a receiving facility, take place for the purpose of identifying appropriate treatment services.
- (20) **“Patient”** means any person who is held or accepted for mental health treatment.
- (21) **“Physician”** means a medical practitioner licensed under chapter 458 or chapter 459 who has experience in the diagnosis and treatment of mental and nervous disorders or a physician employed by a facility operated by the United States Department of Veterans Affairs which qualifies as a receiving or treatment facility under this part.
- (22) **“Private facility”** means any hospital or facility operated by a for-profit or not-for-profit corporation or association that provides mental health services and is not a public facility.
- (23) **“Psychiatric nurse”** means a registered nurse licensed under part I of 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.
- (24) **“Psychiatrist”** means a medical practitioner licensed under chapter 458 or chapter 459 who has primarily diagnosed and treated mental and nervous disorders for a period of not less than 3

- an assigned group of individuals with specific responsibilities identified on the recovery plan who support and facilitate a person’s recovery process. Team members may include the person, psychiatrist, guardian/guardian advocate, community case manager, family member, peer specialist and others as determined by the person’s needs and preferences.
- (15) **Seclusion and Restraint Oversight Committee** is a group of staff members or volunteers that monitors the use of seclusion and restraint in a facility in order to assist in safely reducing the use of these practices. Members are selected by the administrator and include, but are not limited to, the administrator or designee, medical director or a physician designated by the medical director, quality assurance staff, and a certified recovery specialist, if available. If no certified recovery specialist is employed by the facility, a volunteer certified recovery specialist may be selected by the administrator.
- (16) **Standing order** means a broad protocol or delegation of medical authority that is generally applicable to a group of persons, hence not individualized. As limited by this chapter, it prohibits improper delegations of authority to staff that are not authorized by the facility, or not permitted by practice licensing laws, to independently make such medical decisions; such as decisions involving determination of need, medication, routes, dosages for psychotropic medication, or use of restraints or seclusion upon a person.

- years, inclusive of psychiatric residency.
- (25) **“Public facility”** means any facility that has contracted with the department to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose.
- (26) **“Receiving facility”** means any public or private facility designated by the department to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment. The term does not include a county jail.
- (27) **“Representative”** means a person selected to receive notice of proceedings during the time a patient is held in or admitted to a receiving or treatment facility.
- (28)(a) **“Restraint”** means a physical device, method, or drug used to control behavior. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the individual’s body so that he or she cannot easily remove the restraint and which restricts freedom of movement or normal access to one’s body.
- (b) A drug used as a restraint is a medication used to control the person’s behavior or to restrict his or her freedom of movement and is not part of the standard treatment regimen of a person with a diagnosed mental illness who is a client of the department. Physically holding a person during a procedure to forcibly administer psychotropic medication is a physical restraint.
- (c) Restraint does not include physical devices, such as orthopedically prescribed appliances, surgical dressings and bandages, supportive body bands, or other physical holding when necessary for routine physical examinations and tests; or for purposes of orthopedic, surgical, or other similar medical treatment; when used to provide support for the achievement of functional body position or proper balance; or when used to protect a person from falling out of bed.

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Statute

(Chapter 394.455 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5 F.A.C.

- (29) “**Seclusion**” means the physical segregation of a person in any fashion or involuntary isolation of a person in a room or area from which the person is prevented from leaving. The prevention may be by physical barrier or by a staff member who is acting in a manner, or who is physically situated, so as to prevent the person from leaving the room or area. For purposes of this chapter, the term does not mean isolation due to a person’s medical condition or symptoms.
- (30) “**Secretary**” means the Secretary of Children and Family Services.
- (31) “**Transfer evaluation**” means the process, as approved by the appropriate district office of the department, whereby a person who is being considered for placement in a state treatment facility is first evaluated for appropriateness of admission to the facility by a community-based public receiving facility or by a community mental health center or clinic if the public receiving facility is not a community mental health center or clinic.
- (32) “**Treatment facility**” means any state-owned, state-operated, or state-supported hospital, center, or clinic designated by the department for extended treatment and hospitalization, beyond that provided for by a receiving facility, of persons who have a mental illness, including facilities of the United States Government, and any private facility designated by the department when rendering such services to a person pursuant to the provisions of this part. Patients treated in facilities of the United States Government shall be solely those whose care is the responsibility of the United States Department of Veterans Affairs.
- (33) “**Service provider**” means any public or private receiving facility, an entity under contract with the Department of Children and Family Services to provide mental health services, a clinical psychologist, a clinical social worker, a marriage and family therapist, a mental health counselor, a physician, a psychiatric nurse as defined in subsection (23), or a community mental health center or clinic as defined in this part.

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- (34) “**Involuntary examination**” means an examination performed under s. 394.463 to determine if an individual qualifies for involuntary inpatient treatment under s. 394.467(1) or involuntary outpatient treatment under s. 394.4655(1).
- (35) “**Involuntary placement**” means either involuntary outpatient treatment pursuant to s. 394.4655 or involuntary inpatient treatment pursuant to s. 394.467.
- (36) “**Marriage and family therapist**” means a person licensed as a marriage and family therapist under chapter 491.
- (37) “**Mental health counselor**” means a person licensed as a mental health counselor under chapter 491.
- (38) “**Electronic means**” means a form of telecommunication that requires all parties to maintain visual as well as audio communication.

394.457 Operation and administration.

- (1) **ADMINISTRATION.** The Department of Children and Family Services is designated the “Mental Health Authority” of Florida. The department and the Agency for Health Care Administration shall exercise executive and administrative supervision over all mental health facilities, programs, and services.
- (2) **RESPONSIBILITIES OF THE DEPARTMENT.**
The department is responsible for:
- (a) The planning, evaluation, and implementation of a complete and comprehensive statewide program of mental health, including community services, receiving and treatment facilities, child services, research, and training as authorized and approved by the Legislature, based on the annual program budget of the department. The department is also responsible for the coordination of efforts

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Telepsychiatry

65E-5.110 Delegation of Authority.

In order to protect the health and safety of persons treated in or served by any receiving or treatment facility or any service provider, any delegation of an administrator’s authority pursuant to Chapter 394, F.S., or these rules shall be documented in writing prior to exercising the delegated authority. Routine delegations of authority shall be incorporated in the facility’s written policies.

with other departments and divisions of the state government, county and municipal governments, and private agencies concerned with and providing mental health services. It is responsible for establishing standards, providing technical assistance, and exercising supervision of mental health programs of, and the treatment of patients at, community facilities, other facilities for persons who have a mental illness, and any agency or facility providing services to patients pursuant to this part.

(b) The publication and distribution of an information handbook to facilitate understanding of this part, the policies and procedures involved in the implementation of this part, and the responsibilities of the various providers of services under this part. It shall stimulate research by public and private agencies, institutions of higher learning, and hospitals in the interest of the elimination and amelioration of mental illness.

(3) **POWER TO CONTRACT.** The department may contract to provide, and be provided with, services and facilities in order to carry out its responsibilities under this part with the following agencies: public and private hospitals; receiving and treatment facilities; clinics; laboratories; departments, divisions, and other units of state government; the state colleges and universities; the community colleges; private colleges and universities; counties, municipalities, and any other governmental unit, including facilities of the United States Government; and any other public or private entity which provides or needs facilities or services. Baker Act funds for community inpatient, crisis stabilization, short-term residential treatment, and screening services must be allocated to each county pursuant to the department's funding allocation methodology. Notwithstanding s. 287.057(3) (e), contracts for community-based Baker Act services for inpatient, crisis stabilization,

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short-term residential treatment, and screening provided under this part, other than those with other units of government, to be provided for the department must be awarded using competitive sealed bids if the county commission of the county receiving the services makes a request to the department's district office by January 15 of the contracting year. The district may not enter into a competitively bid contract under this provision if such action will result in increases of state or local expenditures for Baker Act services within the district. Contracts for these Baker Act services using competitive sealed bids are effective for 3 years. The department shall adopt rules establishing minimum standards for such contracted services and facilities and shall make periodic audits and inspections to assure that the contracted services are provided and meet the standards of the department.

- (4) **APPLICATION FOR AND ACCEPTANCE OF GIFTS AND GRANTS.** The department may apply for and accept any funds, grants, gifts, or services made available to it by any agency or department of the Federal Government or any other public or private agency or individual in aid of mental health programs. All such moneys shall be deposited in the State Treasury and shall be disbursed as provided by law.

(5) **RULES.**

- (a) The department shall adopt rules establishing forms and procedures relating to the rights and privileges of patients seeking mental health treatment from facilities under this part.
- (b) The department shall adopt rules necessary for the implementation and administration of the provisions of this part, and a program subject to the provisions of this part shall not be permitted to operate unless rules designed to ensure the protection of the health, safety, and welfare of the patients treated through such program have been adopted. Rules adopted under this subsection must include provisions governing the use of restraint and seclusion which are

65E-5.120 Forms.

All forms referred to in this chapter are available from the department's website, <http://www.dcf.state.fl.us/mentalhealth/laws/index.shtml>, by scrolling down to and clicking on "Baker Act Forms" under "Baker Act Handbook," or may be obtained from the department's district or regional mental health program offices. Single copies of all the forms or a disk containing electronic copies of all the forms are also available from district or regional offices. Recommended forms are those which are incorporated by reference because they provide a list of the information necessary to comply with the statutory and rule requirements. Mandatory forms are incorporated by reference and the specific form is required and may not be altered.

Links to the DCF website, including forms, can also be found at the Baker Act Reporting Center website: <http://bakeract.fmhi.usf.edu/>

consistent with recognized best practices	1
and professional judgment; prohibit inher-	2
ently dangerous restraint or seclusion pro-	3
cedures; establish limitations on the use and	4
duration of restraint and seclusion; establish	5
measures to ensure the safety of program	6
participants and staff during an incident of	7
restraint or seclusion; establish procedures	8
for staff to follow before, during, and after	9
incidents of restraint or seclusion; establish	10
professional qualifications of and training	11
for staff who may order or be engaged in	12
the use of restraint or seclusion; and estab-	13
lish mandatory reporting, data collection,	14
and data dissemination procedures and	15
requirements. Rules adopted under this	16
subsection must require that each instance	17
of the use of restraint or seclusion be docu-	18
mented in the record of the patient.	19
(c) The department shall adopt rules	20
establishing minimum standards for	21
services provided by a mental health overlay	22
program or a mobile crisis response service.	23
(6) PERSONNEL.	24
(a) The department shall, by rule, establish	25
minimum standards of education and	26
experience for professional and technical	27
personnel employed in mental health	28
programs, including members of a mobile	29
crisis response service.	30
(b) The department shall design and distribute	31
appropriate materials for the orientation	32
and training of persons actively engaged in	33
implementing the provisions of this part	34
relating to the involuntary examination and	35
placement of persons who are believed to	36
have a mental illness.	37
(7) PAYMENT FOR CARE OF PATIENTS.	38
Fees and fee collections for patients in state-	39
owned, state-operated, or state-supported	40
treatment facilities shall be according to s.	41
402.33.	42
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394.4572 Screening of mental health personnel.

- (1) (a) The department and the Agency for Health Care Administration shall require level 2 background screening pursuant to chapter 435 for mental health personnel. "Mental health personnel" includes all program directors, professional clinicians, staff members, and volunteers working in public or private mental health programs and facilities who have direct contact with individuals held for examination or admitted for mental health treatment. For purposes of this chapter, employment screening of mental health personnel also includes, but is not limited to, employment screening as provided under chapter 435 and s. 408.809.
- (b) Students in the health care professions who are interning in a mental health facility licensed under chapter 395, where the primary purpose of the facility is not the treatment of minors, are exempt from the fingerprinting and screening requirements if they are under direct supervision in the actual physical presence of a licensed health care professional.
- (c) A volunteer who assists on an intermittent basis for less than 10 hours per month is exempt from the fingerprinting and screening requirements if a person who meets the screening requirement of paragraph (a) is always present and has the volunteer within his or her line of sight.
- (d) Mental health personnel working in a facility licensed under chapter 395 who work on an intermittent basis for less than 15 hours per week of direct, face-to-face contact with patients, and who are not listed on the Department of Law Enforcement Career Offender Search or the Dru Sjodin National Sex Offender Public Website, are exempt from the fingerprinting and screening requirements, except that persons working in a mental health facility where the primary

N/A

Level 2 screening
for mental health personnel.
Required

Statute

(Chapter 394.4573 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.130 F.A.C.

purpose of the facility is the mental health treatment of minors must be fingerprinted and meet screening requirements.

- (2) The department or the Agency for Health Care Administration may grant exemptions from disqualification as provided in chapter 435.

394.4573 Continuity of care management system; measures of performance; reports.

- (1) For the purposes of this section:
- (a) “**Case management**” means those activities aimed at assessing client needs, planning services, linking the service system to a client, coordinating the various system components, monitoring service delivery, and evaluating the effect of service delivery.
 - (b) “**Case manager**” means an individual who works with clients, and their families and significant others, to provide case management.
 - (c) “**Client manager**” means an employee of the department who is assigned to specific provider agencies and geographic areas to ensure that the full range of needed services is available to clients.
 - (d) “**Continuity of care management system**” means a system that assures, within available resources, that clients have access to the full array of services within the mental health services delivery system.
- (2) The department is directed to implement a continuity of care management system for the provision of mental health care, through the provision of client and case management, including clients referred from state treatment facilities to community mental health facilities. Such system shall include a network of client managers and case managers throughout the state designed to:
- (a) Reduce the possibility of a client’s admission or readmission to a state treatment facility.

65E-5.130 Continuity of Care Management System.

Persons receiving case management services.

- (1) At the time of admission receiving facilities shall inquire of the person or significant others as to the existence of any advance directives and as to the identity of the person’s case manager. If a case manager for the person is identified, the administrator or designee shall request the person’s authorization to notify the person’s case manager or the case management agency of the person’s admission to the facility. If authorized, such notification shall be made within 12 hours to the published 24-hour telephone listing for the case manager or case management agency. This inquiry, notification, and the identity of the case manager or case management agency, if any, shall be documented on the face sheet or other prominent location in the person’s clinical record.
- (2) A department funded mental health case manager, when notified by a receiving facility that a client has been admitted, shall visit that person as soon as possible but no later than two working days after notification to assist with discharge and aftercare planning to the least restrictive, appropriate and available placement. If the person is located in a receiving facility outside of the case manager’s district or region of residence, the department funded mental health case manager may substitute a telephone contact for a face-to-face visit which shall be documented in the case management record and in the person’s clinical record at the receiving facility.

- (b) Provide for the creation or designation of an agency in each county to provide single intake services for each person seeking mental health services. Such agency shall provide information and referral services necessary to ensure that clients receive the most appropriate and least restrictive form of care, based on the individual needs of the person seeking treatment. Such agency shall have a single telephone number, operating 24 hours per day, 7 days per week, where practicable, at a central location, where each client will have a central record.
- (c) Advocate on behalf of the client to ensure that all appropriate services are afforded to the client in a timely and dignified manner.
- (d) Require that any public receiving facility initiating a patient transfer to a licensed hospital for acute care mental health services not accessible through the public receiving facility shall notify the hospital of such transfer and send all records relating to the emergency psychiatric or medical condition.
- (3) The department is directed to develop and include in contracts with service providers measures of performance with regard to goals and objectives as specified in the state plan. Such measures shall use, to the extent practical, existing data collection methods and reports and shall not require, as a result of this subsection, additional reports on the part of service providers. The department shall plan monitoring visits of community mental health facilities with other state, federal, and local governmental and private agencies charged with monitoring such facilities.

65E-5.1301 Transfer Evaluations for Admission to State Mental Health Treatment Facilities from Receiving Facilities.

- (1) A person in a receiving facility shall not be transferred to a state treatment facility without the completion of a transfer evaluation, in accordance with Section 394.461(2), F.S., using mandatory form CF-MH 3089, Feb. 05, "Transfer Evaluation," which is hereby incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter. The process for conducting such transfer evaluations shall be developed by the community mental health center or clinic and be approved by the district or regional office of the department where the center or clinic is located and shall include:
- (a) Designation of the contracted mental health centers or clinics that are responsible for conducting the transfer evaluations, including the receiving facilities or persons for which each center or clinic is responsible;
 - (b) Establishment of the time within which a mandatory form CF-MH 3089, "Transfer Evaluation," as referenced in subsection 65E-5.1301(1), F.A.C., shall be completed. This form shall be completed by the designated community mental health center and submitted to the court for all persons for whom involuntary placement in a state treatment facility is sought, and directly to the state treatment facility for all persons for whom voluntary admission is sought; and
 - (c) Specification of the minimum training and education of the persons qualified to conduct the transfer evaluations and the training and educational qualifications of the evaluators' immediate supervisor.
Unless otherwise established in writing by the district or region, the evaluator shall have at least a bachelor's degree and the immediate supervisor a master's degree in a clinical or human services area of study.
- (2) A community mental health center or clinic shall evaluate each person seeking voluntary admission to a state treatment facility and each person for whom involuntary placement in a state treatment

- 1 facility is sought, to determine and document:
- 2 (a) Whether the person meets the statutory criteria
- 3 for admission to a state treatment facility; and
- 4 (b) Whether there are appropriate more
- 5 integrated and less restrictive mental health
- 6 treatment resources available to meet the
- 7 person's needs.
- 8
- 9 (3) Following an evaluation of the person, the
- 10 executive director of the community mental health
- 11 center or clinic shall recommend the
- 12 admission to a state treatment facility or, if
- 13 criteria for involuntary placement are not met, to
- 14 alternative treatment programs and shall document
- 15 that recommendation by completing
- 16 and signing the form CF-MH 3089, "Transfer
- 17 Evaluation," as referenced in subsection
- 18 65E-5.1301(1), F.A.C.
- 19
- 20 (a) The executive director's responsibility for
- 21 completing and signing mandatory form CF-MH
- 22 3089, "Transfer Evaluation," as
- 23 referenced in subsection 65E-5.1301(1), F.A.C.,
- 24 may be delegated in writing to the chief clinical
- 25 officer of the center or clinic.
- 26
- 27 (b) An original signature on the mandatory form
- 28 CF-MH 3089, "Transfer Evaluation," as referenced
- 29 in subsection 65E-5.1301(1), F.A.C., is required.
- 30
- 31 (c) A copy of the mandatory form CF-MH 3089,
- 32 "Transfer Evaluation," as referenced in
- 33 subsection 65E-5.1301(1), F.A.C., shall be
- 34 retained in the files of the community
- 35 mental health center or clinic.
- 36
- 37 (d) The completed and signed mandatory form
- 38 CF-MH 3089, "Transfer Evaluation," as referenced
- 39 in subsection 65E-5.1301(1), F.A.C., shall be
- 40 forwarded to the court before the hearing at
- 41 which a person's involuntary placement in a
- 42 state treatment facility will be considered. The
- 43 evaluator, or in the
- 44 absence of the evaluator, another
- 45 knowledgeable staff person employed by the
- 46 community mental health center or clinic,
- 47 shall be present at any hearing on involuntary
- 48 placement in a state treatment facility to provide
- 49 testimony as desired by the court.
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Admission to State Treatment
Facilities.

**65E-5.1302 Admissions to State Treatment
Facilities.**

- (1) Receiving facilities must obtain approval from the state treatment facility prior to the transfer of a person. A state treatment facility shall be permitted to accept persons for transfer from a receiving facility if the administrator of the receiving facility has provided the following documentation, which documentation shall be retained in the person's clinical record:
 - (a) Recommended form CF-MH 7000, Jan. 98, "State Mental Health Facility Admission Form," with all required attachments, which is hereby incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter;
 - (b) Recommended forms CF-MH 3040, Feb. 05, "Application for Voluntary Admission," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or CF-MH 3008, Feb. 05, "Order for Involuntary Inpatient Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter; and
 - (c) Mandatory form CF-MH 3089, "Transfer Evaluation" as referenced in subsection 65E-5.1301(1), F.A.C.
- (2) Use of recommended form CF-MH 7002, Feb. 05, "Physician to Physician Transfer," 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 for documentation when completed by the referring physician or in the absence of the referring physician the physician's designee within state law and approved facility protocols and practice guidelines, at the time of transfer. The form shall accompany the person to the state treatment facility and upon arrival shall be presented to admitting staff.

**65E-5.1303 Discharge from Receiving and
Treatment Facilities.**

- (1) Before discharging a person who has been admitted to a facility, the person shall be encouraged to actively participate in treatment and discharge planning activities and shall be notified in writing of his or her right to seek treatment from the

Aftercare appointment required.

Access to psychotropic medications following discharge required.

- 1 professional or agency of the person's choice and
- 2 the person shall be assisted in making appropriate
- 3 discharge plans. The person shall be advised that,
- 4 pursuant to Section 394.460, F.S., no professional is
- 5 required to accept persons for psychiatric treatment.
- 6 (2) Discharge planning shall include and document
- 7 consideration of the following:
- 8 (a) The person's transportation resources;
- 9 (b) The person's access to stable living arrangements;
- 10 (c) How assistance in securing needed living
- 11 arrangements or shelter will be provided to
- 12 individuals who are at risk of re-admission
- 13 within the next 3 weeks due to homelessness
- 14 or transient status and prior to discharge shall
- 15 request a commitment from a shelter provider
- 16 that assistance will be rendered;
- 17 (d) Assistance in obtaining a timely aftercare
- 18 appointment for needed services, including
- 19 continuation of prescribed psychotropic
- 20 medications. Aftercare appointments for
- 21 psychotropic medication and case management
- 22 shall be requested to occur not later than 7
- 23 days after the expected date of discharge; if the
- 24 discharge is delayed, the facility will notify the
- 25 aftercare provider. The facility shall coordinate
- 26 with the aftercare service provider and shall
- 27 document the aftercare planning;
- 28 (e) To ensure a person's safety and provide
- 29 continuity of essential psychotropic medications,
- 30 such prescribed psychotropic medications,
- 31 prescriptions, or multiple partial prescriptions
- 32 for psychotropic medications, or a combination
- 33 thereof, shall be provided to a person when
- 34 discharged to cover the intervening days until
- 35 the first scheduled psychotropic medication
- 36 aftercare appointment, or for a period of up to 21
- 37 calendar days, whichever occurs first. Discharge
- 38 planning shall address the availability of and
- 39 access to prescribed psychotropic medications in
- 40 the community;
- 41 (f) The person shall be provided education and
- 42 written information about his or her illness
- 43 and psychotropic medications including other
- 44 prescribed and over-the-counter medications,
- 45 the common side-effects of any medications
- 46 prescribed and any adverse clinically significant
- 47 drug-to-drug interactions common between
- 48 that medication and other commonly available
- 49 prescribed and over-the-counter medications;
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Referral to needed
services required.

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- (g) The person shall be provided contact and program information about and referral to any community-based peer support services in the community;
 - (h) The person shall be provided contact and program information about and referral to any needed community resources;
 - (i) Referral to substance abuse treatment programs, trauma or abuse recovery focused programs, or other self-help groups, if indicated by assessments; and
 - (j) The person shall be provided information about advance directives, including how to prepare and use the advance directives.
- (3) Should a person in a receiving or treatment facility meet the criteria for involuntary outpatient placement rather than involuntary inpatient placement, the facility administrator may initiate such involuntary outpatient placement, pursuant to Section 394.4655, F.S., and Rule 65E-5.285, F.A.C., of this rule chapter.
 - (4) Receiving and treatment facilities shall have written discharge policies and procedures which shall contain:
 - (a) Agreements or protocols for transfer and transportation arrangements between facilities;
 - (b) Protocols for assuring that current medical and legal information, including medication administered on the day of discharge, is transferred before or with the person to another facility; and
 - (c) Policy and procedures which address continuity of services and access to necessary psychotropic medications.
 - (5) When a state mental health treatment facility has established an anticipated discharge date for discharge to the community which is more than seven days in advance of the person's actual discharge, at least 7 days notice must be given to the community agency which has been assigned case management responsibility for the implementation of the person's discharge plan. When an impending discharge is known 7 days or less prior to the discharge, the staff of the state mental health treatment facility shall give verbal and written notice of the impending discharge to the community case management agency within 1 working day after the decision to discharge is

394.4574 Department responsibilities for a mental health resident who resides in an assisted living facility that holds a limited mental health license.

- (1) The term “mental health resident,” for purposes of this section, means an individual who receives social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation.
- (2) The department must ensure that:
 - (a) A mental health resident has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or psychiatric nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be provided to the administrator of the facility within 30 days after the mental health resident has been admitted to the facility.

made. Recommended form CF-MH 7001, Jan. 98, “State Mental Health Facility Discharge Form,” which is incorporated by reference, may be used for this purpose, and may be obtained online at <https://www.flrules.org/Gateway/reference.asp?No=Ref-02361>, <http://www.myflfamilies.com/service-programs/mental-health/baker-act-forms>.

(6) On the day of discharge from a state mental health treatment facility, the referring physician, or his or her designee, within the requirements of Section 394.4615, F.S., and the policies and procedures required by subsection (4) of this rule, shall immediately notify the community aftercare provider or entity responsible for dispensing or administering medications. Recommended form CF-MH 7002, Feb. 05, “Physician to Physician Transfer,” as referenced in subsection 65E-5.1302(2), F.A.C., may be used for this purpose, and may be obtained online at <https://www.flrules.org/Gateway/reference.asp?No=Ref-02362>, <http://www.myflfamilies.com/service-programs/mental-health/baker-act-forms>.

N/A

ALF with Limited Mental Health License.

- An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident if it was completed within 90 days prior to admission to the facility.
- (b) A cooperative agreement, as required in s. 429.075, is developed between the mental health care services provider that serves a mental health resident and the administrator of the assisted living facility with a limited mental health license in which the mental health resident is living. Any entity that provides Medicaid prepaid health plan services shall ensure the appropriate coordination of health care services with an assisted living facility in cases where a Medicaid recipient is both a member of the entity's prepaid health plan and a resident of the assisted living facility. If the entity is at risk for Medicaid targeted case management and behavioral health services, the entity shall inform the assisted living facility of the procedures to follow should an emergent condition arise.
- (c) The community living support plan, as defined in s. 429.02, has been prepared by a mental health resident and a mental health case manager of that resident in consultation with the administrator of the facility or the administrator's designee. The plan must be provided to the administrator of the assisted living facility with a limited mental health license in which the mental health resident lives. The support plan and the agreement may be in one document.
- (d) The assisted living facility with a limited mental health license is provided with documentation that the individual meets the definition of a mental health resident.
- (e) The mental health services provider assigns a case manager to each mental health resident who lives in an assisted living facility with a limited mental health license. The case manager is responsible for coordinating the

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development of and implementation of the community living support plan defined in s. 429.02. The plan must be updated at least annually.

- (3) The Secretary of Children and Family Services, in consultation with the Agency for Health Care Administration, shall annually require each district administrator to develop, with community input, detailed plans that demonstrate how the district will ensure the provision of state-funded mental health and substance abuse treatment services to residents of assisted living facilities that hold a limited mental health license. These plans must be consistent with the substance abuse and mental health district plan developed pursuant to s. 394.75 and must address case management services; access to consumer-operated drop-in centers; access to services during evenings, weekends, and holidays; supervision of the clinical needs of the residents; and access to emergency psychiatric care.

394.458 Introduction or removal of certain articles unlawful; penalty.

- (1)(a) Except as authorized by law or as specifically authorized by the person in charge of each hospital providing mental health services under this part, it is unlawful to introduce into or upon the grounds of such hospital, or to take or attempt to take or send therefrom, any of the following articles, which are hereby declared to be contraband for the purposes of this section:
1. Any intoxicating beverage or beverage which causes or may cause an intoxicating effect;
 2. Any controlled substance as defined in chapter 893; or
 3. Any firearms or deadly weapon.
- (b) It is unlawful to transmit to, or attempt to transmit to, or cause or attempt to cause to

N/A

Firearms and deadly weapons
in hospitals providing mental
health services.

Statute

(Chapter 394.459 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.140 F.A.C.

be transmitted to, or received by, any patient of any hospital providing mental health services under this part any article or thing declared by this section to be contraband, at any place which is outside of the grounds of such hospital, except as authorized by law or as specifically authorized by the person in charge of such hospital.

- (2) A person who violates any provision of this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

394.459 Rights of patients.

Federal conditions of participation and other federal/state laws/regulation and accreditation standards may also apply

See bakeracttraining.org for course on Rights of Persons in Mental Health Facilities

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65E-5.140 Rights of Persons.

- (1) Every person admitted to a designated receiving or treatment facility or ordered to treatment at a service provider shall be provided with a written description of his or her rights at the time of admission. Recommended form CF-MH 3103, Feb. 05, "Rights of Persons in Mental Health Facilities and Programs," 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 for this purpose. A copy of the rights statement, signed by the person evidencing receipt of the copy, shall be placed in the person's clinical record and shall also be provided to the person's guardian, guardian advocate, representative, and health care surrogate or proxy.
- (2) To assure that persons have current information as to their rights, a copy of the Florida Mental Health Act (Chapter 394, Part I, F.S.) and Mental Health Act Regulations (Chapter 65E-5, F.A.C.) shall be available, and provided upon request, in every psychiatric unit of each receiving and treatment facility and by each service provider and, upon request shall be made available for review by any person, guardian, guardian advocate, representative, or health care surrogate or proxy. The administrator or designee of the facility or service provider shall make physicians, nurses, and all other direct service staff aware of the location of these documents so they are able to promptly access them upon request.
- (3) Posters delineating rights of persons served in mental health facilities and by service providers, including those with telephone numbers for the

Florida statewide and local advocacy councils no longer exist because they were de-funded by the 2010 Florida Legislature.

(1) RIGHT TO INDIVIDUAL DIGNITY.

It is the policy of this state that the individual dignity of the patient shall be respected at all times and upon all occasions, including any occasion when the patient is taken into custody, held, or transported. Procedures, facilities, vehicles, and restraining devices utilized for criminals or those accused of crime shall not be used in connection with persons who have a mental illness, except for the protection of the patient or others. Persons who have a mental illness but who are not charged with a criminal offense shall not be detained or incarcerated in the jails of this state. A person who is receiving treatment for mental illness shall not be deprived of any constitutional rights. However, if such a person is adjudicated incapacitated, his or her rights may be limited to the same extent the rights of any incapacitated person are limited by law.

Florida Abuse Hotline, Florida Local Advocacy Council, and the Advocacy Center for Persons with Disabilities, shall be legible, a minimum of 14 point font size, and shall be posted immediately next to telephones which are available for persons served by the facility or provider.

- (4) Each person shall be afforded the opportunity to exercise his or her rights in a manner consistent with Section 394.459(1), F.S. The imposition of individual or unit restrictions and the development of unit policies and procedures shall address observance of protecting rights of persons served in developing criteria or processes to provide for care and safety

65E-5.150 Person's Right to Individual Dignity.

- (1) Freedom of movement is a right of persons in mental health receiving and treatment facilities. Any restriction of this right requires a physician's order based upon risk factors. Each receiving and treatment facility shall have policies that describe freedom of movement and access to grounds. When a suitable area is immediately adjacent to the unit, the staff shall afford each person an opportunity to spend at least one half hour per day in an open, out of doors, fresh air activity area, unless there is a physician's order prohibiting this, with documentation in the person's clinical record of the clinical reasons that access to fresh air will not be accommodated.
- (2) Use of special clothing for identification purposes such as surgical scrubs or hospital gowns to identify persons who are in need of specific precautions or behavior modification restrictions is prohibited as a violation of individual dignity. Prison or jail attire shall not be permitted for persons admitted or retained in a receiving facility except while accompanied by a uniformed law enforcement officer, for purposes of security. Under non-psychiatric medical circumstances, use of special clothing may be ordered by the person's physician on an individual basis. Documentation of the circumstances shall be included in the person's clinical record.

(2) RIGHT TO TREATMENT.

- (a) A person shall not be denied treatment for mental illness and services shall not be delayed at a receiving or treatment facility because of inability to pay. However, every reasonable effort to collect appropriate reimbursement for the cost of providing mental health services to persons able to pay for services, including insurance or third-party payments, shall be made by facilities providing services pursuant to this part.
- (b) It is further the policy of the state that the least restrictive appropriate available treatment be utilized based on the individual needs and best interests of the patient and consistent with optimum improvement of the patient's condition.
- (c) Each person who remains at a receiving or treatment facility for more than 12 hours shall be given a physical examination by a health practitioner authorized by law to give such examinations, within 24 hours after arrival at such facility.
- (d) Every patient in a facility shall be afforded the opportunity to participate in activities designed to enhance self-image and the beneficial effects of other treatments, as determined by the facility.
- (e) Not more than 5 days after admission to a facility, each patient shall have and receive an individualized treatment plan in writing which the patient has had an opportunity to assist in preparing and to review prior to its implementation. The plan shall include a space for the patient's comments.

65E-5.160 Right to Treatment.

- (1) Patients shall have the opportunity to participate in the preparation of their own treatment and discharge plans at receiving and treatment facilities and by service providers. In instances when the person refuses or is unable to participate in such planning, such refusal or inability shall be documented in the person's clinical record.
- (2) Comprehensive service assessment and treatment planning, including discharge planning, shall begin the day of admission and shall also include the person's case manager if any, the person's friends, family, significant others, or guardian, as desired by the person. If the person has a court appointed guardian, the guardian shall be included in the service assessment and treatment planning. Obtaining legal consent for treatment, assessment and planning protocols shall also include the following:
 - (a) How any advance directives will be obtained and their provisions addressed and how consent for treatment will be expeditiously obtained for any person unable to provide consent;
 - (b) Completion of necessary diagnostic testing and the integration of the results and interpretations from those tests. The results and interpretation of the results shall be reviewed with the person;
 - (c) The development of treatment goals specifying the factors and symptomology precipitating admission and addressing their resolution or mitigation;
 - (d) The development of a goal within an individualized treatment plan, including the individual's strengths and weaknesses, that addresses each of the following: living arrangements, social supports, financial supports, and health, including mental health. Goals shall be inclusive of the person's choices and preferences and utilize available natural social supports such as family, friends, and peer support group meetings and social activities;
 - (e) Objectives for implementing each goal shall list the actions needed to obtain the goal, and shall be stated in terms of outcomes that are observable, measurable, and time-limited;
 - (f) Progress notes shall be dated and shall address each objective in relation to the goal, describing the corresponding progress, or lack of progress being made. Progress note entries and the name and title of writer must be clearly legible;

Treatment Planning.

- 1 (g) Periodic reviews shall be comprehensive,
2 include the person, and shall be the basis for
3 major adjustments to goals and objectives.
4 Frequency of periodic reviews shall be
5 determined considering the degree to which the
6 care provided is acute care and the projected
7 length of stay of the person;
8 (h) Progress note observations, participation by the
9 person, rehabilitative and social services, and
10 medication changes shall reflect an integrated
11 approach to treatment;
12 (i) Facilities shall update the treatment plan,
13 including the physician summary, at least
14 every 30 days during the time a person is in
15 a receiving or treatment facility except that
16 persons retained for longer than 24 months
17 shall have updates at least every 60 days;
18 (j) The clinical record shall comprehensively
19 document the person's care and treatment,
20 including injuries sustained and all uses of
21 emergency treatment orders; and
22 (k) Persons who will have a continued involuntary
23 outpatient placement hearing pursuant to
24 Section 394.4655(7), F.S., or continued involuntary
25 inpatient placement hearing pursuant to
26 Section 394.467(7), F.S., shall be provided with
27 comprehensive re-assessments, the results of
28 which shall be available at the hearing.
29 3) The physical examination required to be provided to
30 each person who remains at a receiving or treatment
31 facility for more than 12 hours must include:
32 (a) A determination of whether the person is
33 medically stable; and
34 (b) A determination that abnormalities of thought,
35 mood, or behavior due to non-psychiatric causes
36 have been ruled out.
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65E-5.1601 General Management of the Treatment Environment.

- 46 (1) Management and personnel of the facility's
47 treatment environment shall use positive incentives
48 in assisting persons to acquire and maintain socially
49 positive behaviors as determined by the person's
50 age and developmental level.
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- (2) Each designated receiving and treatment facility shall develop a schedule of daily activities listing the times for specific events, which shall be posted in a common area and provided to all persons.
- (3) Interventions such as the loss of personal freedoms, loss of earned privileges or denial of activities otherwise available to other persons shall be minimized and utilized only after the documented failure of the unit's positive incentives for the individuals involved.
- (4) Facilities shall ensure that any verbal or written information provided to persons must be accessible in the language and terminology the person understands.

65E-5.1602 Individual Behavioral Management Programs.

- When an individualized treatment plan requires interventions beyond the existing unit rules of conduct, the person shall be included, and the person's treatment plan shall reflect:
- (1) Documentation, signed by the physician that the person's medical condition does not exclude the proposed interventions;
 - (2) Consent for the treatment to be provided;
 - (3) A general description of the behaviors requiring the intervention, which may include previous emergency interventions;
 - (4) Antecedents of that behavior;
 - (5) The events immediately following the behavior;
 - (6) Objective definition of the target behaviors, such as specific acts, level of aggression, encroachment on others' space, self-injurious behavior or excessive withdrawal;
 - (7) Arrangements for the consistent collection and recording of data;
 - (8) Analysis of data;
 - (9) Based on data analysis, development of intervention strategies, if necessary;
 - (10) Development of a written intervention strategy that includes criteria for starting and stopping specific staff interventions and the process by which they are to occur;
 - (11) Continued data collection, if interventions are implemented; and
 - (12) Periodic review and revision of the plan based upon data collected and analyzed.

(3) RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT.

- (a) 1. Each patient entering treatment shall be asked to give express and informed consent for admission or treatment. If the patient has been adjudicated incapacitated or found to be incompetent to consent to treatment, express and informed consent to treatment shall be sought instead from the patient's guardian or guardian advocate. If the patient is a minor, express and informed consent for admission or treatment shall also be requested from the patient's guardian. Express and informed consent for admission or treatment of a patient under 18 years of age shall be required from the patient's guardian, unless the minor is seeking outpatient crisis intervention services under s. 394.4784. Express and informed consent for admission or treatment given by a patient who is under 18 years of age shall not be a condition of admission when the patient's guardian gives express and informed consent for the patient's admission pursuant to s. 394.463 or s. 394.467.
2. Before giving express and informed consent, the following information shall be provided and explained in plain language to the patient, or to the patient's guardian if the patient is 18 years of age or older and has been adjudicated incapacitated, or to the patient's guardian advocate if the patient has been found to be incompetent to consent to treatment, or to both the patient and the guardian if the patient is a minor: the reason for admission or treatment; the proposed treatment; the purpose of the treatment to be provided; the common risks, benefits, and side effects thereof; the specific dosage range for the medication, when applicable; alternative treatment modalities; the approximate length of care; the

65E-5.170 Right to Express and Informed Consent.

(1) Establishment of Consent.

- (a) **Receiving Facilities.** As soon as possible, but in no event longer than 24 hours from entering a designated receiving facility on a voluntary or involuntary basis, each person shall be examined by the admitting physician to assess the person's ability to provide express and informed consent to admission and treatment. The examination of a minor for this purpose may be limited to the documentation of the minor's age. The examination of a person alleged to be incapacitated for this purpose may be limited to the documentation of letters of guardianship. Documentation of the assessment results shall be placed in the person's clinical record. The facility shall determine whether a person has been adjudicated as incapacitated and whether a guardian has been appointed by the court. If a guardian has been appointed by the court, the limits of the authority of the guardian shall be determined prior to allowing the guardian to authorize treatment. A copy of any court order delineating a guardian's authority to consent to mental health or medical treatment shall be obtained by the facility and included in the person's clinical record prior to allowing the guardian to give express and informed consent to treatment for the person.

- (b) **Treatment Facilities.** Upon entering a designated treatment facility on a voluntary or involuntary basis, each person shall be examined by the admitting physician to assess the person's ability to provide express and informed consent to admission and treatment, which shall be documented in the person's clinical record. The examination of a person alleged to be incapacitated or incompetent to consent to treatment, for this purpose, may be limited to documenting the letters of guardianship or order of the court. If a person has been adjudicated as incapacitated and a guardian appointed by the court or if a person has been found to be incompetent to consent to treatment and a guardian advocate has been appointed by the court, the limits of authority of the guardian or guardian advocate shall be determined prior to

Statute

(Chapter 394.459 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.170 F.A.C.

potential effects of stopping treatment; how treatment will be monitored; and that any consent given for treatment may be revoked orally or in writing before or during the treatment period by the patient or by a person who is legally authorized to make health care decisions on behalf of the patient.

(b) In the case of medical procedures requiring the use of a general anesthetic or electroconvulsive treatment, and prior to performing the procedure, express and informed consent shall be obtained from the patient if the patient is legally competent, from the guardian of a minor patient, from the guardian of a patient who has been adjudicated incapacitated, or from the guardian advocate of the patient if the guardian advocate has been given express court authority to consent to medical procedures or electroconvulsive treatment as provided under s. 394.4598.

(c) When the department is the legal guardian of a patient, or is the custodian of a patient whose physician is unwilling to perform a medical procedure, including an electroconvulsive treatment, based solely on the patient's consent and whose guardian or guardian advocate is unknown or unlocatable, the court shall hold a hearing to determine the medical necessity of the medical procedure. The patient shall be physically present, unless the patient's medical condition precludes such presence, represented by counsel, and provided the right and opportunity to be confronted with, and to cross-examine, all witnesses alleging the medical necessity of such procedure. In such proceedings, the burden of proof by clear and convincing evidence shall be on the party alleging the medical necessity of the procedure.

(d) The administrator of a receiving or treatment facility may, upon the recommendation of the patient's attending physician, authorize emergency medical

allowing the guardian or guardian advocate to authorize treatment for the person. A copy of any court order delineating a guardian's authority to consent to mental health or medical treatment shall be obtained by the facility and included in the person's clinical record prior to allowing the guardian to give express and informed consent to treatment for the person.

(c) If the admission is voluntary, the person's competence to provide express and informed consent for admission shall be documented by the admitting physician. Recommended form CF-MH 3104, Feb. 05, "Certification of Person's Competence to Provide Express and Informed Consent," 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 for this purpose. The completed form or other documentation shall be retained in the person's clinical record. Facility staff monitoring the person's condition shall document any observations which suggest that a person may no longer be competent to provide express and informed consent to his or her treatment. In such circumstances, staff shall notify the physician and document in the person's clinical record that the physician was notified of this apparent change in clinical condition.

(d) In the event there is a change in the ability of a person on voluntary status to provide express and informed consent to treatment, the change shall be immediately documented in the person's clinical record. A person's refusal to consent to treatment is not, in itself, an indication of incompetence to consent to treatment.

1. If the person is assessed to be competent to consent to treatment and meets the criteria for involuntary inpatient placement, the facility administrator shall file with the court a petition for involuntary placement.

Recommended form CF-MH 3032, Feb. 05, "Petition for Involuntary Inpatient Placement," 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 for this purpose.

2. If the person is assessed to be incompetent to consent to treatment, and meets the criteria for involuntary inpatient or

Statute

(Chapter 394.459 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.170 F.A.C.

treatment, including a surgical procedure, if such treatment is deemed lifesaving, or if the situation threatens serious bodily harm to the patient, and permission of the patient or the patient's guardian or guardian advocate cannot be obtained.

Other state statutes governing substitute decision-makers, such as guardians (744 FS) and health care surrogates and proxies (765 FS) may apply.

See Appendix C for summary reference on substitute decision making

involuntary outpatient placement, the facility administrator shall expeditiously file with the court both a petition for the adjudication of incompetence to consent to treatment and appointment of a guardian advocate, and a petition for involuntary inpatient or involuntary outpatient placement. Upon determination that a person is incompetent to consent to treatment the facility shall expeditiously pursue the appointment of a duly authorized substitute decision-maker that can make legally required decisions concerning treatment options or refusal of treatments for the person. Recommended forms CF-MH 3106, Feb. 05, "Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate," which is incorporated by reference may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, and CF-MH 3032, "Petition for Involuntary Inpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)1., F.A.C., or CF-MH 3130, "Petition for Involuntary Outpatient Placement," 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 for this purpose.

- (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.
- (f) Any guardian advocate appointed by a court to provide express and informed consent to treatment for the person shall be discharged and a notice of such guardian advocate discharge provided to the court upon the establishment and documentation that the person is competent to provide express and informed consent.

Authorization for Treatment

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- (g) If a person entering a designated receiving or treatment facility has been adjudicated incapacitated under Chapter 744, F.S., as described in Section 394.455(14), F.S., express and informed consent to treatment shall be sought from the person's guardian.
- (h) If a person entering a designated receiving or treatment facility has been determined by the attending physician to be incompetent to consent to treatment as defined in Section 394.455(15), F.S., express and informed consent to treatment shall be expeditiously sought by the facility from the person's guardian advocate or health care surrogate or proxy.
- (i) A copy of the letter of guardianship, court order, or advance directive shall be reviewed by facility staff to ensure that the substitute decision-maker has the authority to provide consent to the recommended treatment on behalf of the person. If the facility relies upon the expression of express and informed consent for person's treatment from a substitute decision-maker, a copy of this documentation shall be placed in the person's clinical record and shall serve as documentation of the substitute decision-maker's authority to give such consent. With respect to a health care proxy, where no advance directive has been prepared by the person, facility staff shall document in the person's clinical record that the substituted decision-maker was selected in accordance with the list of persons and using the priority set out in Section 765.401, F.S. When a health care surrogate or proxy is used, the facility shall immediately file a petition for the appointment of a guardian advocate.
- (2) **Authorization for Treatment.**
- (a) Express and informed consent, including the right to ask questions about the proposed treatment, to receive complete and accurate answers to those questions, and to negotiate treatment options, shall be obtained from a person who is competent to consent to treatment. If the person is incompetent to consent to treatment, such express and informed consent shall be obtained from the duly authorized substitute decision-maker for the person before any treatment is rendered, except where emergency treatment is ordered by a

Statute

(Chapter 394.459 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.170 F.A.C.

physician for the safety of the person or others. Chapter 394, Part I, F.S., and this rule chapter govern mental health treatment. Medical treatment for persons served in receiving and treatment facilities and by other service providers are governed by other statutes and rules.

- (b) A copy of information disclosed while attempting to obtain express and informed consent shall be given to the person and to any substitute decision-maker authorized to act on behalf of the person.
- (c) When presented with an event or an alternative which requires express and informed consent, a competent person or, if the person is incompetent to consent to treatment, the duly authorized substitute decision-maker shall provide consent to treatment, refuse consent to treatment, negotiate treatment alternatives, or revoke consent to treatment. Recommended forms CF-MH 3042a, Feb. 05, "General Authorization for Treatment Except Psychotropic Medications," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, and CF-MH 3042b, Feb. 05, "Specific Authorization for Psychotropic Medications," 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 as documentation of express and informed consent and any decisions made pursuant to that consent. If used, recommended form CF-MH 3042a, "General Authorization for Treatment Except Psychotropic Medications," as referenced in paragraph 65E-5.170(2)(c), F.A.C., shall be completed at the time of admission to permit routine medical care, psychiatric assessment, and other assessment and treatment except psychotropic medications. The more specific recommended form CF-MH 3042b, "Specific Authorization for Psychotropic Medications," as referenced in paragraph 65E-5.170(2)(c), F.A.C., or its equivalent, shall be completed prior to the administration of any psychotropic medications, except under an emergency treatment order. The completed forms, or equivalent documentation, shall be retained in the person's clinical record.
- (d) No facility or service provider shall initiate any mental health treatment, including psychotropic

Rights of patients

- 1 medication, until express and informed consent
 2 for psychiatric treatment is sought from a person
 3 legally qualified to give it, except in instances
 4 where emergency treatment is ordered by a
 5 physician to preserve the immediate safety of
 6 the person or others.
 7
 8 (3) Receiving and treatment facilities shall request
 9 copies of any advance directives completed by
 10 persons admitted to the facilities, from the person
 11 or the person's family or representative.
 12 (4) In addition to any other requirements, at least
 13 the following must be given to the person before
 14 express and informed consent will be valid:
 15 (a) Identification of the proposed psychotropic
 16 medication, together with a plain language
 17 explanation of the proposed dosage range,
 18 the frequency and method of administration,
 19 the recognized short-term and long-term side
 20 effects, any contraindications which may exist,
 21 clinically significant interactive effects with
 22 other medications, and similar information on
 23 alternative medications which may have less
 24 severe or serious side effects.
 25 (b) A plain language explanation of all other
 26 treatments or treatment alternatives
 27 recommended for the person.
 28
 29 (5) If a change in psychotropic medication is
 30 recommended which is not included in the previously
 31 signed CF-MH 3042b, "Specific Authorization for
 32 Psychotropic Medications" form, as referenced in
 33 paragraph 65E-5.170(2)(c), F.A.C., after an explanation
 34 and disclosure of the altered treatment plan is
 35 provided by the physician express and informed
 36 consent must be obtained from the person
 37 authorized to provide consent and be documented in
 38 the person's clinical record prior to the administration
 39 of the treatment or psychotropic medication.
 40
 41 (6) The facility or service provider staff shall explain
 42 to a guardian, guardian advocate, or health care
 43 surrogate or proxy, the duty of the substitute
 44 decision-maker to provide information to the
 45 facility or service provider on how the substitute
 46 decision-maker may be reached at any time during
 47 the person's hospitalization or treatment to provide
 48 express and informed consent for changes of
 49 treatment from that previously approved.
 50
 51 (7) Electroconvulsive treatment may be recommended
 52 to the person or the person's substitute decision-
 53
 54

Electroconvulsive Treatment
(ECT) Also see
Section 458.325, F.S.

Federal and JCAHO
requirements governing chemical
restraints may apply. Emergency
Treatment Orders (ETOs)
are not the same as chemical
restraints.

maker by the attending physician. Such recommendation must also be concurrently recommended by at least one other physician not directly involved with the person's care who has reviewed the person's clinical record. Such recommendation shall be documented in the person's clinical record and shall be signed by both physicians. Recommended form CF-MH 3057, Feb. 05, "Authorization for Electroconvulsive Treatment," 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 for this purpose. If used, this form shall also be signed by the person, if competent, or by the guardian advocate, if previous court approval has been given, or by the guardian where the person has been found by the court to be incapacitated, or by the health care surrogate if the person had expressly delegated such authority to the surrogate in the advance directive. Express and informed consent from the person or his or her substitute decision-maker, as required by Section 394.459(3), F.S., including an opportunity to ask questions and receive answers about the procedure, shall be noted on or attached to recommended form CF-MH 3057, "Authorization for Electroconvulsive Treatment," as referenced in subsection 65E-5.170(7), F.A.C., or its equivalent, as documentation of the required disclosures and of the consent. Each signed authorization form is permission for the person to receive a series of up to, but not more than, the stated number of electroconvulsive treatments identified on the form. Additional electroconvulsive treatments require additional written authorization. The signed authorization form shall be retained in the person's clinical record and shall comply with the provisions of Section 458.325, F.S.

65E-5.1703 Emergency Treatment Orders for the Administration of Psychotropic Medications.

- (1) An emergency treatment order shall be consistent with the least restrictive treatment interventions, including the emergency administration of psychotropic medications or the emergency use of restraints or seclusion. Use of seclusion or restraint in an emergency situation is addressed in subparagraph 65E-5.180(7)(a)3., F.A.C., and is not addressed in this rule. This rule pertains only to the use of psychotropic medication in an emergency situation.

- 1 (a) The issuance of an emergency treatment order
- 2 requires a physician's review of the person's
- 3 condition for causal medical factors, such as
- 4 insufficiency of psychotropic medication blood
- 5 levels, as determined by drawing a blood sample;
- 6 medication interactions with psychotropic
- 7 or other medications; side effects or adverse
- 8 reactions to medications; organic, disease or
- 9 medication based metabolic imbalances or
- 10 toxicity; or other biologically based or influenced
- 11 symptoms.
- 12
- 13 (b) All emergency treatment orders may only
- 14 be issued by a physician licensed under the
- 15 authority of Chapter 458 or 459, F.S.
- 16
- 17 (c) The physician must review, integrate and address
- 18 such metabolic imbalances in the issuance of an
- 19 emergency treatment order.
- 20
- 21 (d) The use of an emergency treatment order must
- 22 be consistent with the least restrictive treatment
- 23 requirements, and, absent more appropriate
- 24 interventions, an emergency treatment order
- 25 is for immediate administration of rapid
- 26 response psychotropic medications to a person
- 27 to expeditiously treat symptoms, that if left
- 28 untreated, present an immediate danger to the
- 29 safety of the person or others.
- 30 (2) An emergency treatment order for psychotropic
- 31 medication supersedes the person's right to
- 32 refuse psychotropic medication if based upon
- 33 the physician's assessment that the individual is
- 34 not capable of exercising voluntary control over
- 35 his or her own symptomatic behavior and that
- 36 these uncontrolled symptoms and behavior are
- 37 an imminent danger to the person or to others
- 38 in the facility. When emergency treatment with
- 39 psychotropic medication is ordered for a minor
- 40 or an incapacitated or incompetent adult, facility
- 41 staff shall document attempts to promptly contact
- 42 the guardian, guardian advocate, or health
- 43 care surrogate or proxy to obtain express and
- 44 informed consent for the treatment in advance of
- 45 administration where possible and if not possible, as
- 46 soon thereafter as practical.
- 47
- 48 (3) The physician's initial order for emergency
- 49 treatment may be by telephone but such a verbal
- 50 order must be reduced to writing upon receipt and
- 51 signed by a physician within 24 hours.
- 52
- 53 (4) Each emergency treatment order shall only be valid
- 54 and shall be authority for emergency treatment only

- 1 for a period not to exceed 24 hours.
- 2 (5) The need for each emergency treatment order
- 3 must be documented in the person's clinical record
- 4 in the progress notes and in the section used for
- 5 physician's orders and must describe the specific
- 6 behavior which constitutes a danger to the person
- 7 or to others in the facility, and the nature and extent
- 8 of the danger posed.
- 9
- 10 (6) Upon the initiation of an emergency treatment
- 11 order the facility shall, within two court working
- 12 days, petition the court for the appointment of
- 13 a guardian advocate pursuant to the provisions
- 14 of Section 394.4598, F.S., to provide express and
- 15 informed consent, unless the person voluntarily
- 16 withdraws a revocation of consent or requires only
- 17 a single emergency treatment order for emergency
- 18 treatment.
- 19
- 20 (7) If a second emergency treatment order is issued
- 21 for the same person within any 7 day period, the
- 22 petition for the appointment of a guardian advocate
- 23 pursuant to the provisions of Section 394.4598, F.S.,
- 24 to provide express and informed consent shall be
- 25 filed with the court within 1 court working day.
- 26
- 27 (8) While awaiting court action, treatment may be
- 28 continued without the consent of the person, but
- 29 only upon the daily written emergency treatment
- 30 order of a physician who has determined that the
- 31 person's behavior each day during the wait for court
- 32 action continues to present an immediate danger
- 33 to the safety of the person or others and who
- 34 documents the nature and extent of the emergency
- 35 each day of the specific danger posed. Such orders
- 36 may not be written in advance of the demonstrated
- 37 need for same.
- 38
- 39 (9) To assure the safety and rights of the person, and
- 40 since emergency treatment orders by a physician
- 41 absent express and informed consent are permitted
- 42 only in an emergency, any use of psychotropic
- 43 medications other than rapid response psychotropic
- 44 medications requires a detailed and complete
- 45 justification for the use of such medication. Both the
- 46 nature and extent of the imminent emergency and
- 47 any orders for the continuation of that medication
- 48 must be clearly documented daily as required
- 49 above.
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(4) QUALITY OF TREATMENT.

- (a) Each patient shall receive services, including, for a patient placed under s. 394.4655, those services included in the court order which are suited to his or her needs, and which shall be administered skillfully, safely, and humanely with full respect for the patient's dignity and personal integrity. Each patient shall receive such medical, vocational, social, educational, and rehabilitative services as his or her condition requires in order to live successfully in the community. In order to achieve this goal, the department is directed to coordinate its mental health programs with all other programs of the department and other state agencies.
- (b) Facilities shall develop and maintain, in a form accessible to and readily understandable by patients and consistent with rules adopted by the department, the following:
 1. Criteria, procedures, and required staff training for any use of close or elevated levels of supervision, of restraint, seclusion, or isolation, or of emergency treatment orders, and for the use of bodily control and physical management techniques.
 2. Procedures for documenting, monitoring, and requiring clinical review of all uses of the procedures described in subparagraph 1. and for documenting and requiring review of any incidents resulting in injury to patients.
 3. A system for investigating, tracking, managing, and responding to complaints by persons receiving services or individuals acting on their behalf.
- (c) A facility may not use seclusion or restraint for punishment, to compensate for inadequate staffing, or for the convenience of staff. Facilities shall ensure that all staff are made aware of these restrictions on

65E-5.180 Right to Quality Treatment.

The following standards shall be required in the provision of quality mental health treatment:

- (1) Each receiving and treatment facility and service provider shall, using nationally accepted accrediting standards for guidance, develop written policies and procedures for planned program activities designed to enhance the person's self image, as required by Section 394.459(2)(d), F.S. These policies and procedures shall include curriculum, specific content, and performance objectives and shall be delivered by staff with content expertise. Medical, rehabilitative, and social services shall be integrated and provided in the least restrictive manner consistent with the safety of the persons served.
- (2) Each facility and service provider, using nationally accepted accrediting standards for guidance, shall adopt written professional standards of quality, accuracy, completeness, and timeliness for all diagnostic reports, evaluations, assessments, examinations, and other procedures provided to persons under the authority of Chapter 394, Part I, F.S. Facilities shall monitor the implementation of those standards to assure the quality of all diagnostic products. Standards shall include and specify provisions addressing:
 - (a) The minimum qualifications to assure competence and performance of staff who administer and interpret diagnostic procedures and tests;
 - (b) The inclusion and updating of pertinent information from previous reports, including admission history and key demographic, social, economic, and medical factors;
 - (c) The dating, accuracy and the completeness of reports;
 - (d) The timely availability of all reports to users;
 - (e) Reports shall be legible and understandable;
 - (f) The documentation of facts supporting each conclusion or finding in a report;
 - (g) Requirements for the direct correlation of identified problems with problem resolutions that consider the immediacy of the problem or time frames for resolution and which include recommendations for further diagnostic work-ups;
 - (h) Requirement that the completed report be signed and dated by the administering staff; and

the use of seclusion and restraint and shall make and maintain records which demonstrate that this information has been conveyed to individual staff members.

Psychiatric Examinations

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- (i) Consistency of information across various reports and integration of information and approaches across reports.
 - (3) Psychiatric Examination. Psychiatric examinations shall include:
 - (a) Medical history, including psychiatric history, developmental abnormalities, physical or sexual abuse or trauma, and substance abuse;
 - (b) Examination, evaluative or laboratory results, including mental status examination;
 - (c) Working diagnosis, ruling out non-psychiatric causes of presenting symptoms of abnormal thought, mood or behaviors;
 - (d) Course of psychiatric interventions including:
 1. Medication history, trials and results;
 2. Current medications and dosages;
 3. Other psychiatric interventions in response to identified problems;
 - (e) Course of other non-psychiatric medical problems and interventions;
 - (f) Identification of prominent risk factors including physical health, psychiatric and co-occurring substance abuse; and
 - (g) Discharge or transfer diagnoses.
 - (4) So that care will not be delayed upon arrival, procedures for the transfer of the physical custody of persons shall specify and require that documentation necessary for legal custody and medical status, including the person's medication administration record for that day, shall either precede or accompany the person to his or her destination.
 - (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.

Complaint investigation procedure required. See 65E-5.352 for additional complaint investigation procedures.

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- (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; and
 4. Required involvement of the person and guardian, guardian advocate, or health care surrogate or proxy, in treatment and discharge planning.
- (e) Use of age sensitive interventions in the implementation of seclusion or in the use of physical force as well as the authorization and training of staff to implement restraints, including the safe positioning of persons in restraints. Policies, procedures and services shall incorporate specific provisions regarding the restraining of minors, elders, and persons who are frail or with medical problems such as potential problems with respiration.
- (f) Plain language documentation in the person's clinical record of all uses of "as needed" or emergency applications of psychotropic medications, and all uses of physical force, restraints, seclusion, or "time-out" procedures upon persons, and the explicit reasons for their use.
- (g) The prohibition of standing orders or similar protocols for the emergency use of psychotropic medication, restraint, or seclusion.
- (h) Provision of required training for guardian advocates including activities and available resources designed to assist family members and guardian advocates in understanding applicable treatment issues and in identifying and contacting local self-help organizations.
- (6) Each facility shall develop a written policy and procedure for receiving, investigating, tracking, managing and responding to formal and informal complaints by a person receiving services or by an individual acting on his or her behalf.
- (a) The complaint process shall be verbally

Statute

(Chapter 394.459 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.180 F.A.C.

Florida statewide and local advocacy councils no longer exist because they were de-funded by the 2010 Florida Legislature.

explained during the orientation process and provided in writing in language and terminology that the person receiving services can understand. It will explain how individuals may address complaints informally through the facility staff and treatment team, and formally through the staff person assigned to handle formal complaints, as well as the administrator or designee of the facility. The person receiving services shall also be advised that he or she may contact the Local Advocacy Council, the Florida Abuse Registry, the Advocacy Center for Persons with Disabilities, or any other individual or agency at anytime during the complaint process to request assistance. The complaint process, including telephone numbers for the above named entities, shall be posted in plain view in common areas and next to telephones used by individuals receiving services. Any complaint may be verbal or written. Any staff person receiving an informal or formal complaint dealing with life-safety issues will take immediate action to resolve the matter.

- (b) Informal complaints are initial complaints that are usually made verbally by a person receiving services or by an individual acting on his or her behalf. If resolution cannot be mutually agreed upon, a formal written complaint may be initiated.
- (c) When the person receiving services, or a person acting upon that person's behalf, makes a formal complaint a staff person not named in the complaint shall assist the person in initiating the complaint. The complaint shall include the date and time of the complaint and detail the issue and the remedy sought. All formal complaints shall be forwarded to the staff person, or designee, who is assigned to track and monitor formal complaints. All formal complaints shall be tracked and monitored for compliance and shall contain the following information:
 - 1. The date and time the formal complaint was originally received by staff;
 - 2. The date and time the formal complaint was received by the staff assigned to track formal complaints;
 - 3. The nature of the complaint;
 - 4. The name of the person receiving services;
 - 5. The name of the person making the complaint;

Rights of patients

Seclusion and Restraint also governed by federal conditions of participation, accreditation organizations, and facility policies and procedures.

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6. The name of the individual assigned to investigate the complaint;
 7. The date the individual making the complaint was notified of the individual assigned to investigate the complaint;
 8. The due date for the written response; and
 9. At closure, the written disposition of the formal complaint.
- (d) The investigation shall be completed within 7 days from the date of entry into the system for tracking complaints.
- (e) A written response must be given or mailed to the person receiving services within 24 hours of disposition. The individual acting on behalf of the person receiving services shall be notified of the completion of the investigation but will not be given specific details of the disposition unless they have a legal right to the information or a signed release of information is in place.
- (f) The disposition of a complaint may be appealed to the administrator of the facility. If appealed, the facility administrator or designee shall review the written complaint and the initial disposition. Within five working days, the facility administrator or designee will make a final decision concerning the outcome of the complaint and will provide a written response within 24 hours to the person receiving services. A copy of the written response shall also be given to the staff member assigned to track complaints.
- (7) **Seclusion and Restraint for Behavior Management Purposes.** All facilities, as defined in Section 394.455(10), F.S., are required to adhere to the standards and requirements of subsection (7).
- (a) **General Standards.**
1. Each facility will provide a therapeutic milieu that supports a culture of recovery and individual empowerment and responsibility. Each person will have a voice in determining his or her treatment options. Treatment will foster trusting relationships and partnerships for safety between staff and individuals. Facility practices will be particularly sensitive to persons with a history of trauma.
 2. The health and safety of the person shall be the primary concern at all times.
 3. Seclusion or restraint shall be employed only

Statute

(Chapter 394.459 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.180 F.A.C.

Trauma Informed Care.

- 1 in emergency situations when necessary
- 2 to prevent a person from seriously injuring
- 3 self or others, and less restrictive techniques
- 4 have been tried and failed, or if it has been
- 5 clinically determined that the danger is
- 6 of such immediacy that less restrictive
- 7 techniques cannot be safely applied.
- 8
- 9 4. There is a high prevalence of past traumatic
- 10 experience among persons who receive
- 11 mental health services. The response
- 12 to trauma can include intense fear and
- 13 helplessness, a reduced ability to cope,
- 14 and an increased risk to exacerbate or
- 15 develop a range of mental health and other
- 16 medical conditions. The experience of being
- 17 placed in seclusion or being restrained is
- 18 potentially traumatizing. Seclusion and
- 19 restraint practices shall be guided by the
- 20 following principles of trauma-informed
- 21 care: assessment of traumatic histories
- 22 and symptoms; recognition of culture and
- 23 practices that are re-traumatizing; processing
- 24 the impact of a seclusion or restraint with the
- 25 person; and addressing staff training needs to
- 26 improve knowledge and sensitivity.
- 27
- 28 5. When a person demonstrates a need for
- 29 immediate medical attention in the course
- 30 of an episode of seclusion or restraint, the
- 31 seclusion or restraint shall be discontinued,
- 32 and immediate medical attention shall be
- 33 obtained.
- 34
- 35 6. Persons will not be restrained in a prone
- 36 position. Prone containment will be used
- 37 only when required by the immediate
- 38 situation to prevent imminent serious harm
- 39 to the person or others. To reduce the risk of
- 40 positional asphyxiation, the person will be
- 41 repositioned as quickly as possible.
- 42
- 43 7. Responders will pay close attention to
- 44 respiratory function of the person during
- 45 containment and restraint. All staff involved
- 46 will observe the person's respiration,
- 47 coloring, and other possible signs of distress
- 48 and immediately respond if the person
- 49 appears to be in distress. Responding to the
- 50 person's distress may include repositioning
- 51 the person, discontinuing the seclusion or
- 52 restraint, or summoning medical attention,
- 53 as necessary.
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Rights of patients

Training required for all
direct service staff. See
also 65E-5.330, F.A.C.

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8. Objects that impair respiration shall not be placed over a person's face. In situations where precautions need to be taken to protect staff, staff may wear protective gear.
 9. Unless necessary to prevent serious injury, a person's hands shall not be secured behind the back during containment or restraint.
 10. The use of walking restraints is prohibited except for purposes of off-unit transportation and may only be used under direct observation of trained staff. In this instance, direct observation means that staff maintains continual visual contact of the person and is within close physical proximity to the person at all times.
 11. The person shall be released from seclusion or restraint as soon as he or she is no longer an imminent danger to self or others.
 12. Seclusion or restraint use shall not be based on the person's seclusion or restraint use history or solely on a history of dangerous behavior. Dangerous behaviors include those behaviors that jeopardize the physical safety of oneself or others.
 13. Seclusion and restraint may not be used simultaneously for children less than 18 years of age.
 14. A person who is restrained must not be located in areas, whenever possible, subject to view by persons other than involved staff or where exposed to potential injury by other persons. This does not apply to the use of walking restraints.
 15. Each facility utilizing seclusion or restraint procedures shall establish and utilize a Seclusion and Restraint Oversight Committee.
- (b) **Staff training.**
Staff must be trained as part of orientation and subsequently on at least an annual basis. Staff responsible for the following actions will demonstrate relevant competency in the following areas before participating in a seclusion or restraint event or related assessment, or before monitoring or providing care during an event:
1. Strategies designed to reduce confrontation and to calm and comfort people, including the development and use of a personal safety plan,

Prior to Seclusion and Restraint.

2. Use of nonphysical intervention skills as well as bodily control and physical management techniques, based on a team approach, to ensure safety,
 3. Observing for and responding to signs of physical and psychological distress during the seclusion or restraint event,
 4. Safe application of restraint devices,
 5. Monitoring the physical and psychological well-being of the person who is restrained or secluded, including but not limited to: respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by facility policy associated with the one hour face-to-face evaluation,
 6. Clinical identification of specific behavioral changes that indicate restraint or seclusion is no longer necessary,
 7. The use of first aid techniques, and
 8. Certification in the use of cardiopulmonary resuscitation, including required periodic recertification. The frequency of training for cardiopulmonary resuscitation will be in accordance with certification requirements, notwithstanding provision subparagraph (7)(b).
- (c) Prior to the Implementation of Seclusion or Restraint.**
1. Prior intervention shall include individualized therapeutic actions such as those identified in a personal safety plan that address individual triggers leading to psychiatric crisis. Recommended form CF-MH 3124, Feb. 05, "Personal Safety Plan," 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 for the purpose of guiding individualized techniques. Prior interventions may also include verbal de-escalation and calming strategies. Non physical interventions shall be the first choice unless safety issues require the use of physical intervention.
 2. A personal safety plan shall be completed or updated as soon as possible after admission and filed in the person's medical record.
 - a. This form shall be reviewed by the recovery team, and updated if necessary,

Rights of patients

Federal conditions of participation and JCAHO/CARF requirements governing seclusion/restraints may also apply. The most stringent standard applying to each facility must be followed.

- 1 after each incident of seclusion or
- 2 restraint.
- 3
- 4 b. Specific intervention techniques from
- 5 the personal safety plan that are offered
- 6 or used prior to a seclusion or restraint
- 7 event shall be documented in the per-
- 8 son's medical record after each use of
- 9 seclusion or restraint.
- 10 c. All staff shall be aware of and have
- 11 ready access to each person's personal
- 12 safety plan.
- 13
- 14 **(d) Implementation of Seclusion or Restraint.**
- 15 1. A registered nurse or highest level staff
- 16 member, as specified by written facility
- 17 policy, who is immediately available and
- 18 who is trained in seclusion and restraint
- 19 procedures may initiate seclusion or restraint
- 20 in an emergency when danger to oneself or
- 21 others is imminent. An order for seclusion
- 22 or restraint must be obtained from the
- 23 physician, Advanced Registered Nurse
- 24 Practitioner (ARNP), or Physician's Assistant
- 25 (PA), if permitted by the facility to order
- 26 seclusion and restraint and stated within
- 27 their professional protocol. The treating
- 28 physician must be consulted as soon as
- 29 possible if the seclusion or restraint was not
- 30 ordered by the person's treating physician.
- 31
- 32 2. An examination of the person will be
- 33 conducted within one hour by the physician
- 34 or may be delegated to an Advanced
- 35 Registered Nurse Practitioner, Physician's
- 36 Assistant, or Registered Nurse (RN), if
- 37 authorized by the facility and trained
- 38 in seclusion and restraint procedures
- 39 as described in paragraph (7)(b). This
- 40 examination shall include a face-to face
- 41 assessment of the person's medical and
- 42 behavioral condition, a review of the
- 43 clinical record for any pre-existing medical
- 44 diagnosis or physical condition which
- 45 may contraindicate the use of seclusion or
- 46 restraint, a review of the person's medication
- 47 orders including an assessment of the need
- 48 to modify such orders during the period of
- 49 seclusion or restraint, and an assessment
- 50 of the need or lack of need to elevate the
- 51 person's head and torso during restraint.
- 52 The comprehensive examination must
- 53
- 54

Statute

(Chapter 394.459 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.180 F.A.C.

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determine that the risks associated with the use of seclusion or restraint are significantly less than not using seclusion or restraint and whether to continue or terminate the intervention. A licensed psychologist may conduct only the behavioral assessment portion of the comprehensive assessment if authorized by the facility and trained in seclusion and restraint procedures as described in paragraph (7)(b). Documentation of the comprehensive examination, including the time and date completed, shall be included in the person's medical record. If the face-to-face evaluation is conducted by a trained Registered Nurse, the attending physician who is responsible for the care of the person must be consulted as soon as possible after the evaluation is completed.

3. Each written order for seclusion or restraint is limited to four hours for adults, age 18 and over; two hours for children and adolescents age nine through 17; or one hour for children under age nine. A seclusion or restraint order may be renewed in accordance with these limits for up to a total of 24 hours, after consultation and review by a physician, ARNP, or PA in person, or by telephone with a Registered Nurse who has physically observed and evaluated the person. When the order has expired after 24 hours, a physician, ARNP, or PA must see and assess the person before seclusion or restraint can be re-ordered. The results of this assessment must be documented. Seclusion or restraint use exceeding 24 hours requires the notification of the Facility Administrator or designee.
4. All orders must be signed within 24 hours of the initiation of seclusion or restraint.
5. The order shall include the specific behavior prompting the use of seclusion or restraint, the time limit for seclusion or restraint, and the behavior necessary for the person's release. Additionally, for restraint, the order shall contain the type of restraint ordered and the positioning of the person, including possibly elevating the person's head for respiratory and other medical safety considerations. Consideration shall be

Rights of patients

Statute

(Chapter 394.459 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.180 F.A.C.

- 1 given to age, physical fragility, and physical
- 2 disability when ordering restraint type.
- 3
- 4 6. An order for seclusion or restraint shall not
- 5 be issued as a standing order or on an as-
- 6 needed basis.
- 7
- 8 7. In order to protect the safety of each
- 9 person served by a facility, each person
- 10 shall be searched for contraband before
- 11 or immediately after being placed into
- 12 seclusion or restraints.
- 13
- 14 8. The person shall be clothed appropriately for
- 15 temperature and at no time shall a person
- 16 be placed in seclusion or restraint in a nude
- 17 or semi-nude state.
- 18
- 19 9. Every secluded or restrained person shall be
- 20 immediately informed of the behavior that
- 21 resulted in the seclusion or restraint and the
- 22 behavior and the criteria reflecting absence
- 23 of imminent danger that are necessary for
- 24 release.
- 25
- 26 10. For persons under the age of 18, the facility
- 27 must notify the parent(s) or legal guardian(s)
- 28 of the person who has been restrained or
- 29 placed in seclusion as soon as possible, but
- 30 no later than 24 hours, after the initiation
- 31 of each seclusion or restraint event. This
- 32 notification must be documented in the
- 33 person's medical record, including the date
- 34 and time of notification and the name of the
- 35 staff person providing the notification.
- 36
- 37 11. For each use of seclusion or restraint, the
- 38 following information shall be documented
- 39 in the person's medical record: the
- 40 emergency situation resulting in the
- 41 seclusion or restraint event; alternatives
- 42 or other less restrictive interventions
- 43 attempted, as applicable, or the clinical
- 44 determination that less restrictive
- 45 techniques could not be safely applied;
- 46 the name and title of the staff member
- 47 initiating the seclusion or restraint; the
- 48 date/time of initiation and release; the
- 49 person's response to seclusion or restraint,
- 50 including the rationale for continued use of
- 51 the intervention; and that the person was
- 52 informed of the behavior that resulted in
- 53 the seclusion or restraint and the criteria
- 54 necessary for release.

Statute

(Chapter 394.459 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.180 F.A.C.

During seclusion and restraint.

Federal and JCAHO requirements governing seclusion and restraints may apply.

(e) During Seclusion or Restraint Use.

1. When restraint is initiated, nursing staff shall see and assess the person as soon as possible but no later than 15 minutes after initiation and at least every hour thereafter. The assessment shall include checking the person's circulation and respiration, including necessary vital signs (pulse and respiratory rate at a minimum).
2. The person over age 12 who is secluded shall be observed by trained staff every 15 minutes. At least one observation an hour will be conducted by a 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 the first hour and then at least every 15 minutes thereafter.
3. Monitoring the physical and psychological well-being of the person who is secluded or restrained shall include but is not limited to: respiratory and circulatory status; signs of injury; vital signs; skin integrity; and any special requirements specified by facility policies. This monitoring shall be conducted by trained staff as required in paragraph (7)(b).
4. During each period of seclusion or restraint, the person must be offered reasonable opportunities to drink and toilet as requested. In addition, the person who is restrained must be offered opportunities to have range of motion at least every two hours to promote comfort. Each facility shall have written policies and procedures specifying the frequency of providing drink, toileting, and check of bodily positioning to avoid traumatizing a person and retaining the person's maximum degree of dignity and comfort during the use of bodily control and physical management techniques.
5. Documentation of the observations and the staff person's name shall be recorded at the time the observation takes place.

(f) Release from Seclusion or Restraint and Post-Release Activities.

1. Release from seclusion or restraint shall

Rights of patients

Release and Post-Release from
seclusion and restraint.

- 1 occur as soon as the person no longer
- 2 appears to present an imminent danger
- 3 to themselves or others. Upon release
- 4 from seclusion or restraint, the person's
- 5 physical condition shall be observed,
- 6 evaluated, and documented by trained staff.
- 7 Documentation shall also include: the name
- 8 and title of the staff releasing the person;
- 9 and the date and time of release.
- 10
- 11 2. After a seclusion or restraint event, a
- 12 debriefing process shall take place to
- 13 decrease the likelihood of a future seclusion
- 14 or restraint event for the person and to
- 15 provide support.
- 16 a. Each facility shall develop policies to ad-
- 17 dress:
- 18 (I) A review of the incident with the person
- 19 who was secluded or restrained. The
- 20 person shall be given the opportunity to
- 21 process the seclusion or restraint event
- 22 as soon as possible but no longer than
- 23 within 24 hours of release. This debrief-
- 24 ing discussion shall take place between
- 25 the person and either the recovery team
- 26 or another preferred staff member. This
- 27 review shall seek to understand the
- 28 incident within the framework of the
- 29 person's life history and mental health
- 30 issues. It should assess the impact of
- 31 the event on the person and help the
- 32 person identify and expand coping
- 33 mechanisms to avoid the use of seclu-
- 34 sion or restraint in the future. The discus-
- 35 sion will include constructive coping
- 36 techniques for the future. A summary
- 37 of this review should be documented in
- 38 the person's medical record.
- 39 (II) A review of the incident with all staff
- 40 involved in the event and supervisors
- 41 or administrators. This review shall be
- 42 conducted as soon as possible after the
- 43 event and shall address: the circum-
- 44 stances leading to the event, the nature
- 45 of de-escalation efforts and alternatives
- 46 to seclusion and restraint attempted,
- 47 staff response to the incident, and ways
- 48 to effectively support the person's con-
- 49 structive coping in the future and avoid
- 50 the need for future seclusion or restraint.
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Reporting events of seclusion
and restraint.

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- The outcomes of this review should be documented by the facility for purposes of continuous performance improvement and monitoring. The review findings will be forwarded to the Seclusion and Restraint Oversight Committee, and
- (III) Support for other persons served and staff, as needed, to return the unit to a therapeutic milieu.
- b. Within 2 working days after any use of seclusion or restraint, the recovery team shall meet and review the circumstances preceding its initiation and review the person's recovery plan and personal safety plan to determine whether any changes are needed in order to prevent the further use of seclusion or restraint. The recovery team shall also assess the impact the event had on the person and provide any counseling, services, or treatment that may be necessary as a result. The recovery team shall analyze the person's clinical record for trends or patterns relating to conditions, events, or the presence of other persons immediately before or upon the onset of the behavior warranting the seclusion or restraint, and upon the person's release from seclusion. The recovery team shall review the effectiveness of the emergency intervention and develop more appropriate therapeutic interventions. Documentation of this review shall be placed in the person's clinical record.
- c. The Seclusion and Restraint Oversight Committee shall conduct timely reviews of each use of seclusion and restraints and monitor patterns of use, for the purpose of assuring least restrictive approaches are utilized to prevent or reduce the frequency and duration of use.
- (g) Reporting.**
1. All facilities, as defined in Section 394.455(10), Florida Statutes, are required to report each seclusion and restraint event to the Department of Children and Families. This reporting shall be done electronically using the Department's web-based application either directly via

- 1 the data input screens or indirectly via the
- 2 File Transfer Protocol batch process. The
- 3 required reporting elements are: Provider
- 4 tax identification number; Person's social
- 5 security number and identification number;
- 6 date and time the seclusion or restraint
- 7 event was initiated; discipline of the person
- 8 ordering the seclusion or restraint; discipline
- 9 of the person implementing the seclusion or
- 10 restraint; reason seclusion or restraint was
- 11 initiated; type of restraint used; whether
- 12 significant injuries were sustained by the
- 13 person; and date and time seclusion or
- 14 restraint was terminated. Facilities shall
- 15 report seclusion and restraint events on a
- 16 monthly basis. Events that result in death or
- 17 significant injury either to a staff member or
- 18 person shall be reported to the department's
- 19 web based system in accordance with
- 20 department operating procedures.
- 21
- 22
- 23 2. All facilities that are subject to the
- 24 Conditions of Participation for Hospitals,
- 25 42 Code of Federal Regulations, part
- 26 482, under the Centers for Medicare and
- 27 Medicaid Services (CMS), must report to
- 28 CMS any death that occurs in the following
- 29 circumstances:
- 30
- 31 a. While a person is restrained or secluded;
- 32 b. Within 24 hours after release from seclu-
- 33 sion or restraint; or
- 34 c. Within one week after seclusion or re-
- 35 straint, where it is reasonable to assume
- 36 that use of the seclusion or restraint
- 37 contributed directly or indirectly to the
- 38 person's death.
- 39 Each death described in this section shall be
- 40 reported to CMS by telephone no later than
- 41 the close of business the next business day
- 42 following knowledge of the persons' death.
- 43 A report shall simultaneously be submitted
- 44 to the Director of Mental Health/Designee
- 45 in the Mental Health Program Office
- 46 headquarters in Tallahassee, FL. The address
- 47 is: 1317 Winewood Blvd., Tallahassee, FL,
- 48 32399-0700.
- 49
- 50 3. The Department shall collect and review
- 51 the data on a monthly basis. The Director
- 52 of Mental Health shall be informed of any
- 53 deaths or significant injuries related to
- 54

Protective Medical Devices.

- seclusion or restraint and significant trends regarding seclusion and restraint use.
- (h) Nothing herein shall affect the ability of emergency medical technicians, paramedics or physicians or any person acting under the direct medical supervision of a physician to provide examination or treatment of incapacitated persons in accordance with Section 401.445, F.S.
- (8) **Use of Protective Medical Devices with Frail or Mobility Impaired Persons.**
- (a) When ordering safety or protective devices such as posey vests, geri-chairs, mittens, and bed rails which also restrain, facility staff shall consider alternative means of providing such safety so that the person's need for regular exercise is accommodated to the greatest extent possible.
- (b) Where frequent or prolonged use of safety or protective devices is required, the person's treatment plan shall address debilitating effects due to decreased exercise levels such as circulation, skin, and muscle tone and the person's need for maintaining or restoring bowel and bladder continence.
- (c) The treatment plan shall include scheduled activities to lessen deterioration due to the usage of such protective medical devices.
- (9) **Elevated Levels of Supervision.** Receiving and treatment facilities shall ensure that where one-on-one supervision is ordered by a physician, it shall be continuous and shall not be interrupted as a result of shift changes or due to conflicting staff assignments. Such supervision shall be continuous until documented as no longer medically necessary by a physician.

65E-5.1802 Maintenance of the Facility.

The facility shall ensure the proper functioning and maintenance of the facility structure, finishes, fixtures, furnishings, and equipment. The facility shall ensure the ready availability of necessary medical equipment or devices for the populations served, including restraint equipment that is suitable to the safety and medical needs of the persons being served.

(5) COMMUNICATION, ABUSE REPORTING, AND VISITS.

- (a) Each person receiving services in a facility providing mental health services under this part has the right to communicate freely and privately with persons outside the facility unless it is determined that such communication is likely to be harmful to the person or others. Each facility shall make available as soon as reasonably possible to persons receiving services a telephone that allows for free local calls and access to a long-distance service. A facility is not required to pay the costs of a patient's long-distance calls. The telephone shall be readily accessible to the patient and shall be placed so that the patient may use it to communicate privately and confidentially. The facility may establish reasonable rules for the use of this telephone, provided that the rules do not interfere with a patient's access to a telephone to report abuse pursuant to paragraph (e).
- (b) Each patient admitted to a facility under the provisions of this part shall be allowed to receive, send, and mail sealed, unopened correspondence; and no patient's incoming or outgoing correspondence shall be opened, delayed, held, or censored by the facility unless there is reason to believe that it contains items or substances which may be harmful to the patient or others, in which case the administrator may direct reasonable examination of such mail and may regulate the disposition of such items or substances.
- (c) Each facility must permit immediate access to any patient, subject to the patient's right to deny or withdraw consent at any time, by the patient's family members, guardian, guardian advocate, representative, Florida statewide or local advocacy council, or attorney, unless such access would be detrimental to the patient. If a patient's

65E-5.190 Right to Communication and Visits.

- (1) If the treatment team imposes any restrictions on whom a person in a receiving or treatment facility may communicate, such restrictions and justification shall be recorded in the person's clinical record. Recommended form CF-MH 3049, Feb. 05, "Restriction of Communication or Visitors," 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 for this purpose. Facility staff shall make competent adults aware that they have the ability to waive the confidentiality of their presence in a receiving or treatment facility and allowing all or specified individuals the person selects access to private and open communication with the person. Recommended form CF-MH 3048, Feb. 05, "Confidentiality Agreement," incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.
- (2) Immediate access to a telephone shall be provided to each person requesting to call his or her legal counsel, Florida Abuse Registry, Florida Local Advocacy Council, or the Advocacy Center for Persons with Disabilities.

Florida statewide and local advocacy councils no longer exist because they were de-funded by the 2010 Florida Legislature.

Statute

(Chapter 394.459 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.190 F.A.C.

- right to communicate or to receive visitors
is restricted by the facility, written notice
of such restriction and the reasons for
the restriction shall be served on the
patient, the patient's attorney, and the
patient's guardian, guardian advocate, or
representative; and such restriction shall
be recorded on the patient's clinical record
with the reasons therefor. The restriction
of a patient's right to communicate or to
receive visitors shall be reviewed at least
every 7 days. The right to communicate
or receive visitors shall not be restricted as
a means of punishment. Nothing in this
paragraph shall be construed to limit the
provisions of paragraph (d).
- (d) Each facility shall establish reasonable rules
governing visitors, visiting hours, and the
use of telephones by patients in the least
restrictive possible manner. Patients shall
have the right to contact and to receive
communication from their attorneys at any
reasonable time.
- (e) Each patient receiving mental health
treatment in any facility shall have ready
access to a telephone in order to report an
alleged abuse. The facility staff shall orally
and in writing inform each patient of the
procedure for reporting abuse and shall
make every reasonable effort to present
the information in a language the patient
understands. A written copy of that
procedure, including the telephone number
of the central abuse hotline and reporting
forms, shall be posted in plain view.
- (f) The department shall adopt rules providing
a procedure for reporting abuse. Facility
staff shall be required, as a condition of
employment, to become familiar with
the requirements and procedures for the
reporting of abuse.

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(6) CARE AND CUSTODY OF PERSONAL EFFECTS OF PATIENTS.

A patient's right to the possession of his or her clothing and personal effects shall be respected. The facility may take temporary custody of such effects when required for medical and safety reasons. A patient's clothing and personal effects shall be inventoried upon their removal into temporary custody. Copies of this inventory shall be given to the patient and to the patient's guardian, guardian advocate, or representative and shall be recorded in the patient's clinical record. This inventory may be amended upon the request of the patient or the patient's guardian, guardian advocate, or representative. The inventory and any amendments to it must be witnessed by two members of the facility staff and by the patient, if able. All of a patient's clothing and personal effects held by the facility shall be returned to the patient immediately upon the discharge or transfer of the patient from the facility, unless such return would be detrimental to the patient. If personal effects are not returned to the patient, the reason must be documented in the clinical record along with the disposition of the clothing and personal effects, which may be given instead to the patient's guardian, guardian advocate, or representative. As soon as practicable after an emergency transfer of a patient, the patient's clothing and personal effects shall be transferred to the patient's new location, together with a copy of the inventory and any amendments, unless an alternate plan is approved by the patient, if able, and by the patient's guardian, guardian advocate, or representative.

(7) VOTING IN PUBLIC ELECTIONS.

A patient who is eligible to vote according to the laws of the state has the right to vote in the primary and general elections. The department shall establish rules to enable patients to obtain voter registration forms, applications for absentee ballots, and absentee ballots.

65E-5.200 Right to Care and Custody of Personal Effects.

Each designated receiving and treatment facility shall develop policies and procedures governing what personal effects will be removed from persons for reasons of personal or unit safety, how they will be safely retained by the facility, and how and when they will be returned to the person or other authorized individual. Policies and procedures shall specify how contraband and other personal effects determined to be detrimental to the person will be addressed when not returned to the person or other authorized individual. An inventory of personal effects shall be witnessed by two staff and by the person, if able, at the time of admission, at any time the inventory is amended, and at the time the personal effects are returned or transferred. Recommended form CF-MH 3043, Feb. 05, "Inventory of Personal Effects," 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 for this purpose.

65E-5.210 Right to Vote in Public Elections.

The facility shall have voter registration forms and applications for absentee ballots readily available at the facility or in accordance with the procedures established by the 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 receiving and treatment facility shall develop policies and procedures governing how persons will be assisted in exercising their right to vote.

(8) HABEAS CORPUS.

- (a) At any time, and without notice, a person held in a receiving or treatment facility, or a relative, friend, guardian, guardian advocate, representative, or attorney, or the department, on behalf of such person, may petition for a writ of habeas corpus to question the cause and legality of such detention and request that the court order a return to the writ in accordance with chapter 79. Each patient held in a facility shall receive a written notice of the right to petition for a writ of habeas corpus.
- (b) At any time, and without notice, a person who is a patient in a receiving or treatment facility, or a relative, friend, guardian, guardian advocate, representative, or attorney, or the department, on behalf of such person, may file a petition in the circuit court in the county where the patient is being held alleging that the patient is being unjustly denied a right or privilege granted herein or that a procedure authorized herein is being abused. Upon the filing of such a petition, the court shall have the authority to conduct a judicial inquiry and to issue any order needed to correct an abuse of the provisions of this part.
- (c) The administrator of any receiving or treatment facility receiving a petition under this subsection shall file the petition with the clerk of the court on the next court working day.
- (d) No fee shall be charged for the filing of a petition under this subsection.

(9) VIOLATIONS.

The department shall report to the Agency for Health Care Administration any violation of the rights or privileges of patients, or of any procedures provided under this part, by any facility or professional licensed or regulated by the agency. The agency is authorized to impose any sanction authorized for violation of this part, based solely on the investigation and findings of the department.

65E-5.220 Right to Habeas Corpus.

- (1) Upon admission to a receiving or treatment facility, each person shall be given notice of his or her right to petition for a writ of habeas corpus and for redress of grievances. Recommended form CF-MH 3036, Feb. 05, "Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances," 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 for this purpose. A copy of the notice shall be provided to the guardian, guardian advocate, representative, or the health care surrogate or proxy, and the person's clinical record shall contain documentation that the notice was provided. A petition form shall be promptly provided by staff to any person making a request for such a petition. Recommended form CF-MH 3090, Feb. 05, "Petition for Writ of Habeas Corpus or for Redress of Grievances," 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 for this purpose.
- (2) Receiving and treatment facilities shall accept and forward to the appropriate court of competent jurisdiction a petition submitted by the person or others in any form in which it is presented.

65E-5.601 Operation and Administration of State Mental Health Treatment Facilities.

- (1) In order to protect the welfare of the individuals residing in state civil mental health facilities, the department shall establish the following grievance process for residents of all state civil mental health treatment facilities. The process shall be explained during the orientation process and in written orientation materials.

(10) LIABILITY FOR VIOLATIONS.

Any person who violates or abuses any rights or privileges of patients provided by this part is liable for damages as determined by law. Any person who acts in good faith in compliance with the provisions of this part is immune from civil or criminal liability for his or her actions in connection with the admission, diagnosis, treatment, or discharge of a patient to or from a facility. However, this section does not relieve any person from liability if such person commits negligence.

(11) RIGHT TO PARTICIPATE IN TREATMENT AND DISCHARGE PLANNING.

The patient shall have the opportunity to participate in treatment and discharge planning and shall be notified in writing of his or her right, upon discharge from the facility, to seek treatment from the professional or agency of the patient's choice.

(12) POSTING OF NOTICE OF RIGHTS OF PATIENTS.

Each facility shall post a notice listing and describing, in the language and terminology that the persons to whom the notice is addressed can understand, the rights provided in this section. This notice shall include a statement that provisions of the federal Americans with Disabilities Act apply and the name and telephone number of a person to contact for further information. This notice shall be posted in a place readily accessible to patients and in a format easily seen by patients. This notice shall include the telephone numbers of the Florida local advocacy council and Advocacy Center for Persons with Disabilities, Inc.

Florida Local Advocacy Council is no longer in existence. Advocacy Center for Persons with Disabilities is now known as Disability Rights Florida, Inc.

- (2) Any grievance may be verbal or written. When the grievance is verbal, the facility will provide a party not named in the dispute to assist the resident in writing the grievance. The grievance shall detail the issue and the remedy sought. All resident grievances shall be addressed to the resident advocate and the unit director or treatment team leader. The Resident Advocacy Office shall monitor all grievances.
- (3) The grievance shall be date-stamped upon receipt by the unit director or treatment team leader. At a minimum, the resident shall receive a written response to the grievance within 14 calendar days from date of receipt. The resident or the resident's representative may appeal the disposition of a grievance to the facility administrator.
- (4) The steps for filing a grievance as stated in this rule shall be conspicuously posted in the living areas where the residents can read the steps.

65E-5.602 Rights of Residents of State Mental Health Treatment Facilities.

- (1) Each state civil mental health treatment facility shall make telephones available for residents. Any restriction on telephone usage shall be documented in the clinical record. Such documentation shall specify the reason for the restriction, its duration, and the treatment goals and interventions aimed at lifting the restriction. At no time, shall there be a restriction of telephone access to his or her legal counsel, the Florida Abuse Registry, Local or Statewide Advocacy Councils, or the Advocacy Center for Persons with Disabilities.
- (2) The Department shall protect the confidentiality of records within the facility and in transport to other facilities and other therapeutic services.
- (3) Each state civil mental health treatment facility shall post instructions conspicuously in living areas and visiting areas where residents and visitors can read the instructions on how to report a complaint.
- (4) Each state civil mental health treatment facility shall establish visiting hours for each of its residential units. The visiting hours shall be based on the needs of residents and their visitors and shall minimize interruption of the individual's treatment program

- schedules. Each state civil mental health treatment facility shall post its visiting hours in places where residents and visitors frequent. Visiting hours shall be provided to the resident, family, and representatives at the time of admission. Visitors may request exceptions to posted visiting hours with the Unit Director or treatment team leader.
- (5) Each state civil mental health treatment facility shall establish with the local county supervisor of elections, a process for allowing eligible residents to register and to vote in public elections. The process shall be published and provided to each resident and conspicuously posted in living areas where residents can read it. The resident's representative shall also be informed of the process. The facility shall make available voter registration forms, applications for absentee ballots, and absentee ballots.
- (6) No state civil mental health treatment facility shall initiate any mental health treatment, including psychotropic medication, until express and informed consent for psychiatric treatment is obtained from a person legally qualified to give it, except in the following situations:
- (a) Where emergency psychotropic medication treatment is ordered by a physician, as defined in Section 394.455(21), F.S., to preserve the immediate safety of the resident or others in the facility;
- (b) When a person is admitted to a state mental health treatment facility and has a current prescription for psychotropic medication(s), is unable to provide express and informed consent, is determined by the admitting physician to be in need of the medication prescribed prior to admission and an alternative decision maker is being pursued through the court; or
- (c) When a Court Order is obtained after adequate notice and hearing.
- (7) (a) Any limitation or restriction of a resident's access to the grounds or treatment program shall be based on clearly documented evidence of risks to self or others.
- (b) The time span during which residents are allowed access to the grounds shall be specified conspicuously and posted in living areas. Access to grounds may be limited during the hours a resident is scheduled to attend prescribed programming. Access to grounds status shall

- 1 be established and documented in the clinical
- 2 record for all newly admitted persons within 72
- 3 hours of admission.
- 4 (c) An individualized plan shall be developed and
- 5 documented in the clinical record for residents
- 6 who have been identified by the treatment team
- 7 as experiencing significant loss of independent
- 8 access to grounds.
- 9 (d) Those residents certified by the facility as
- 10 experiencing long-term loss of independent
- 11 access to grounds based on physical health
- 12 issues or adaptive deficits shall be provided
- 13 opportunities to go outside unless medically
- 14 contraindicated.
- 15 (e) Any change to access to the grounds status shall
- 16 be based on the treatment team's assessment.
- 17 An assessment of risk shall consider, at a
- 18 minimum, the following categories of risk:
- 19 1. Suicide attempts or threats,
- 20 2. Intentional self-injury,
- 21 3. Homicide,
- 22 4. Assault,
- 23 5. Elopement,
- 24 6. Substance abuse,
- 25 7. Physically vulnerable,
- 26 8. Psychotropic medication issues, and
- 27 9. Other potentially harmful behaviors.
- 28 (f) Decisions about changes in access to grounds
- 29 status shall be based in part on an assessment
- 30 of risk, with criteria influencing access changes
- 31 being documented and filed in the person-
- 32 centered record.
- 33 (g) Teams shall show progressive actions taken
- 34 to manage significant, recurring issues for
- 35 residents in the least restrictive manner possible.
- 36 The exception shall be those changes where a
- 37 resident's access to the grounds is limited due to
- 38 serious, acute health/safety matters. Interventions
- 39 must be documented in order to show the use of
- 40 the least intrusive, most positive methods for the
- 41 restoration of freedom of movement and follow
- 42 through with treatment before the use of more
- 43 restrictive options.
- 44 (h) Residents who disagree with limitations to
- 45 grounds access shall have a right to a review of
- 46 those limitations. Each treatment facility shall
- 47 publish procedures to insure the limitations
- 48 are reviewed. The resident or the resident's
- 49 representative may appeal the restriction to
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Statute

(Chapter 394.4593 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.602 F.A.C.

394.4593 Sexual misconduct prohibited; reporting required; penalties.

- (1) As used in this section, the term:
 - (a) “Employee” includes any paid staff member, volunteer, or intern of the department; any person under contract with the department; and any person providing care or support to a client on behalf of the department or its providers.
 - (b) “Sexual activity” means:
 1. Fondling the genital area, groin, inner thighs, buttocks, or breasts of a person.
 2. The oral, anal, or vaginal penetration by or union with the sexual organ of another or the anal or vaginal penetration of another by any other object.
 3. Intentionally touching in a lewd or lascivious manner the breasts, genitals, the genital area, or buttocks, or the clothing covering them, of a person, or forcing or enticing a person to touch the perpetrator.
 4. Intentionally masturbating in the presence of another person.
 5. Intentionally exposing the genitals in a lewd or lascivious manner in the presence of another person.

the facility administrator through the grievance process.

- (i) Residents shall retain their access to grounds status when transferred from one residential area to another, unless their psychological or physical condition has changed, based on a comprehensive risk assessment.
- (j) Residents who do not have full access to the grounds shall be provided the opportunity to exit the building for outside time and physical exercise on a daily basis, excluding severe weather conditions, for at least a half-hour per day. Residents have the right to decline to go outside, if they so choose.
- (k) All residents with full or prescribed access to grounds (as indicated in their individualized service plan) shall be provided with an orientation to grounds and boundaries of the facility.

N/A

6. Intentionally committing any other sexual act that does not involve actual physical or sexual contact with the victim, including, but not limited to, sadomasochistic abuse, sexual bestiality, or the simulation of any act involving sexual activity in the presence of a victim.
- (c) "Sexual misconduct" means any sexual activity between an employee and a patient, regardless of the consent of the patient. The term does not include an act done for a bona fide medical purpose or an internal search conducted in the lawful performance of duty by an employee.
- (2) An employee who engages in sexual misconduct with a patient who:
 - (a) Is in the custody of the department; or
 - (b) Resides in a receiving facility or a treatment facility, as those terms are defined in s. 394.455, commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. An employee may be found guilty of violating this subsection without having committed the crime of sexual battery.
- (3) The consent of the patient to sexual activity is not a defense to prosecution under this section.
- (4) This section does not apply to an employee who:
 - (a) Is legally married to the patient; or
 - (b) Has no reason to believe that the person with whom the employee engaged in sexual misconduct is a patient receiving services as described in subsection (2).
- (5) An employee who witnesses sexual misconduct, or who otherwise knows or has reasonable cause to suspect that a person has engaged in sexual misconduct, shall immediately report the incident to the department's central abuse hotline and to the appropriate local law enforcement agency. Such employee shall also prepare, date, and sign an independent report that specifically describes the nature of the sexual misconduct, the location and time of the incident, and the persons involved. The

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Sexual misconduct

Statute

(Chapter 394.4595 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5 F.A.C.

employee shall deliver the report to the supervisor or program director, who is responsible for providing copies to the department's inspector general. The inspector general shall immediately conduct an appropriate administrative investigation, and, if there is probable cause to believe that sexual misconduct has occurred, the inspector general shall notify the state attorney in the circuit in which the incident occurred.

- (6) (a) Any person who is required to make a report under this section and who knowingly or willfully fails to do so, or who knowingly or willfully prevents another person from doing so, commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.
- (b) Any person who knowingly or willfully submits inaccurate, incomplete, or untruthful information with respect to a report required under this section commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.
- (c) Any person who knowingly or willfully coerces or threatens any other person with the intent to alter testimony or a written report regarding an incident of sexual misconduct commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
- (7) The provisions and penalties set forth in this section are in addition to any other civil, administrative, or criminal action provided by law which may be applied against an employee.

394.4595 Florida statewide and local advocacy councils; access to patients and records.

Any facility designated by the department as a receiving or treatment facility must allow access to any patient and the clinical and legal records of any patient admitted pursuant to the provisions of this act by members of the Florida statewide and local advocacy councils.

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N/A

Florida statewide and local advocacy councils no longer exist because they were de-funded by the 2010 Florida Legislature.

Local advocacy council

394.4597 Persons to be notified; patient's representative.

- (1) VOLUNTARY PATIENTS. At the time a patient is voluntarily admitted to a receiving or treatment facility, the identity and contact information of a person to be notified in case of an emergency shall be entered in the patient's clinical record.
- (2) INVOLUNTARY PATIENTS.
 - (a) At the time a patient is admitted to a facility for involuntary examination or placement, or when a petition for involuntary placement is filed, the names, addresses, and telephone numbers of the patient's guardian or guardian advocate, or representative if the patient has no guardian, and the patient's attorney shall be entered in the patient's clinical record.
 - (b) If the patient has no guardian, the patient shall be asked to designate a representative. If the patient is unable or unwilling to designate a representative, the facility shall select a representative.
 - (c) The patient shall be consulted with regard to the selection of a representative by the receiving or treatment facility and shall have authority to request that any such representative be replaced.
 - (d) When the receiving or treatment facility selects a representative, first preference shall be given to a health care surrogate, if one has been previously selected by the patient. If the patient has not previously selected a health care surrogate, the selection, except for good cause documented in the patient's clinical record, shall be made from the following list in the order of listing:
 1. The patient's spouse.
 2. An adult child of the patient.
 3. A parent of the patient.
 4. The adult next of kin of the patient.
 5. An adult friend of the patient.
 6. The appropriate Florida local advocacy council as provided in s. 402.166.

N/A

All adults on involuntary status must have a representative designated unless a guardian has been appointed by the court.

This list is not part of this section of the rule. It is taken from multiple sections of the statute/rule and compiled here as one list because it is relevant to the content of this part of the statutes/rules.

Role of Designated Representative

- 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
- 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

(e) A licensed professional providing services to the patient under this part, an employee of a facility providing direct services to the patient under this part, a department employee, a person providing other substantial services to the patient in a professional or business capacity, or a creditor of the patient shall not be appointed as the patient's representative.

394.4598 Guardian advocate.

- (1) The administrator may petition the court for the appointment of a guardian advocate based upon the opinion of a psychiatrist that the patient is incompetent to consent to treatment. If the court finds that a patient is incompetent to consent to treatment and has not been adjudicated incapacitated and a guardian with the authority to consent to mental health treatment appointed, it shall appoint a guardian advocate. The patient has the right to have an attorney represent him or her at the hearing. If the person is indigent, the court shall appoint the office of the public defender to represent him or her at the hearing. The patient has the right to testify, cross-examine witnesses, and present witnesses. The proceeding shall be recorded either electronically or stenographically, and testimony shall be provided under oath. One of the professionals authorized to give an opinion in support of a petition for involuntary placement, as described in s. 394.4655 or s. 394.467, must testify. A guardian advocate must meet the qualifications of a guardian contained in part IV of chapter 744, except that a professional referred to in this part, an employee of the facility providing direct services to the patient under this part, a departmental employee, a facility administrator, or member of the Florida local advocacy council shall not be appointed. A person who is appointed as a guardian advocate must agree to the appointment.

65E-5.230 Guardian Advocate.

- (1) A copy of the completed recommended form CF-MH 3106, "Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate," as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., or its equivalent, shall be given to the person, the person's representative if any, and to the prospective guardian advocate with a copy retained in the person's clinical record.
- (2) The person's clinical record shall reflect that the guardian advocate has been appointed by the court and has completed the training required by Section 394.4598(4), F.S., and further training required pursuant to a court order, prior to being asked to provide express and informed consent to treatment. Recommended form CF-MH 3120, Feb. 05, "Certification of Guardian Advocate Training Completion," 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 for this purpose.
- (3) When a guardian advocate previously appointed by the court cannot or will not continue to serve in that capacity, and the person remains incompetent to consent to treatment, the facility administrator shall petition the court for a replacement guardian advocate. A copy of the completed petition shall be given to the person, the current guardian advocate, the prospective replacement guardian advocate, person's attorney, and representative, with a copy retained in the person's clinical record. Recommended form CF-MH 3106, "Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate," as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., may be used for this documentation if Parts I and III are completed.

- (2) A facility requesting appointment of a guardian advocate must, prior to the appointment, provide the prospective guardian advocate with information about the duties and responsibilities of guardian advocates, including the information about the ethics of medical decisionmaking. Before asking a guardian advocate to give consent to treatment for a patient, the facility shall provide to the guardian advocate sufficient information so that the guardian advocate can decide whether to give express and informed consent to the treatment, including information that the treatment is essential to the care of the patient, and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects. Before giving consent to treatment, the guardian advocate must meet and talk with the patient and the patient's physician in person, if at all possible, and by telephone, if not. The decision of the guardian advocate may be reviewed by the court, upon petition of the patient's attorney, the patient's family, or the facility administrator.
- (3) Prior to a guardian advocate exercising his or her authority, the guardian advocate shall attend a training course approved by the court. This training course, of not less than 4 hours, must include, at minimum, information about the patient rights, psychotropic medications, diagnosis of mental illness, the ethics of medical decisionmaking, and duties of guardian advocates. This training course shall take the place of the training required for guardians appointed pursuant to chapter 744.
- (4) The information to be supplied to prospective guardian advocates prior to their appointment and the training course for guardian advocates must be developed and completed through a course developed by the department and approved by the chief judge of the circuit court and taught by a court-approved organization. Court-approved organizations may include, but are not limited to, community or junior colleges, guardianship organizations, and the local

- (4) If the court finds the person incompetent to consent to treatment a guardian advocate shall be appointed. Recommended form CF-MH 3107, Feb. 05, "Order Appointing Guardian Advocate," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or other order used by the court, may be used for documentation of this finding. The order shall be provided to the person, guardian advocate, representative, and to the facility administrator for retention in the person's clinical record.
- (5) If a guardian advocate is required by Section 394.4598, F.S., or otherwise to petition the court for authority to consent to extraordinary treatment, a copy of the completed petition form shall be given to the person, a copy to the attorney representing the person, and a copy retained in the person's clinical record. Recommended form CF-MH 3108, Feb. 05, "Petition Requesting Court Approval for Guardian Advocate to Consent to Extraordinary Treatment," 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 for this purpose. Any order issued by the court in response to such a petition shall be given to the person, attorney representing the person, guardian advocate, and to the facility administrator, with a copy retained in the person's clinical record. Recommended form CF-MH 3109, Feb. 05, "Order Authorizing Guardian Advocate to Consent to Extraordinary Treatment," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or other order used by the court may be used for such documentation.
- (6) At any time a person, who has previously been determined to be incompetent to consent to treatment and had a guardian advocate appointed by the court, has been found by the attending physician to have regained competency to consent to treatment, the facility shall notify the court that appointed the guardian advocate of the patient's competence and the discharge of the guardian advocate. Recommended form CF-MH 3121, Feb. 05, "Notification to Court of Person's Competence to Consent to Treatment and Discharge of Guardian Advocate," 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 for this purpose.

bar association or The Florida Bar. The court may, in its discretion, waive some or all of the training requirements for guardian advocates or impose additional requirements. The court shall make its decision on a case-by-case basis and, in making its decision, shall consider the experience and education of the guardian advocate, the duties assigned to the guardian advocate, and the needs of the patient.

- (5) In selecting a guardian advocate, the court shall give preference to a health care surrogate, if one has already been designated by the patient. If the patient has not previously selected a health care surrogate, except for good cause documented in the court record, the selection shall be made from the following list in the order of listing:
 - (a) The patient's spouse.
 - (b) An adult child of the patient.
 - (c) A parent of the patient.
 - (d) The adult next of kin of the patient.
 - (e) An adult friend of the patient.
 - (f) An adult trained and willing to serve as guardian advocate for the patient.
- (6) If a guardian with the authority to consent to medical treatment has not already been appointed or if the patient has not already designated a health care surrogate, the court may authorize the guardian advocate to consent to medical treatment, as well as mental health treatment. Unless otherwise limited by the court, a guardian advocate with authority to consent to medical treatment shall have the same authority to make health care decisions and be subject to the same restrictions as a proxy appointed under part IV of chapter 765. Unless the guardian advocate has sought and received express court approval in proceeding separate from the proceeding to determine the competence of the patient to consent to medical treatment, the guardian advocate may not consent to:
 - (a) Abortion.
 - (b) Sterilization.
 - (c) Electroconvulsive treatment.

65E-5.2301 Health Care Surrogate or Proxy.

- (1) During the interim period between the time a person is determined to be incompetent to consent to treatment by one or more physicians, pursuant to Section 765.204, F.S., and the time a guardian advocate is appointed by a court to provide express and informed consent to the person's treatment, a health care surrogate designated by the person, pursuant to Chapter 765, Part II, F.S., may provide such consent to treatment.
- (2) In the absence of an advance directive or when the health care surrogate named in the advance directive is no longer able or willing to serve, a health care proxy, pursuant to Chapter 765, Part IV, F.S., may also provide interim consent to treatment.
- (3) Upon the documented determination that a patient is incompetent to make health care decisions for himself or herself by one or more physicians, pursuant to Section 765.204, F.S., the facility shall notify the surrogate or proxy in writing that the conditions under which he or she can exercise his or her authority under the law have occurred. Recommended form CF-MH 3122, Feb. 05, "Certification of Person's Incompetence to Consent to Treatment and Notification of Health Care Surrogate/Proxy," 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 for this purpose.
- (4) If the surrogate selected by the person is not available or is unable to serve or if no advance directive had been prepared by the person, a proxy may be designated as provided by law. Recommended form CF-MH 3123, Feb. 05, "Affidavit of Proxy," 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 for this purpose.
- (5) A petition for adjudication of incompetence to consent to treatment and appointment of a guardian advocate shall be filed with the court within 2 court working days of the determination of the patient's incompetence to consent to treatment by one or more physicians, pursuant to Section 765.204, F.S. Recommended form CF-MH 3106, "Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate," as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., may be used for this purpose.

Statute

(Chapter 394.4599 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.2301 F.A.C.

- (d) Psychosurgery.
- (e) Experimental treatments that have not been approved by a federally approved institutional review board in accordance with 45 C.F.R. part 46 or 21 C.F.R. part 56.

The court must base its decision on evidence that the treatment or procedure is essential to the care of the patient and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects. The court shall follow the procedures set forth in subsection (1) of this section.

- (7) The guardian advocate shall be discharged when the patient is discharged from an order for involuntary outpatient placement or involuntary inpatient placement or when the patient is transferred from involuntary to voluntary status. The court or a hearing officer shall consider the competence of the patient pursuant to subsection (1) and may consider an involuntarily placed patient's competence to consent to treatment at any hearing. Upon sufficient evidence, the court may restore, or the hearing officer may recommend that the court restore, the patient's competence. A copy of the order restoring competence or the certificate of discharge containing the restoration of competence shall be provided to the patient and the guardian advocate.

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.

- (6) The facility shall immediately provide to the health care surrogate or proxy the same information required by statute to be provided to the guardian advocate. In order to protect the safety of the person, the facility shall make available to the health care surrogate or proxy the training required of guardian advocates and ensure that the surrogate or proxy communicate with the person and person's physician prior to giving express and informed consent to treatment.
- (7) Each designated receiving and treatment facility shall adopt policies and procedures specifying how its direct care and assessment staff will be trained on how to honor each person's treatment preferences as detailed in his or her advance directives. The person being served shall be provided information about advance directives and offered assistance in completing an advance directive, if willing and able to do so.

See Appendix C-4 for summary
reference on Substitute
Decision-making including
surrogates and proxies

N/A

Statute

(Chapter 394.4598 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5 F.A.C.

1. When notice is required to be given to a patient, it shall be given both orally and in writing, in the language and terminology that the patient can understand, and, if needed, the facility shall provide an interpreter for the patient.
2. Notice to a patient's guardian, guardian advocate, attorney, and representative shall be given by United States mail and by registered or certified mail with the receipts attached to the patient's clinical record. Hand delivery by a facility employee may be used as an alternative, with delivery documented in the clinical record. If notice is given by a state attorney or an attorney for the department, a certificate of service shall be sufficient to document service.
- (b) A receiving facility shall give prompt notice of the whereabouts of a patient who is being involuntarily held for examination, by telephone or in person within 24 hours after the patient's arrival at the facility, unless the patient requests that no notification be made. Contact attempts shall be documented in the patient's clinical record and shall begin as soon as reasonably possible after the patient's arrival. Notice that a patient is being admitted as an involuntary patient shall be given to the Florida local advocacy council no later than the next working day after the patient is admitted.
- (c) The written notice of the filing of the petition for involuntary placement must contain the following:
 1. Notice that the petition has been filed with the circuit court in the county in which the patient is hospitalized and the address of such court.
 2. Notice that the office of the public defender has been appointed to represent the patient in the proceeding, if the patient is not otherwise represented by counsel.

Representatives must be notified of involuntary admissions unless person objects. No other notices to representatives can be waived.

Guardian must be notified of all involuntary admissions - cannot be waived.

Florida statewide and local advocacy councils no longer exist because they were de-funded by the 2010 Florida Legislature.

3. The date, time, and place of the hearing and the name of each examining expert and every other person expected to testify in support of continued detention.
 4. Notice that the patient, the patient's guardian or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the patient.
 5. Notice that the patient is entitled to an independent expert examination and, if the patient cannot afford such an examination, that the court will provide for one.
- (d) A treatment facility shall provide notice of a patient's involuntary admission on the next regular working day after the patient's arrival at the facility.
- (e) When a patient is to be transferred from one facility to another, notice shall be given by the facility where the patient is located prior to the transfer.

394.460 Rights of professionals.

No professional referred to in this part shall be required to accept patients for treatment of mental, emotional, or behavioral disorders. Such participation shall be voluntary.

394.461 Designation of receiving and treatment facilities.

The department is authorized to designate and monitor receiving facilities and treatment facilities and may suspend or withdraw such designation for failure to comply with this part and rules adopted under this part. Unless designated by the department, facilities are not permitted to hold or treat involuntary patients under this part.

- (1) **RECEIVING FACILITY.** The department may designate any community facility as a receiving facility. Any other facility within the

Designation of facilities

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N/A

Professionals employed by, under contract with, or having privileges at any hospital or receiving facility must comply with any state/federal laws and rules governing those facilities.

65E-5.350 Eligibility Criteria and Procedures for Designation of Baker Act Receiving Facilities.

- (1) **General Provisions.** Pursuant to Sections 394.455(26) and 394.461, F.S., only facilities designated by the department are permitted to involuntarily hold and treat persons for a mental illness, except as required by 42 USC 1395 for all hospitals providing emergency services for access, assessment, stabilization and transfer.
- (2) Designation as a private receiving or treatment facility shall not entitle the facility to receive any

- state, including a private facility or a federal facility, may be so designated by the department, provided that such designation is agreed to by the governing body or authority of the facility.
- (2) **TREATMENT FACILITY.** The department may designate any state-owned, state-operated, or state-supported facility as a state treatment facility. A civil patient shall not be admitted to a state treatment facility without previously undergoing a transfer evaluation. Before a court hearing for involuntary placement in a state treatment facility, the court shall receive and consider the information documented in the transfer evaluation. Any other facility, including a private facility or a federal facility, may be designated as a treatment facility by the department, provided that such designation is agreed to by the appropriate governing body or authority of the facility.
- (3) **PRIVATE FACILITIES.** Private facilities designated as receiving and treatment facilities by the department may provide examination and treatment of involuntary patients, as well as voluntary patients, and are subject to all the provisions of this part.
- (4) (a) A facility designated as a public receiving or treatment facility under this section shall report to the department on an annual basis the following data, unless these data are currently being submitted to the Agency for Health Care Administration:
1. Number of licensed beds.
 2. Number of contract days.
 3. Number of admissions by payor class and diagnoses.
 4. Number of bed days by payor class.
 5. Average length of stay by payor class.
 6. Total revenues by payor class.
- (b) For the purposes of this subsection, “payor class” means Medicare, Medicare HMO, Medicaid, Medicaid HMO, private-pay health insurance, private-pay health maintenance organization, private preferred provider organization, the Department of Children and Family Services, other government programs, self-pay patients, and charity care.

- funding appropriated for the Baker Act. Such funding is based solely on a contract between the department and the facility, specifically for this purpose.
- (3) Two types of licensed civil facilities are authorized to provide acute psychiatric treatment and are eligible to apply for designation as receiving facilities. Since designation to receive persons under Chapter 394, Part I, F.S., does not distinguish between the capacity to serve adults and minors, all designated facilities are required to provide emergency services, consistent with their facility’s licensure to persons regardless of age, except as provided for under subsection (4) of this rule.
- (a) Hospitals licensed under the authority of Chapter 395, F.S., to provide psychiatric care may be designated as either public or private receiving facilities.
- (b) Facilities licensed under the provisions of Chapter 394, Part IV, F.S., shall only be designated as public receiving facilities and may include only crisis stabilization units (CSU) and children’s crisis stabilization units (CCSU). Short-term residential treatment facilities (SRT) are not free-standing emergency care units and may only be designated collectively with a CSU or CCSU as part of a public receiving facility.
- (4) **Specific Circumstances for Designation.** Pursuant to the exceptions authorized under Section 394.462(3), F.S., for transportation purposes, and at the discretion of the department’s district or regional office with the approval of the mental health and substance abuse program supervisor, a facility designation may be modified or restricted to specify services for just adults or for just children, consistent with its license and subject to inclusion and subsequent approval by required parties as part of an approved transportation exemption plan.
- (5) **Application and Supporting Documentation for Designation.** In order to apply for designation as a receiving facility, an applicant must complete and submit mandatory form CF-MH 3125, Feb. 05, “Application for Designation as a Receiving Facility,” which is hereby incorporated by reference and may be obtained in accordance with Rule 65E-5.120, F.A.C., of this rule chapter. Required application information includes:
- (a) A copy of the facility’s license issued pursuant to Chapter 394 or 395, F.S., evidencing its eligibility

- (c) The data required under this subsection shall be submitted to the department no later than 90 days following the end of the facility's fiscal year. A facility designated as a public receiving or treatment facility shall submit its initial report for the 6-month period ending June 30, 2008.
- (d) The department shall issue an annual report based on the data required pursuant to this subsection. The report shall include individual facilities' data, as well as statewide totals. The report shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives.
- (5) **RULES.** The department shall adopt rules relating to:
- (a) Procedures and criteria for receiving and evaluating facility applications for designation, which may include onsite facility inspection and evaluation of an applicant's licensing status and performance history, as well as consideration of local service needs.
- (b) Minimum standards consistent with this part that a facility must meet and maintain in order to be designated as a receiving or treatment facility and procedures for monitoring continued adherence to such standards.
- (c) Procedures for receiving complaints against a designated facility and for initiating inspections and investigations of facilities alleged to have violated the provisions of this part or rules adopted under this part.
- (d) Procedures and criteria for the suspension or withdrawal of designation.

- to apply for designation;
- (b) A current certificate of good standing for the applicant organization issued by the Florida Secretary of State;
- (c) Documentation of the applicant's governing authority action authorizing the application for designation;
- (d) Description of proposed psychiatric services including any distinct programs to be provided to each of the following consumer age groups, and the projected numbers of persons to be served in each following group:
1. Minors below 10 years of age;
 2. Minors between the ages of 10 to 17 years;
 3. Adults;
 4. Persons 60 or more years of age; and
 5. Other specific populations.
- (e) The corresponding street address for each reception and treatment location for the above services must be provided. Designation is limited to only the locations specified in the application and approved by the department; and
- (f) Documentation of community need for maintaining or expanding the present level of designated facilities' services to meet the existing need, and why the applicant is best suited to meet this need.
1. The information may address the public's need for specific services for minors, aged, blind or hearing-impaired persons. Evidence of such need may include: Certificate of Need data and other information published by the Agency for Health Care Administration, the organization's or community's utilization of available or licensed bed capacity, geographical accessibility information, input from local governmental agencies, or information on the specific needs of persons if the particular specialty services offered are accredited or certified by a nationally recognized body for that specific population or service.
 2. The applicant shall describe local need and accommodation of that need for indigent and low income individuals and families receiving the facility's services. The applicant shall describe how it shall protect economically vulnerable persons received for involuntary examination or

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treatment from exorbitant charges and billings for services. A statement comparing representative facility charges and billings for individuals who are uninsured or without a third party payer who are held under the provisions of the Baker Act to otherwise similar representative charges and billings for group health care members and insurers shall be included.

3. The applicant shall describe local need and accommodation of that need for indigent and low income individuals and families being discharged from the facility in need of continuing psychotropic medications. The applicant shall describe how it shall directly provide, or otherwise assist the person in ensuring continuity of availability of necessary psychotropic medications until a scheduled aftercare psychotropic medication appointment.

(g) Documentation of key facility protocols to assure all involved practitioners and staff are knowledgeable of, and implement, person's legal rights, key psychiatric care, records standards, complaint reporting, investigation and reviews to maintain a consistently high level of compliance with applicable Baker Act laws, ethical principles, and rights protections;

(h) Description of how the facility's physical structure, staffing and policies offers frequent, if not daily, opportunity for persons to have exercise, fresh air and sunshine, except as individually restricted and documented in the person's clinical record and within the physical limitations of the facility;

(i) Description of how the facility's discharge planning policies provide for continuity of psychotropic medication availability until post-discharge follow-up services are scheduled; and

(j) For general hospitals, a description of the means utilized to create or approximate a distinct psychiatric emergency reception and triage area that minimizes individual's exposure to undue and exacerbating environmental stresses while awaiting or receiving services.

- (6) **Application Process for Designation.** All facilities desiring to obtain, or to retain, designation as a receiving facility must complete and submit mandatory form CF-MH 3125, "Application for

Designation of facilities

Florida statewide and local advocacy councils no longer exist because they were de-funded by the 2010 Florida Legislature.

Designation as a Receiving Facility," as referenced in subsection 65E-5.350(5), F.A.C., for departmental review. All receiving facility designations shall be subject to departmental review and authorization in accordance with the provisions of Chapter 394, Part I, F.S., and this chapter after receipt of the application.

(a) The department's district or regional office is responsible for receipt of the application, reviewing the application, requesting additional information as needed, verifying essential information, and forwarding the information along with the recommendation of the mental health and substance abuse program supervisor to the Secretary for final action. Applications received that are incomplete will be returned by certified mail with a letter informing the applicant of missing items. The district or region will seek and review pertinent information from any source such as:

1. Accreditation status and submission of the latest survey report of any applicable accrediting bodies;
2. Relevant history of compliance with the Baker Act and other related protection laws protecting persons served by mental health facilities;
3. Agency for Health Care Administration (AHCA) licensure reports and complaint investigation findings against the facility or professionals associated with the facility;
4. Actions, findings or reports of the Florida Local Advocacy Council, and other district or regional consumer complaint offices;
5. Florida Abuse Hotline receipt, or lack or receipt, of complaints and actions;
6. Actions initiated by any state enforcement authority including the Florida Attorney General's Office, the Florida Department of Law Enforcement, the Florida Department of Insurance, and statewide or local State's Attorneys Offices; and
7. Actions initiated by any federal law enforcement or investigative authority including the federal Department of Health and Human Services, the federal Centers for Medicare and Medicaid Services, and the Federal Bureau of Investigation against the facility, its employees, privileged personnel

- 1 or contractors, subcontractors, or operators
- 2 relating to services, billings or operations.
- 3 (b) The district or region, upon receipt of a properly
- 4 completed application, shall schedule and
- 5 advertise a public meeting for purposes of
- 6 obtaining public input and information on the
- 7 initial designation of the applicant.
- 8 (c) In meeting the local need for designated
- 9 facilities, priority shall be given to facilities with
- 10 management that consistently exhibits high
- 11 levels of compliance with Chapter 394, Part I,
- 12 F.S., this rule chapter, and related protection
- 13 laws in Chapters 395, 415, 458, and 817, F.S., as
- 14 documented in state agencies' files.
- 15 (d) The submission of the district or region's
- 16 recommendation to the Secretary must
- 17 include a listing of the key information sources
- 18 and pertinent factors relied upon in making
- 19 the recommendation and a summary of the
- 20 comments and information received at the
- 21 public meeting.
- 22 (e) Within 60 days of receiving the recommendation
- 23 from the district or region, the Secretary, or the
- 24 Secretary's designee, will review the district
- 25 or region recommendation and supporting
- 26 documentation and will issue final departmental
- 27 action with regard to the application which
- 28 may be approved, denied, or returned to the
- 29 district or region for additional information or
- 30 processing.
- 31 (f) The designation shall be for 3 years.
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- 35 (7) **Re-Applications for Renewal of Designation.**
- 36 (a) A re-application must be submitted for re-
- 37 designation every 3 calendar years, after
- 38 approval of initial applications or 90 days in
- 39 advance of the relocation of a facility to a new
- 40 address. The designation is valid only for the
- 41 address to which it was issued.
- 42 (b) A renewal application shall be forwarded to
- 43 the department at least 90 days prior to the
- 44 expiration of its existing designation.
- 45 (c) A re-application must be submitted by a facility
- 46 upon a change of controlling ownership of
- 47 the facility or of the contractual management
- 48 entity for the psychiatric service. Failure to
- 49 submit notification to the department of
- 50 changes of controlling ownership or a change
- 51 in the management entity within 30 days
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1 after the change will terminate the facility's
2 designation 60 days after the effective date of
3 the action changing the control of ownership or
4 management.

5 (d) Any change in the name of a facility, that remains
6 under the same ownership and management,
7 must be reported in writing to the department's
8 district or regional office within 30 days after
9 the effective date of the change. Upon receipt
10 of the notification, the department will issue
11 a letter confirming receipt of the notification
12 and extending designation until a replacement
13 certificate of designation showing the correct
14 facility name is received by the facility. Failure
15 to provide such notification to the district or
16 region within 30 days of the change will result
17 in the withdrawal of the designation upon the
18 expiration of the 60th day following the facility
19 name change.

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22 **(8) Certificate of Designation.**

23 (a) Upon approval by the Secretary or his or her
24 designee, the department shall issue a certificate
25 of designation which shall include the following
26 information on the face of the Certificate of
27 Designation:

- 28 1. Effective commencement date and
29 expiration date;
- 30 2. Name of the owner and licensee as stated on
31 the facility license issued by the Agency for
32 Health Care Administration; and
- 33 3. Street address of where services are
34 provided.

35 (b) The certificate shall be prominently displayed to
36 the general public at the service site. Designation
37 provided by this certificate is invalid if the
38 information on the certificate is not correct
39 or the information provided in the submitted
40 application is false or misleading.
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45 **65E-5.351 Minimum Standards for**
46 **Designated Receiving Facilities.**
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- 48 (1) Any facility designated as a receiving facility
49 failing to comply with this chapter may have such
50 designation suspended or withdrawn.
- 51 (2) Each receiving facility shall have policies and
52 procedures that prescribe, monitor and enforce all
53 requirements specified in Chapter 65E-5, F.A.C.
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Public Receiving Facilities must ensure centralized coordination of acute care services.

See 65E-5.180(6), FAC for additional complaint investigation procedures.

- (3) Each receiving facility shall assure that its reception, screening, and inpatient services are fully operational 24-hours-per-day, 7-days-per-week.
- (4) Each receiving facility shall have a compliance program that monitors facility and professional compliance with Chapter 394, Part I, F.S., and this chapter. Every such program shall specifically monitor the adequacy of and the timeframes involved in the facility procedures utilized to expedite obtaining informed consent for treatment. This program may be integrated with other activities.
- (5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

65E-5.352 Procedures for Complaints and Investigations in Receiving Facilities.

Complaints with regard to the provisions of this chapter shall be filed with the district or region mental health and substance abuse program supervisor, or designee, of the district or region in which the violation is alleged to have occurred. The district or region mental health and substance abuse program supervisor shall appoint one or more employees to determine if an investigation is warranted. If warranted, the investigation may include the assistance of other agencies having jurisdiction over the facility. If the district or region mental health and substance abuse program supervisor determines that a violation of this chapter has occurred:

- (1) Corrective action shall be required and a reasonable time in which to correct the violation shall be accorded to the facility; or
- (2) If the corrective action is not sufficient, or the district or region mental health and substance abuse program supervisor determines that the violation warrants suspension or removal of designation, such action shall be considered pursuant to Rule 65E-5.353, F.A.C.

Florida statewide and local advocacy councils no longer exist because they were de-funded by the 2010 Florida Legislature.

65E-5.353 Criteria and Procedures for Suspension or Withdrawal of Designation of Receiving Facilities.

- (1) The district or regional offices of the department shall continuously collect and monitor information relative to complaints or allegations against designated facilities from sources such as individuals, local advocacy or self-help groups, local organizations including law enforcement, the Agency for Health Care Administration, and the Florida Local Advocacy Council. When a district or region mental health and substance abuse program supervisor recommends to the Secretary, or the Secretary's designee, withdrawal or suspension of designation, at least the following information must be submitted with the recommendation:
 - (a) Description of violations such as extent of violations of Chapter 394, F.S., and this rule chapter, and the extent and seriousness of known injuries or injury including the severity and number of violations, severity and chronic violation of rights, and any pattern of inadequate supervision, injury or harm to individuals; and
 - (b) Mitigating circumstances including the responsiveness and extent of any actions taken by the facility to remediate, compensate, or correct the situation, as well as the facility's recent history of charitable public service to persons with psychiatric disabilities in the community, and compliance and responsiveness to any prior violations or complaints.
- (2) **Suspension of Designation.** When the district or region determines that it is more likely than not that a facility, or its related entities, has failed to consistently meet one or more of the standards for designation or maintenance of designation under this chapter, it may suspend designation pending corrective action plan implementation. During the suspension period, no persons on involuntary status may be admitted to the facility. No re-application for designation as a receiving facility is required for reinstatement of designation.
- (3) **Withdrawal of Designation.**
 - (a) Designation may be withdrawn upon approval of the Secretary, or the Secretary's designee, when the district or region determines that it is more likely than not that any pattern of violations, or combination of violations, of

Statute

(Chapter 394.4612 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.353 F.A.C.

394.4612 Integrated adult mental health crisis stabilization and addictions receiving facilities.

- (1) The Agency for Health Care Administration, in consultation with the Department of Children and Family Services, may license facilities that integrate services provided in an adult mental health crisis stabilization unit with services provided in an adult addictions receiving facility. Such a facility shall be licensed by the agency as an adult crisis stabilization unit under part IV and must meet all licensure requirements for crisis stabilization units providing integrated services.
- (2) An integrated mental health crisis stabilization unit and addictions receiving facility may provide services under this section to adults who are 18 years of age or older and who fall into one or more of the following categories:
 - (a) An adult meeting the requirements for voluntary admission for mental health treatment under s. 394.4625.

Chapter 394, F.S., this rule chapter, and Chapter 65E-12, F.A.C., exists such as deficient admission, transfer or care practices, deficient observation or documentation of rights abuses, deficient discharge practices, deceptive or misleading practices in marketing, admission recruitment or referral practices; fraudulent clinical or billing practices; or patient brokering is evident. Examples of such offenses include violations by the facility, or parties acting on behalf of or in concert with the facility, or acting under its supervision, having engaged in deceptive, fraudulent, exploitative, abusive, or neglect type violations of Florida law, including Chapters 394 and 415, F.S., Sections 817.505 and 458.331, F.S.

(b) Upon re-application after withdrawal of designation, the department must have clear and convincing evidence that the problems with the facility, or its practitioners, leading to withdrawal of designation have been corrected and will not reoccur. This may include required internal and external monitoring to document continued satisfactory performance.

N/A

Designation of facilities

- (b) An adult meeting the criteria for involuntary examination for mental illness under s. 394.463.
- (c) An adult qualifying for voluntary admission for substance abuse treatment under s. 397.601.
- (d) An adult meeting the criteria for involuntary admission for substance abuse impairment under s. 397.675.
- (3) The department, in consultation with the agency, shall adopt by rule standards that address eligibility criteria; clinical procedures; staffing requirements; operational, administrative, and financing requirements; and the investigation of complaints.

394.4615 Clinical records; confidentiality.

- (1) A clinical record shall be maintained for each patient. The record shall include data pertaining to admission and such other information as may be required under rules of the department. A clinical record is confidential and exempt from the provisions of s. 119.07(1). Unless waived by express and informed consent, by the patient or the patient's guardian or guardian advocate or, if the patient is deceased, by the patient's personal representative or the family member who stands next in line of intestate succession, the confidential status of the clinical record shall not be lost by either authorized or unauthorized disclosure to any person, organization, or agency.
- (2) The clinical record shall be released when:
 - (a) The patient or the patient's guardian authorizes the release. The guardian or guardian advocate shall be provided access to the appropriate clinical records of the patient. The patient or the patient's guardian or guardian advocate may authorize the release of information and clinical records to appropriate persons to ensure the continuity of the patient's health care or mental health care.

65E-5.250 Clinical Records; Confidentiality.

- (1) Except as otherwise provided by law, verbal or written information about a person shall only be released when the competent person, or a duly authorized legal decision-maker such as guardian, guardian advocate, or health care surrogate or proxy provides consent to such release. When such information is released, a copy of a signed authorization form shall be retained in the person's clinical record. Recommended form CF-MH 3044, Feb. 05, "Authorization for Release of Information," 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 as documentation. Consent or authorization forms may not be altered in any way after signature by the person or other authorized decision-maker nor may a person or other authorized decision-maker be allowed to sign a blank form.
- (2) Facility staff shall inform each person that he or she has the right to waive, in writing, the confidentiality of his or her presence in a receiving or treatment facility and to communicate with all or a group of individuals as specified by the person. Recommended form CF-MH 3048, Feb. 05, "Confidentiality Agreement," as referenced in subsection 65E-5.190(1), F.A.C., may be used for this purpose.

Statute

(Chapter 394.4615 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.250 F.A.C.

- (b) The patient is represented by counsel and the records are needed by the patient's counsel for adequate representation.
 - (c) The court orders such release. In determining whether there is good cause for disclosure, the court shall weigh the need for the information to be disclosed against the possible harm of disclosure to the person to whom such information pertains.
 - (d) The patient is committed to, or is to be returned to, the Department of Corrections from the Department of Children and Family Services, and the Department of Corrections requests such records. These records shall be furnished without charge to the Department of Corrections.
- (3) Information from the clinical record may be released in the following circumstances:
- (a) When a patient has declared an intention to harm other persons. When such declaration has been made, the administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient.
 - (b) When the administrator of the facility or secretary of the department deems release to a qualified researcher as defined in administrative rule, an aftercare treatment provider, or an employee or agent of the department is necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, aftercare planning, or evaluation of programs. For the purpose of determining whether a person meets the criteria for involuntary outpatient placement or for preparing the proposed treatment plan pursuant to s. 394.4655, the clinical record may be released to the state attorney, the public defender or the patient's private legal counsel, the court, and to the appropriate mental health professionals, including the service provider identified in s. 394.4655(6)(b)2., in accordance with state and federal law.

- (3) For purposes of Section 394.4615(3)(b), F.S., a "qualified researcher" is one who after making application to review confidential data and who, after documenting his or her bona fide academic, scientific or medical credentials and describing the particular research which gives rise to the request, is determined by the administrator of a receiving or treatment facility or by the Secretary of the department, to be eligible to review such data. In making that determination the administrator or the Secretary shall weigh the person's right to privacy against the benefit of disclosure and shall determine whether the disclosure is in the best interest of the state. Person identifying information obtained by such a qualified researcher shall not be further disclosed without the express and informed consent of the person or individual authorized to provide consent for him or her.
- (4) When a person's access to his or her clinical record or any part of his or her record is restricted by written order of the attending physician such restriction shall be documented in the person's clinical record. If the request is denied or such access is restricted, a written response shall be provided to the person. Recommended form CF-MH 3110, Feb. 05, "Restriction of Person's Access to Own Record," 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 for such documentation.
- (5) Each receiving facility shall develop detailed policies and procedures governing release of records to each person requesting release, including criteria for determining what type of information may be harmful to the person, establishing a reasonable time for responding to requests for access, and identifying methods of providing access that ensure clinical support to the person while securing the integrity of the record.

Clinical records; confidentiality

- (4) Information from clinical records may be used for statistical and research purposes if the information is abstracted in such a way as to protect the identity of individuals.
- (5) Information from clinical records may be used by the Agency for Health Care Administration, the department, and the Florida advocacy councils for the purpose of monitoring facility activity and complaints concerning facilities.
- (6) Clinical records relating to a Medicaid recipient shall be furnished to the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request.
- (7) Any person, agency, or entity receiving information pursuant to this section shall maintain such information as confidential and exempt from the provisions of s. 119.07(1).
- (8) Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to this section is not subject to civil or criminal liability for such release.
- (9) Nothing in this section is intended to prohibit the parent or next of kin of a person who is held in or treated under a mental health facility or program from requesting and receiving information limited to a summary of that person's treatment plan and current physical and mental condition. Release of such information shall be in accordance with the code of ethics of the profession involved.
- (10) Patients shall have reasonable access to their clinical records, unless such access is determined by the patient's physician to be harmful to the patient. If the patient's right to inspect his or her clinical record is restricted by the facility, written notice of such restriction shall be given to the patient and the patient's guardian, guardian advocate, attorney, and representative. In addition, the restriction shall be recorded in the clinical record, together with the reasons for it. The restriction of a patient's right to inspect his or her clinical record shall expire after 7 days but may be renewed, after review, for subsequent 7-day periods.

Other federal and state laws governing confidentiality may also apply.

Statute

(Chapter 394.462 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.260 F.A.C.

- (11) Any person who fraudulently alters, defaces, or falsifies the clinical record of any person receiving mental health services in a facility subject to this part, or causes or procures any of these offenses to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

394.462 Transportation.

(1) TRANSPORTATION TO A RECEIVING FACILITY.

- (a) Each county shall designate a single law enforcement agency within the county, or portions thereof, to take a person into custody upon the entry of an ex parte order or the execution of a certificate for involuntary examination by an authorized professional and to transport that person to the nearest receiving facility for examination. The designated law enforcement agency may decline to transport the person to a receiving facility only if:

1. The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service or private transport company for transportation of persons to receiving facilities pursuant to this section at the sole cost of the county; and
2. The law enforcement agency and the emergency medical transport service or private transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others.
3. The jurisdiction designated by the county may seek reimbursement for transportation expenses. The party responsible for payment for such transportation is the person receiving the transportation. The county shall seek reimbursement from the following sources in the following order:

65E-5.260 Transportation.

- (1) Each law enforcement officer who takes a person into custody upon the entry of recommended form CF-MH 3001, Feb. 05, "Ex Parte Order for Involuntary Examination," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or other form provided by the court, or the execution of mandatory form CF-MH 3052b, Sept. 06, "Certificate of Professional Initiating Involuntary Examination," which is hereby incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter or completion of mandatory form CF-MH 3052a, Sept. 06, "Report of a Law Enforcement Officer Initiating Involuntary Examination," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter shall ensure that such forms accompany the person to the receiving facility for inclusion in the person's clinical record.
- (2) The designated law enforcement agency shall transport the person to the nearest receiving facility as required by statute, documenting this transport on mandatory form CF-MH 3100, Feb. 05, "Transportation to Receiving Facility," which is hereby incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter. The designated law enforcement agency may decline to transport the person to a receiving facility only if the provisions of Section 394.462(1), F.S., apply. When the designated law enforcement agency and the medical transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others. Part II of mandatory form CF-MH 3100, "Transportation to Receiving Facility," as referenced in subsection 65E-5.260(2), F.A.C., reflecting the agreement between law enforcement and the transport service shall accompany the person to the receiving facility. The completed form shall be retained in the person's clinical record.

Transportation

- a. From an insurance company, health care corporation, or other source, if the person receiving the transportation is covered by an insurance policy or subscribes to a health care corporation or other source for payment of such expenses.
 - b. From the person receiving the transportation.
 - c. From a financial settlement for medical care, treatment, hospitalization, or transportation payable or accruing to the injured party.
- (b) Any company that transports a patient pursuant to this subsection is considered an independent contractor and is solely liable for the safe and dignified transportation of the patient. Such company must be insured and provide no less than \$100,000 in liability insurance with respect to the transportation of patients.
- (c) Any company that contracts with a governing board of a county to transport patients shall comply with the applicable rules of the department to ensure the safety and dignity of the patients.
- (d) When a law enforcement officer takes custody of a person pursuant to this part, the officer may request assistance from emergency medical personnel if such assistance is needed for the safety of the officer or the person in custody.
- (e) When a member of a mental health overlay program or a mobile crisis response service is a professional authorized to initiate an involuntary examination pursuant to s. 394.463 and that professional evaluates a person and determines that transportation to a receiving facility is needed, the service, at its discretion, may transport the person to the facility or may call on the law enforcement agency or other transportation arrangement best suited to the needs of the patient.

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Law enforcement mandated to transport people on involuntary status to receiving facilities—Not to treatment facilities.

Statute

(Chapter 394.462 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5, F.A.C.

- (f) When any law enforcement officer has custody of a person based on either noncriminal or minor criminal behavior that meets the statutory guidelines for involuntary examination under this part, the law enforcement officer shall transport the person to the nearest receiving facility for examination.
- (g) When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under this part, such person shall first be processed in the same manner as any other criminal suspect. The law enforcement agency shall thereafter immediately notify the nearest public receiving facility, which shall be responsible for promptly arranging for the examination and treatment of the person. A receiving facility is not required to admit a person charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide mental health examination and treatment to the person where he or she is held.
- (h) If the appropriate law enforcement officer believes that a person has an emergency medical condition as defined in s. 395.002, the person may be first transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated receiving facility.
- (i) The costs of transportation, evaluation, hospitalization, and treatment incurred under this subsection by persons who have been arrested for violations of any state law or county or municipal ordinance may be recovered as provided in s. 901.35.
- (j) The nearest receiving facility must accept persons brought by law enforcement officers for involuntary examination.
- (k) Each law enforcement agency shall develop a memorandum of understanding with each receiving facility within the law enforcement

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← MISDEMEANOR CHARGES

← FELONY CHARGES

Nearest Receiving Facility
must accept any person brought by
law enforcement for involuntary
examination.

Transportation

agency's jurisdiction which reflects a single set of protocols for the safe and secure transportation of the person and transfer of custody of the person. These protocols must also address crisis intervention measures.

- (l) When a jurisdiction has entered into a contract with an emergency medical transport service or a private transport company for transportation of persons to receiving facilities, such service or company shall be given preference for transportation of persons from nursing homes, assisted living facilities, adult day care centers, or adult family-care homes, unless the behavior of the person being transported is such that transportation by a law enforcement officer is necessary.

- (m) Nothing in this section shall be construed to limit emergency examination and treatment of incapacitated persons provided in accordance with the provisions of s. 401.445.

(2) TRANSPORTATION TO A TREATMENT FACILITY.

- (a) If neither the patient nor any person legally obligated or responsible for the patient is able to pay for the expense of transporting a voluntary or involuntary patient to a treatment facility, the governing board of the county in which the patient is hospitalized shall arrange for such required transportation and shall ensure the safe and dignified transportation of the patient. The governing board of each county is authorized to contract with private transport companies for the transportation of such patients to and from a treatment facility.
- (b) Any company that transports a patient pursuant to this subsection is considered an independent contractor and is solely liable for the safe and dignified transportation of the patient. Such company must be insured and provide no less than \$100,000 in liability insurance with respect to the transportation of patients.

Treatment facilities are different from receiving facilities.

- (c) Any company that contracts with the governing board of a county to transport patients shall comply with the applicable rules of the department to ensure the safety and dignity of the patients.
- (d) County or municipal law enforcement and correctional personnel and equipment shall not be used to transport patients adjudicated incapacitated or found by the court to meet the criteria for involuntary placement pursuant to s. 394.467, except in small rural counties where there are no cost-efficient alternatives.
- (3) **TRANSFER OF CUSTODY.** Custody of a person who is transported pursuant to this part, along with related documentation, shall be relinquished to a responsible individual at the appropriate receiving or treatment facility.
- (4) **EXCEPTIONS.**
An exception to the requirements of this section may be granted by the secretary of the department for the purposes of improving service coordination or better meeting the special needs of individuals. A proposal for an exception must be submitted by the district administrator after being approved by the governing boards of any affected counties, prior to submission to the secretary.
- (a) A proposal for an exception must identify the specific provision from which an exception is requested; describe how the proposal will be implemented by participating law enforcement agencies and transportation authorities; and provide a plan for the coordination of services such as case management.
- (b) The exception may be granted only for:
1. An arrangement centralizing and improving the provision of services within a district, which may include an exception to the requirement for transportation to the nearest receiving facility;
 2. An arrangement by which a facility may provide, in addition to required psychiatric services, an environment and ser-

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65E-5.2601 Transportation Exception Plan.

- (1) In determining whether to approve a proposal for an exception or exceptions to the transportation requirements of Section 394.462(3), F.S., the following shall be considered by the department:
- (a) The specific provision from which an exception is requested;
 - (b) Evidence presented by the department's district or region of community need and support for the request;
 - (c) Whether the proposal is presented in a format that is clear, simple, and can be readily implemented by all parties and the public;
 - (d) How the proposed plan will improve services to the public and persons needing Baker Act services; and
 - (e) Whether the geographic boundaries identified in the proposal are distinct and unambiguous.
- (2) The proposal must include provisions which address:
- (a) Accountability for delays or confusion when transportation fails to respond appropriately;
 - (b) How disputes which may arise over implementation of the plan will be resolved;
 - (c) Identification of the public official whose position is responsible for the continuing oversight and monitoring of the service in compliance with the terms of the approved proposal;

vices which are uniquely tailored to the needs of an identified group of persons with special needs, such as persons with hearing impairments or visual impairments, or elderly persons with physical frailties; or

3. A specialized transportation system that provides an efficient and humane method of transporting patients to receiving facilities, among receiving facilities, and to treatment facilities.
- (c) Any exception approved pursuant to this subsection shall be reviewed and approved every 5 years by the secretary.

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.
- (b) A mental health overlay program or a mobile crisis response service or a licensed professional who is authorized to initiate an involuntary examination pursuant to s. 394.463 and is employed by a community mental health center or clinic must, pursuant to district procedure approved by the respective district administrator, conduct an initial assessment of the ability of the following persons to give express and

- (d) The plan for periodically monitoring compliance with the proposal, public satisfaction with the service provided, and assurance of rights of each person served by the facility;
 - (e) The method complaints and grievances are to be received and resolved; and
 - (f) Community support and involvement including a description of the participation of designated public and private receiving facilities, law enforcement, transportation officials, consumers, families, and advocacy groups.
- (3) The approval by the governing boards of any affected counties, shall be certified in writing by the district or region's mental health and substance abuse program supervisor, prior to the plan's submission to the Secretary of the Department.

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.

Statute

(Chapter 394.4625 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.270 F.A.C.

informed consent to treatment before such persons may be admitted voluntarily:

1. A person 60 years of age or older for whom transfer is being sought from a nursing home, assisted living facility, adult day care center, or adult family-care home, when such person has been diagnosed as suffering from dementia.
2. A person 60 years of age or older for whom transfer is being sought from a nursing home pursuant to s. 400.0255(12).
3. 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.

(c) When an initial assessment of the ability of a person to give express and informed consent to treatment is required under this section, and a mobile crisis response service does not respond to the request for an assessment within 2 hours after the request is made or informs the requesting facility that it will not be able to respond within 2 hours after the request is made, the requesting facility may arrange for assessment by any licensed professional authorized to initiate an involuntary examination pursuant to s. 394.463 who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made.

(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.

(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.

(2) Persons on voluntary status shall be advised of their right to request discharge. Recommended forms CF-MH 3051a, Feb. 05, "Notice of Right of Person on Voluntary Status to Request Discharge from a Receiving Facility," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or CF-MH 3051b, Feb. 05, "Notice of Right of Person on Voluntary Status to Request Discharge from a Treatment Facility," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter and used to document the giving of such advice. A copy of the notice or its equivalent shall be given to the person and to the person's parent if a minor, with the original of each completed application and notice retained in the person's clinical record.

(3) Documenting the assessment of each person pursuant to Section 394.4615(1)(b), F.S., shall be done prior to moving the person from his or her residence to a receiving facility for voluntary admission. Recommended form CF-MH 3099, Feb. 05, "Certification of Ability to Provide Express and Informed Consent for Voluntary Admission and Treatment of Selected Persons from Facilities Licensed under Chapter 400, F.S.," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter and used for this purpose.

(4) If a competent adult or the guardian of a minor refuses to consent to mental health treatment, the person shall not be eligible for admission on a voluntary status. A person on voluntary status who refuses to consent to or revokes consent to treatment shall be discharged from a designated receiving or treatment facility within 24 hours after such refusal or revocation, unless the person is transferred to involuntary status or unless the refusal or revocation is freely and voluntarily rescinded by the person. When a person refuses or revokes consent to treatment, facility staff shall document

Voluntary admissions

(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).

(2) DISCHARGE OF VOLUNTARY PATIENTS.

(a) A facility shall discharge a voluntary patient:

1. Who has sufficiently improved so that retention in the facility is no longer desirable. A patient may also be discharged to the care of a community facility.
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.

this immediately in the person's clinical record. Recommended form CF-MH 3105, Feb. 05, "Refusal or Revocation of Consent to Treatment," 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 for this purpose. Should a competent person withdraw his or her refusal or revocation of consent to treatment, the person shall be asked to complete Part II of recommended form CF-MH 3105, "Refusal or Revocation of Consent to Treatment," as referenced in subsection 65E-5.270(4), F.A.C., or similar documentation, and the original shall be retained in the person's clinical record.

(5) An oral or written request for discharge made by any person following admission to the facility shall be immediately documented in the person's clinical record. Recommended forms CF-MH 3051a, "Notice of Right of Person on Voluntary Status to Request Discharge from a Receiving Facility," as referenced in subsection 65E-5.270(2), F.A.C., or CF-MH 3051b, "Notice of Right of Person on Voluntary Status to Request Discharge from a Treatment Facility," as referenced in subsection 65E-5.270(2), F.A.C., may be used for this purpose. This form may also be completed by a relative, adult friend, or attorney of the person.

(6) When a person on voluntary status refuses treatment or requests discharge and the facility administrator makes the determination that the person will not be discharged within 24 hours from a designated receiving or treatment facility, a petition for involuntary inpatient placement or involuntary outpatient placement shall be filed with the court by the facility administrator. Recommended form CF-MH 3032, "Petition for Involuntary Inpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)1., F.A.C., or recommended form CF-MH 3130, "Petition for Involuntary Outpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., may be used for this purpose. The first expert opinion by a psychiatrist shall be obtained on the petition form within 24 hours of the request for discharge or refusal of treatment to justify the continued detention of the person and the petition shall be filed with the court within 2 court working days after the request for discharge or refusal to consent to treatment was made.

Statute

(Chapter 394.4625 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.270 F.A.C.

- (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.
- (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.
- (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.

- (7) If a person is delivered to a receiving facility for voluntary examination from any program or residential placement licensed under the provisions of Chapter 400, F.S., without first arranging an independent evaluation of the resident's competence to provide express and informed consent to admission and treatment, as required in Sections 394.4625(1)(b) and (c), F.S., the receiving facility shall notify the Agency for Health Care Administration by using recommended form CF-MH 3119, Feb. 05, "Notification of Non-Compliance with Required Certificate," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter.

See Appendix B for extensive information on voluntary admission.

Transfers between legal statuses

394.463 Involuntary examination.

(1) **CRITERIA.** A person may be taken to a receiving facility for involuntary examination if there is reason to believe that the person has a mental illness and because of his or her mental illness:

- (a) 1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or
2. The person is unable to determine for himself or herself whether examination is necessary; and
- (b) 1. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or
2. There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

(2) INVOLUNTARY EXAMINATION.

- (a) An involuntary examination may be initiated by any one of the following means:
 1. A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on sworn testimony, written or oral. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to the nearest receiving facility for involuntary examination. The

65E-5.280 Involuntary Examination.

- (1) **Court Order.** Sworn testimony shall be documented by using recommended form CF-MH 3002, Feb. 05, "Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or other form used by the court. Documentation of the findings of the court on recommended form CF-MH 3001, "Ex Parte Order for Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or other order used by the court, shall be used when there is reason to believe the criteria for involuntary examination are met. The ex parte order for involuntary examination shall accompany the person to the receiving facility and be retained in the person's clinical record.
- (2) **Law Enforcement.**
 - (a) If a law enforcement officer, in the course of his or her official duties, initiates an involuntary examination, the officer shall complete the mandatory form CF-MH 3052a, "Report of Law Enforcement Officer Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C.
 - (b) Mandatory form CF-MH 3052a, "Report of Law Enforcement Officer Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., shall accompany the person to the nearest receiving facility for retention in the person's clinical record.
- (3) **Professional Certificate.**
 - (a) A professional authorized by Section 394.463(2)(a)3., F.S., who determines, after personally examining a person believed to meet the involuntary examination criteria within the preceding 48 hours, verifies that the criteria are met, is authorized to execute the mandatory form CF-MH 3052b, "Certificate of Professional Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C.
 - (b) Mandatory form CF-MH 3052b, "Certificate of Professional Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., shall be executed immediately upon its initiation and is valid throughout the state. The completed certificate shall accompany the person to a receiving facility and be retained in the person's clinical record.

Statute

(Chapter 394.463 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.280 F.A.C.

- order of the court shall be made a part of the patient's clinical record. No fee shall be charged for the filing of an order under this subsection. Any receiving facility accepting the patient based on this order must send a copy of the order to the Agency for Health Care Administration on the next working day. The order shall be valid only until executed or, if not executed, for the period specified in the order itself. If no time limit is specified in the order, the order shall be valid for 7 days after the date that the order was signed.
2. A law enforcement officer shall take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to the nearest receiving facility for examination. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, and the report shall be made a part of the patient's clinical record. Any receiving facility accepting the patient based on this report must send a copy of the report to the Agency for Health Care Administration on the next working day.
3. A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer shall take the person named in the certificate into custody and deliver him or her to the nearest receiving

- (4) **Emergency Medical Conditions.**
- (a) Recommended form CF-MH 3101, Feb. 05, "Hospital Determination that Person Does Not Meet Involuntary Placement Criteria," 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 the results of the examination prescribed in Section 394.463(2)(g), F.S.
- (b) Receiving facilities shall develop policies and procedures that expedite the transfer of persons referred from non-designated hospitals after examination or treatment of an emergency medical condition, within the 12 hours permitted by Section 394.463(2)(h), F.S.
- (c) The 72-hour involuntary examination period set out in Section 394.463(2)(f), F.S., shall not be exceeded. In order to document the 72-hour period has not been exceeded, recommended form CF-MH 3102, Feb. 05, "Request for Involuntary Examination After Stabilization of Emergency Medical Condition," 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 for this purpose. The form may be sent by fax, or otherwise, to promptly communicate its contents to a designated receiving facility at which appropriate medical treatment is available.
- (5) In order for the department to implement the provisions of Section 394.463(2)(e), F.S., and to ensure that the Agency for Health Care Administration will be able to analyze the data it receives pursuant to that section, designated receiving facilities shall forward copies of each recommended form CF-MH 3001, "Ex Parte Order for Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or other order provided by the court, mandatory form CF-MH 3052a, "Report of Law Enforcement Officer Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., mandatory form CF-MH 3052b, "Certificate of Professional Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., accompanied by mandatory form CF-MH 3118, Sept. 06, "Cover Sheet to Agency for Health Care Administration," which is hereby incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this

Involuntary examination

facility for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report and certificate shall be made a part of the patient's clinical record. Any receiving facility accepting the patient based on this certificate must send a copy of the certificate to the Agency for Health Care Administration on the next working day.

- (b) A person shall not be removed from any program or residential placement licensed under chapter 400 or chapter 429 and transported to a receiving facility for involuntary examination unless an ex parte order, a professional certificate, or a law enforcement officer's report is first prepared. If the condition of the person is such that preparation of a law enforcement officer's report is not practicable before removal, the report shall be completed as soon as possible after removal, but in any case before the person is transported to a receiving facility. A receiving facility admitting a person for involuntary examination who is not accompanied by the required ex parte order, professional certificate, or law enforcement officer's report shall notify the Agency for Health Care Administration of such admission by certified mail no later than the next working day. The provisions of this paragraph do not apply when transportation is provided by the patient's family or guardian.
- (c) A law enforcement officer acting in accordance with an ex parte order issued pursuant to this subsection may serve and execute such order on any day of the week, at any time of the day or night.
- (d) A law enforcement officer acting in accordance with an ex parte order issued pursuant to this subsection may use such reasonable physical force as is necessary to gain entry to the premises, and any

rule chapter to: BA Reporting Center, FMHI-MHC 2737, 13301 Bruce B. Downs Boulevard, Tampa, Florida 33612-3807.

- (6) If a person is delivered to a receiving facility for an involuntary examination from any program or residential placement licensed under the provisions of Chapter 400, F.S., without an ex parte order, the 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., the receiving facility shall notify the Agency for Health Care Administration by the method and timeframe required by Section 394.463(2)(b), F.S. The receiving facility may use recommended form CF-MH 3119, Feb. 05, "Notification of Non-Compliance with Required Certificate," as referenced in subsection 65E-5.270(7), F.A.C., for this purpose.
- (7) Documentation that each completed form was submitted in a timely way shall be retained in the person's clinical record.
- (8) Recommended form CF-MH 3045, Feb. 05, "Notice of Person's Admission for Involuntary Examination," 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 when notifying authorized individuals of a person's involuntary admission to a receiving facility.

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;

Statute

(Chapter 394.463 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.2801 F.A.C.

- 1 dwellings, buildings, or other structures
2 located on the premises, and to take custody
3 of the person who is the subject of the ex
4 parte order.
5
6 (e) The Agency for Health Care Administration
7 shall receive and maintain the copies of
8 ex parte orders, involuntary outpatient
9 placement orders issued pursuant to
10 s. 394.4655, involuntary inpatient
11 placement orders issued pursuant to s.
12 394.467, professional certificates, and
13 law enforcement officers' reports. These
14 documents shall be considered part of the
15 clinical record, governed by the provisions
16 of s. 394.4615. The agency shall prepare
17 annual reports analyzing the data obtained
18 from these documents, without information
19 identifying patients, and shall provide
20 copies of reports to the department, the
21 President of the Senate, the Speaker of the
22 House of Representatives, and the minority
23 leaders of the Senate and the House of
24 Representatives.
25
26 (f) A patient shall be examined by a physician
27 or clinical psychologist at a receiving
28 facility without unnecessary delay and may,
29 upon the order of a physician, be given
30 emergency treatment if it is determined
31 that such treatment is necessary for the
32 safety of the patient or others. The patient
33 may not be released by the receiving
34 facility or its contractor without the
35 documented approval of a psychiatrist, a
36 clinical psychologist, or, if the receiving
37 facility is a hospital, the release may also
38 be approved by an attending emergency
39 department physician with experience in
40 the diagnosis and treatment of mental and
41 nervous disorders and after completion of
42 an involuntary examination pursuant to this
43 subsection. However, a patient may not be
44 held in a receiving facility for involuntary
45 examination longer than 72 hours.
46
47 (g) A person for whom an involuntary
48 examination has been initiated who is being
49
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- (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

Involuntary examination

evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3) (c) have been met.

(h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or
2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an

shall be examined by a psychiatrist to determine if the criteria for involuntary inpatient or involuntary outpatient placement are met.

- (7) After the initial mandatory involuntary examination, the person's clinical record shall include:
 - (a) An intake interview;
 - (b) The mandatory form CF-MH 3100, "Transportation to Receiving Facility," as referenced in subsection 65E-5.260(1), 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.; and
 - (c) The psychiatric evaluation, including the mental status examination or the psychological status report.
- (8) Disposition Upon Initial Mandatory Involuntary Examination.
 - (a) The release of a person from a receiving facility requires the documented approval of a psychiatrist, clinical psychologist, or if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician after the completion of an initial mandatory involuntary examination. Recommended form CF-MH 3111, Feb. 05, "Approval for Release of Person on Involuntary Status from a Receiving 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 for this purpose. A copy of the form used shall be retained in the person's clinical record.
 - (b) In order to document a person's transfer from involuntary to voluntary status, 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., completed prior to transfer, may be used.
 - (c) A person for whom an involuntary examination has been initiated shall not be permitted to

Involuntary examination

Statute

(Chapter 394.463 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.2801 F.A.C.

emergency medical condition does not exist.

- (i) Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;
2. The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;
3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or
4. A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(3)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

- (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.

consent to voluntary admission until after examination by a physician to confirm his or her ability to provide express and informed 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., may be used for documentation.

- (d) If the facility administrator, based on facts and expert opinions, believes the person meets the criteria for involuntary inpatient or involuntary outpatient placement or is incompetent to consent to treatment, the facility shall initiate involuntary placement within 72 hours of the person's arrival by filing a petition for involuntary placement. Recommended form CF-MH 3032, "Petition for Involuntary Inpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)1., F.A.C., or CF-MH 3130, "Petition for Involuntary Outpatient Placement" as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., may be used for this purpose. Such petition shall be signed by the facility administrator or designee within the 72-hour examination period. The petition shall be filed with the court within the 72-hour examination period or, if the 72 hours ends on a weekend or legal holiday, no later than the next court working day thereafter. A copy of the completed petition shall be retained in the person's clinical record and a copy given to the person and his or her duly authorized legal decision-maker or representatives.
- (e) When a person on involuntary status is released, notice shall be given to the person's guardian or representative, to any individual who executed a certificate for involuntary examination, and to any court which ordered the person's examination with a copy retained in the person's clinical record. Recommended form CF-MH 3038, Feb. 05, "Notice of Release or Discharge," 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 for this purpose.

394.4655 Involuntary outpatient placement.

(1) CRITERIA FOR INVOLUNTARY OUTPATIENT PLACEMENT.

A person may be ordered to involuntary outpatient placement upon a finding of the court that by clear and convincing evidence:

- (a) The person is 18 years of age or older;
- (b) The person has a mental illness;
- (c) The person is unlikely to survive safely in the community without supervision, based on a clinical determination;
- (d) The person has a history of lack of compliance with treatment for mental illness;
- (e) The person has:
 1. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving or treatment facility as defined in s. 394.455, or has received mental health services in a forensic or correctional facility. The 36-month period does not include any period during which the person was admitted or incarcerated; or
 2. Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others, within the preceding 36 months;
- (f) The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary;
- (g) In view of the 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

65E-5.285 Involuntary Outpatient Placement.

(1) Petition for Involuntary Outpatient Placement.

- (a) Each criterion alleged must be substantiated by evidence, as follows:
 1. Evidence of age must be substantiated, whenever there is any question as to whether the person may be age 18 or older.
 2. A diagnosis of mental illness shall be substantiated by 2 professionals as provided in Section 394.4655(2)(a), F.S., who have recently examined the person and whose observations of the person's condition are consistent with the statutory definition of mental illness, pursuant to Section 394.455(18), F.S., and the clinical description of that diagnosis as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, American Psychiatric Association, which is incorporated by reference and may be obtained from the American Psychiatric Association, 1000 Wilson Boulevard, Arlington, VA 22209-3901.
 3. The clinical determination that a person is unlikely to survive safely in the community without supervision must be substantiated by evidence of current or past behaviors.
 4. The person's history of lack of compliance with treatment for mental illness must be substantiated by evidence showing specific previous incidents in which the person was non-compliant with treatment, including time periods in which the person was non-compliant with treatment.
 5. The person's involuntarily admission to a receiving or treatment facility or the mental health services in a forensic or correctional facility at least twice in the preceding 36 months, or the person's acts of serious violent behavior toward self or others or attempted serious bodily harm to self or others at least once during the preceding 36 months, shall be substantiated by evidence.
 6. Evidence of the unlikelihood of the person to voluntarily participate in the

Statute

(Chapter 394.4655 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.285 F.A.C.

harm to himself or herself or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1);

(h) It is likely that the person will benefit from involuntary outpatient placement; and

(i) 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.

(2) INVOLUNTARY OUTPATIENT PLACEMENT.

(a)1. A patient who is being recommended for involuntary outpatient placement by the administrator of the receiving facility where the patient has been examined may be retained by the facility after adherence to the notice procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient placement are met. However, in a county having a population of fewer than 50,000, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental and nervous disorders or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient placement certificate that authorizes the receiving facility to retain the patient pending completion of a hearing. The certificate shall be made a part of the patient's clinical record.

recommended treatment plan, and either his or her refusal of voluntary placement or inability to determine whether placement is necessary must be substantiated by behaviors, events, and statements by the person supporting this finding.

7. Evidence of the person's treatment history and current behavior must be presented, including time periods of such treatment to substantiate the conclusion that the person needs involuntary 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 or her well-being.
8. Evidence must be presented to substantiate the likelihood of how the person will benefit from involuntary outpatient placement.
9. Evidence must be presented to substantiate each less restrictive alternative that was examined that would have offered an opportunity for the improvement of the person's condition.

(b) Petition Filed by Receiving Facility Administrator.

1. If a person is retained involuntarily in a receiving facility, a petition for involuntary outpatient placement must be filed with the circuit court by the facility administrator within the 72-hour examination period, or if the 72 hours ends on a weekend or legal holiday, the petition shall be filed no later than the next court working day thereafter. Recommended form CF-MH 3130, Feb. 05, "Petition for Involuntary Outpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., may be used for this purpose. A copy of the completed petition shall be retained in the person's clinical record.
2. A petition filed by a receiving facility administrator shall be filed in the county where the facility is located.
3. The administrator of the receiving facility or a designated department representative shall identify the service provider that will have the responsibility of developing a treatment plan and primary responsibility for service provision under an order for

Involuntary outpatient placement

Statute

(Chapter 394.4655 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.285 F.A.C.

2. If the patient has been stabilized and no longer meets the criteria for involuntary examination pursuant to s. 394.463(1), the patient must be released from the receiving facility while awaiting the hearing for involuntary outpatient placement. Before filing a petition for involuntary outpatient treatment, the administrator of a receiving facility or a designated department representative must identify the service provider that will have primary responsibility for service provision under an order for involuntary outpatient placement, unless the person is otherwise participating in outpatient psychiatric treatment and is not in need of public financing for that treatment, in which case the individual, if eligible, may be ordered to involuntary treatment pursuant to the existing psychiatric treatment relationship.
3. The service provider shall prepare a written proposed treatment plan in consultation with the patient or the patient's guardian advocate, if appointed, for the court's consideration for inclusion in the involuntary outpatient placement order. The service provider shall also provide a copy of the proposed treatment plan to the patient and the administrator of the receiving facility. The treatment plan must specify the nature and extent of the patient's mental illness, address the reduction of symptoms that necessitate involuntary outpatient placement, and include measurable goals and objectives for the services and treatment that are provided to treat the person's mental illness and assist the person in living and functioning in the community or to prevent a relapse or deterioration. Service providers may select and supervise other individuals to implement specific aspects of the treatment plan. The services in the treatment plan must be deemed

- involuntary outpatient placement, unless the person is otherwise participating in outpatient psychiatric treatment and is not in need of public financing for that treatment. Recommended form CF-MH 3140, Sept. 06, "Designation of Service Provider for Involuntary Outpatient Placement," 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 for this purpose.
4. A treatment plan, complying with the requirements of Section 394.4655, F.S., and this rule, shall be attached to the petition, along with a certification from the service provider that:
 - a. The proposed services are available in the person's local community;
 - b. There is space available in the program or service for the person;
 - c. Funding is available for the program or service;
 - d. The service provider agrees to provide those services; and
 - e. Proposed services have been deemed to be clinically appropriate by a physician, clinical psychologist, clinical social worker, mental health counselor, marriage and family therapist, or psychiatric nurse, as defined in Section 394.455, F.S., who consults with, is employed by, or has a contract with the service provider.
5. Recommended form CF-MH 3145, Sept. 06, "Proposed Individualized Treatment Plan for Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement," 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 for the development of a treatment plan.
6. If the service provider developing a treatment plan, pursuant to involuntary outpatient placement determines the person is in need of services that cannot be proposed due to non-availability of services, funding, a willing provider, or other reason, it shall submit a completed recommended

Involuntary outpatient placement

Statute

(Chapter 394.4655 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.285 F.A.C.

clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker who consults with, or is employed or contracted by, the service provider. The service provider must certify to the court in the proposed treatment plan whether sufficient services for improvement and stabilization are currently available and whether the service provider agrees to provide those services. If the service provider certifies that the services in the proposed treatment plan are not available, the petitioner may not file the petition.

- (b) If a patient in involuntary inpatient placement meets the criteria for involuntary outpatient placement, the administrator of the treatment facility may, before the expiration of the period during which the treatment facility is authorized to retain the patient, recommend involuntary outpatient placement. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient placement are met. However, in a county having a population of fewer than 50,000, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental and nervous disorders or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient

form CF-MH 3150, Feb. 05, "Notice to Department of Children and Families of Non-Filing of Petition for Involuntary Outpatient Placement or Diminished Treatment Plan Due to Non-Availability of Services or Funding," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter.

7. A copy of the petition for involuntary outpatient placement and the proposed treatment plan shall be provided within 1 working day after filing by the clerk of the court to the respondent, department, guardian or representative, state attorney, and counsel for the respondent. A notice of filing of the petition shall be provided by the clerk of court using recommended form CF-MH 3021, Feb. 05, "Notice of Petition for Involuntary Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or other form adopted by the court.

(c) Petition Filed by Treatment Facility Administrator.

1. A petition for involuntary outpatient placement filed by a treatment facility administrator shall be filed prior to the expiration of the involuntary inpatient placement order in the county where the person will be living after discharge from the treatment facility.
2. A copy of form CF-MH 7001, Jan. 98, "State Mental Health Facility Discharge Form," as referenced in subsection 65E-5.1305(1), F.A.C., shall be attached to the petition.
3. The service provider designated by the department that will have primary responsibility for service provision shall provide a certification to the court, attached to the petition, that the services recommended in the discharge plan are available in the local community and that the provider agrees to provide those services.
4. The petition shall have attached an individualized treatment or service plan that addresses the needs identified in the discharge plan developed by the treatment

Involuntary outpatient placement

placement certificate, and the certificate must be made a part of the patient's clinical record.

- (c) 1. The administrator of the treatment facility shall provide a copy of the involuntary outpatient placement certificate and a copy of the state mental health discharge form to a department representative in the county where the patient will be residing. For persons who are leaving a state mental health treatment facility, the petition for involuntary outpatient placement must be filed in the county where the patient will be residing.

2. The service provider that will have primary responsibility for service provision shall be identified by the designated department representative prior to the order for involuntary outpatient placement and must, prior to filing a petition for involuntary outpatient placement, certify to the court whether the services recommended in the patient's discharge plan are available in the local community and whether the service provider agrees to provide those services. The service provider must develop with the patient, or the patient's guardian advocate, if appointed, a treatment or service plan that addresses the needs identified in the discharge plan. The plan must be deemed to be clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker, as defined in this chapter, who consults with, or is employed or contracted by, the service provider.

3. If the service provider certifies that the services in the proposed treatment or service plan are not available, the petitioner may not file the petition.

(3) PETITION FOR INVOLUNTARY OUTPATIENT PLACEMENT.

- (a) A petition for involuntary outpatient

facility as represented by form CF-MH 3145, "Proposed Individualized Treatment Plan for Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement," as referenced in subparagraph 65E-5.285(1)(b)5., F.A.C. The plan must have been deemed to be clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker, as defined in Section 394.455, F.S.

5. A copy of the petition for involuntary outpatient placement and the proposed treatment plan shall be provided within 1 working day after filing by the clerk of the court to the respondent, department, guardian or representative, state attorney, and counsel for the respondent. A notice of filing of the petition shall be provided by the clerk of court using recommended form CF-MH 3021, Feb. 05, "Notice of Petition for Involuntary Placement," as referenced in subparagraph 65E-5.285(1)(b)7., F.A.C., or other equivalent form adopted by the court.

(2) Hearing on Petition for Involuntary Outpatient Placement.

- (a) The clerk of court shall provide notice of the hearing, using recommended form CF-MH 3021, Feb. 05, "Notice of Petition for Involuntary Placement," as referenced in subparagraph 65E-5.285(1)(b)7., F.A.C., or other form used by the court.
- (b) A hearing on the petition for involuntary outpatient placement shall be conducted within 5 working days after the filing of the petition in the county in which the petition is filed. The person is entitled, with the concurrence of counsel, to at least 1 continuance of the hearing, for a period of up to 4 weeks. Recommended form CF-MH 3113, Feb. 05, "Notice to Court – Request for Continuance of Involuntary Placement Hearing," 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 for this purpose.
- (c) The person and his representative or guardian shall be informed by the court of the right to an independent expert examination and that if the person cannot afford such an examination,

Involuntary outpatient placement

Statute

(Chapter 394.4655 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.285 F.A.C.

placement may be filed by:

1. The administrator of a receiving facility; or
2. The administrator of a treatment facility.

(b) Each required criterion for involuntary outpatient placement must be alleged and substantiated in the petition for involuntary outpatient placement. A copy of the certificate recommending involuntary outpatient placement completed by a qualified professional specified in subsection (2) must be attached to the petition. A copy of the proposed treatment plan must be attached to the petition. Before the petition is filed, the service provider shall certify that the services in the proposed treatment plan are available. If the necessary services are not available in the patient's local community to respond to the person's individual needs, the petition may not be filed.

(c) The petition for involuntary outpatient placement must be filed in the county where the patient is located, unless the patient is being placed from a state treatment facility, in which case the petition must be filed in the county where the patient will reside. When the petition has been filed, the clerk of the court shall provide copies of the petition and the proposed treatment plan to the department, the patient, the patient's guardian or representative, the state attorney, and the public defender or the patient's private counsel. A fee may not be charged for filing a petition under this subsection.

(4) APPOINTMENT OF COUNSEL.

Within 1 court working day after the filing of a petition for involuntary outpatient placement, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of the appointment. The public defender shall represent the person until the petition is dismissed, the court order expires,

the court shall provide for one. Recommended form CF-MH 3022, Feb. 05, "Application for Appointment of Independent Expert Examiner," 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 for this purpose.

(d) Recommended form CF-MH 3033, Feb. 05, "Notification to Court of Withdrawal of Petition on Involuntary Inpatient or Involuntary Outpatient Placement," 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 if the facility administrator seeks to withdraw the petition for involuntary outpatient placement prior to the hearing. The facility will retain a copy in the person's clinical record. When a facility withdraws a petition for involuntary placement, it shall notify the court, state attorney, public defender or other attorney for the person, and guardian or representative by telephone within 1 business day of its decision to withdraw the petition, unless such decision is made within 24 hours prior to the hearing. In such cases, the notification must be made immediately.

(e) If the court determines the person does not meet the criteria for involuntary outpatient placement, but instead meets the criteria for involuntary inpatient placement use of recommended form CF-MH 3001, Feb. 05, "Ex Parte Order for Involuntary Inpatient Examination," as referenced in subsection 65E-5.260(1), F.A.C., or other order used by the court, may be used.

(f) If the court determines the person meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to Section 397.675, F.S., and issues an order for one of the same, recommended form CF-MH 3114, Feb. 05, "Order Requiring Involuntary Assessment and Stabilization for Substance Abuse and for Baker Act Discharge of Person," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or other order entered by the court, may be used.

(3) Court Order.

(a) If the court concludes that the person meets the criteria for involuntary outpatient placement pursuant to Section 394.4655, F.S., it shall

Involuntary outpatient placement

or the patient is discharged from involuntary outpatient placement. An attorney who represents the patient shall have access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.

(5) CONTINUANCE OF HEARING.

The patient is entitled, with the concurrence of the patient's counsel, to at least one continuance of the hearing. The continuance shall be for a period of up to 4 weeks.

(6) HEARING ON INVOLUNTARY OUTPATIENT PLACEMENT.

(a) 1. The court shall hold the hearing on involuntary outpatient placement within 5 working days after the filing of the petition, unless a continuance is granted. The hearing shall be held in the county where the petition is filed, shall be as convenient to the patient as is consistent with orderly procedure, and shall be conducted in physical settings not likely to be injurious to the patient's condition. If the court finds that the patient's attendance at the hearing is not consistent with the best interests of the patient and if the patient's counsel does not object, the court may waive the presence of the patient from all or any portion of the hearing. The state attorney for the circuit in which the patient is located shall represent the state, rather than the petitioner, as the real party in interest in the proceeding.

2. The court may appoint a master to preside at the hearing. One of the professionals who executed the involuntary outpatient placement certificate shall be a witness. The patient and the patient's guardian or representative shall be informed by the court of the right to an independent expert examination. If the patient cannot afford such an examination, the court shall provide for one. The

prepare an order. Recommended form CF-MH 3155, Feb. 05, "Order for Involuntary Outpatient Placement or Continued Involuntary Outpatient Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or other order entered by the court, may be used for this purpose. This signed order shall be given to the person, guardian, guardian advocate or representative, counsel for the person, state attorney, and administrator of the receiving or treatment facility, with a copy of the order retained in the person's clinical record.

(b) Upon receipt of the court order for involuntary outpatient placement, the administrator of a treatment facility will provide a copy of the court order and adequate documentation of a person's mental illness to the service provider, including any advance directives, a psychiatric evaluation of the person, and any evaluations of the person performed by a clinical psychologist, mental health counselor, marriage and family therapist, or clinical social worker.

(c) In order for the department to implement the provisions of Section 394.463(2)(e), F.S., and to ensure that the Agency for Health Care Administration will be able to analyze the data it receives pursuant to that section, service providers shall forward copies of each recommended form CF-MH 3155, "Order for Involuntary Outpatient Placement or Continued Involuntary Outpatient Placement," as referenced in paragraph 65E-5.285(3)(a), F.A.C., or other order provided by the court, accompanied by mandatory form CF-MH 3118, "Cover Sheet to Agency for Health Care Administration," as referenced in subsection 65E-5.280(5), F.A.C., to: BA Reporting Center, FMHI-MHC 2637, 13301 Bruce B. Downs Boulevard, Tampa, Florida 33612-3807.

(d) At any time material modifications are proposed to the court ordered treatment plan for which the person and his or her substitute decision-maker if any, agree, the service provider shall submit recommended form CF-MH 3160, Feb. 05, "Notice to Court of Modification to Treatment Plan for Involuntary Outpatient Placement and/or Petition Requesting Approval of Material Modifications to Plan," which is incorporated

Statute

(Chapter 394.4655 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.285 F.A.C.

independent expert's report shall be confidential and not discoverable, unless the expert is to be called as a witness for the patient at the hearing. The court shall allow testimony from individuals, including family members, deemed by the court to be relevant under state law, regarding the person's prior history and how that prior history relates to the person's current condition. The testimony in the hearing must be given under oath, and the proceedings must be recorded. The patient may refuse to testify at the hearing.

- (b)1. If the court concludes that the patient meets the criteria for involuntary outpatient placement pursuant to subsection (1), the court shall issue an order for involuntary outpatient placement. The court order shall be for a period of up to 6 months. The order must specify the nature and extent of the patient's mental illness. The order of the court and the treatment plan shall be made part of the patient's clinical record. The service provider shall discharge a patient from involuntary outpatient placement when the order expires or any time the patient no longer meets the criteria for involuntary placement. Upon discharge, the service provider shall send a certificate of discharge to the court.

2. The court may not order the department or the service provider to provide services if the program or service is not available in the patient's local community, if there is no space available in the program or service for the patient, or if funding is not available for the program or service. A copy of the order must be sent to the Agency for Health Care Administration by the service provider within 1 working day after it is received from the court. After the placement order is issued, the service provider and

by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter or other form adopted by the court. Each person undergoing involuntary outpatient placement and his or her substitute decision-maker if any, must be given a copy of this form by the service provider, and if requested, the service provider shall assist the person or substitute decision-maker in its completion. If the person or his substitute decision-maker object to the modifications proposed by the service provider or wish to propose modifications not proposed by the service provider, recommended form CF-MH 3160, Feb. 05, "Notice to Court of Modification to Treatment Plan for Involuntary Outpatient Placement and/or Petition Requesting Approval of Material Modifications to Plan," as referenced in this subsection, or other form adopted by the court may be used.

- (e) If a physician has determined the person who is subject to a court order for involuntary outpatient placement has failed or has refused to comply with the treatment ordered by the court, and in his or her clinical judgment, efforts were made to solicit compliance and the person meets the criteria for involuntary examination, the person may be brought to a receiving facility pursuant to Section 394.463, F.S. Mandatory form CF-MH 3052b, "Certificate of a Professional Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., shall be used.

(4) Continued Involuntary Outpatient Placement.

- (a) A request for continued involuntary outpatient placement by the service provider administrator shall be filed prior to the expiration of the period for which the treatment was ordered. Recommended form CF-MH 3180, Feb. 05, "Petition Requesting Authorization for Continued Involuntary Outpatient Placement," 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 as documentation of that request. The petition shall be filed with the clerk of the circuit court in the county where the person who is the subject of the petition resides.
- (b) The petition requesting authorization for continued involuntary outpatient placement shall contain the signed statement of the person's physician or clinical psychologist

Involuntary outpatient placement

Statute

(Chapter 394.4655 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.285 F.A.C.

the patient may modify provisions of the treatment plan. For any material modification of the treatment plan to which the patient or the patient's guardian advocate, if appointed, does agree, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient's guardian advocate, if appointed, must be approved or disapproved by the court consistent with subsection (2).

3. If, in the clinical judgment of a physician, the patient has failed or has refused to comply with the treatment ordered by the court, and, in the clinical judgment of the physician, efforts were made to solicit compliance and the patient may meet the criteria for involuntary examination, a person may be brought to a receiving facility pursuant to s. 394.463. If, after examination, the patient does not meet the criteria for involuntary inpatient placement pursuant to s. 394.467, the patient must be discharged from the receiving facility. The involuntary outpatient placement order shall remain in effect unless the service provider determines that the patient no longer meets the criteria for involuntary outpatient placement or until the order expires. The service provider must determine whether modifications should be made to the existing treatment plan and must attempt to continue to engage the patient in treatment. For any material modification of the treatment plan to which the patient or the patient's guardian advocate, if appointed, does agree, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient's guardian advocate, if

justifying the request and shall be accompanied by the following additional documentation:

1. Evidence justifying the request by the physician or clinical psychologist for continued involuntary outpatient placement, including how the person meets each of the statutorily required criteria;
 2. A brief summary of the person's treatment during the time he or she was subject to involuntary outpatient placement; and
 3. An individualized plan of continued treatment.
- (c) If the service provider developing a treatment plan pursuant to involuntary outpatient placement determines the person is in need of services that cannot be proposed due to non-availability of services, funding, a willing provider, or other reason, it shall submit completed recommended form CF-MH 3150, Feb. 05, "Notice to Department of Children and Families of Non-Filing of Petition for Involuntary Outpatient Placement or Diminished Treatment Plan Due to Non-Availability of Services or Funding," as referenced in subparagraph 65E-5.285(1)(b)6., F.A.C. This completed form shall be submitted to the BA Reporting Center, FMHI-MHC 2637, 13301 Bruce B. Downs Boulevard, Tampa, Florida 33612-3807.
- (d) Each criterion alleged must be substantiated by evidence.
- (e) The clerk of court shall provide notice of the hearing, using recommended form CF-MH 3021, Feb. 05, "Notice of Petition for Involuntary Placement," as referenced in subparagraph 65E-5.285(1)(b)7., F.A.C., or other form approved by the court.
- (f) The person and his or her attorney may agree to a period of continued outpatient placement without a court hearing. Should such a hearing be waived, recommended form CF-MH 3185, Feb. 05, "Notice to Court of Waiver of Continued Involuntary Outpatient Placement Hearing and Request for Order," 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 for this purpose.
- (g) Use of recommended form CF-MH 3033, Feb. 05, "Notification to Court of Withdrawal of Petition on Involuntary Inpatient or Involuntary

Involuntary outpatient placement

Statute

(Chapter 394.4655 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.285 F.A.C.

- appointed, must be approved or disapproved by the court consistent with subsection (2).
- (c) If, at any time before the conclusion of the initial hearing on involuntary outpatient placement, it appears to the court that the person does not meet the criteria for involuntary outpatient placement under this section but, instead, meets the criteria for involuntary inpatient placement, the court may order the person admitted for involuntary inpatient examination under s. 394.463. If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to s. 397.675, the court may order the person to be admitted for involuntary assessment for a period of 5 days pursuant to s. 397.6811. Thereafter, all proceedings shall be governed by chapter 397.
- (d) At the hearing on involuntary outpatient placement, the court shall consider testimony and evidence regarding the patient's competence to consent to treatment. If the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate as provided in s. 394.4598. The guardian advocate shall be appointed or discharged in accordance with s. 394.4598.
- (e) The administrator of the receiving facility or the designated department representative shall provide a copy of the court order and adequate documentation of a patient's mental illness to the service provider for involuntary outpatient placement. Such documentation must include any advance directives made by the patient, a psychiatric evaluation of the patient, and any evaluations of the patient performed by a clinical psychologist or a clinical social worker.

- Outpatient Placement," as referenced in paragraph 65E-5.285(2)(d), F.A.C., if the facility administrator seeks to withdraw the petition for continued involuntary outpatient placement prior to the hearing. The facility will retain a copy in the person's clinical record. When a facility withdraws a petition for continued involuntary outpatient placement, it shall notify the court, state attorney, public defender or other attorney for the person, and guardian or representative by telephone within 1 business day of its decision to withdraw the petition, unless such decision is made within 24 hours prior to the hearing. In such cases, the notification must be made immediately.
- (h) Based on the findings at the hearing, the court may extend the period of involuntary outpatient placement, release the person from involuntary outpatient placement, or find the person eligible for voluntary status. Recommended form CF-MH 3155, Feb. 05, "Order for Involuntary Outpatient Placement or Continued Involuntary Outpatient Placement," as referenced in paragraph 65E-5.285(3)(a), F.A.C., or other equivalent form adopted by the court may be used. A copy of the completed order shall be filed in the person's clinical record and a copy shall be provided to the person, attorney, facility administrator, and guardian, guardian advocate or representative.
- (i) In order for the department to implement the provisions of Section 394.463(2)(e), F.S., and to ensure that the Agency for Health Care Administration will be able to analyze the data it receives pursuant to that section, service providers shall forward copies of each recommended form CF-MH 3155, "Order for Involuntary Outpatient Placement or Continued Involuntary Outpatient Placement," as referenced in paragraph 65E-5.285(3)(a), F.A.C., or other order provided by the court, accompanied by mandatory form CF-MH 3118, "Cover Sheet to Agency for Health Care Administration," as referenced in subsection 65E-5.280(5), F.A.C., to: BA Reporting Center, FMHI-MHC 2637, 13301 Bruce B. Downs Boulevard, Tampa, Florida 33612-3807.
- (j) If at any time material modifications are proposed to the court ordered treatment plan to which the person and his or her substitute

Involuntary outpatient placement

(7) **PROCEDURE FOR CONTINUED INVOLUNTARY OUTPATIENT PLACEMENT.**

- (a) 1. If the person continues to meet the criteria for involuntary outpatient placement, the service provider shall, before the expiration of the period during which the treatment is ordered for the person, file in the circuit court a petition for continued involuntary outpatient placement.
2. The existing involuntary outpatient placement order remains in effect until disposition on the petition for continued involuntary outpatient placement.
3. A certificate shall be attached to the petition which includes a statement from the person's physician or clinical psychologist justifying the request, a brief description of the patient's treatment during the time he or she was involuntarily placed, and an individualized plan of continued treatment.
4. The service provider shall develop the individualized plan of continued treatment in consultation with the patient or the patient's guardian advocate, if appointed. When the petition has been filed, the clerk of the court shall provide copies of the certificate and the individualized plan of continued treatment to the department, the patient, the patient's guardian advocate, the state attorney, and the patient's private counsel or the public defender.
- (b) Within 1 court working day after the filing of a petition for continued involuntary outpatient placement, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of such appointment. The public defender shall represent the person until the petition

- 1 decision-maker, if any, agree, the service provider
- 2 shall submit recommended form CF-MH 3160,
- 3 Feb. 05, "Notice to Court of Modification to
- 4 Treatment Plan for Involuntary Outpatient
- 5 Placement and/or Petition Requesting Approval
- 6 of Material Modifications to Plan," as referenced
- 7 in paragraph 65E-5.285(3)(d), F.A.C., or other
- 8 form adopted by the court. If the person or
- 9 his substitute decision-maker object to the
- 10 modifications proposed by the service provider
- 11 or wish to propose modifications not proposed
- 12 by the service provider, recommended form
- 13 CF-MH 3160, Feb. 05, "Notice to Court of
- 14 Modification to Treatment Plan for Involuntary
- 15 Outpatient Placement and/or Petition
- 16 Requesting Approval of Material Modifications to
- 17 Plan," as referenced in paragraph 65E-5.285(3)(d),
- 18 F.A.C., or other form adopted by the court may
- 19 be used.
- 20
- 21
- 22 (k) If a physician has determined the person
- 23 who is subject to a court order for involuntary
- 24 outpatient placement has failed or has refused
- 25 to comply with the treatment ordered by the
- 26 court, and in his or her clinical judgment, efforts
- 27 were made to solicit compliance and the person
- 28 meets the criteria for involuntary examination,
- 29 the person may be brought to a receiving facility
- 30 pursuant to Section 394.463, F.S. Mandatory
- 31 form CF-MH 3052b, "Certificate of a Professional
- 32 Initiating Involuntary Examination," as referenced
- 33 in subsection 65E-5.260(1), F.A.C., shall be used.
- 34
- 35 (5) **Discharge from Involuntary Outpatient**
- 36 **Placement.**
- 37
- 38 (a) At any time a person no longer meets each of
- 39 the criteria for involuntary outpatient placement,
- 40 the administrator of the service provider shall
- 41 discharge the person from treatment or transfer
- 42 the person, if the person is able and willing
- 43 to provide express and informed consent, to
- 44 voluntary status.
- 45
- 46 (b) The administrator of the service provider will
- 47 provide notification to the person, guardian,
- 48 guardian advocate, representative, attorney
- 49 for the person, and the court that ordered such
- 50 treatment, with a copy placed in the person's
- 51 clinical record. Recommended form CF-MH
- 52 3038, Feb. 05, "Notice of Release or Discharge," as
- 53 referenced in paragraph 65E-5.2801(8)(e), F.A.C.,
- 54 may be used for this purpose.

Involuntary outpatient placement

Statute

(Chapter 394.4655 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.285 F.A.C.

is dismissed or the court order expires or the patient is discharged from involuntary outpatient placement. Any attorney representing the patient shall have access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.

- (c) Hearings on petitions for continued involuntary outpatient placement shall be before the circuit court. The court may appoint a master to preside at the hearing. The procedures for obtaining an order pursuant to this paragraph shall be in accordance with subsection (6), except that the time period included in paragraph (1)(e) is not applicable in determining the appropriateness of additional periods of involuntary outpatient placement.
- (d) Notice of the hearing shall be provided as set forth in s. 394.4599. The patient and the patient's attorney may agree to a period of continued outpatient placement without a court hearing.
- (e) The same procedure shall be repeated before the expiration of each additional period the patient is placed in treatment.
- (f) If the patient has previously been found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the patient's competence. Section 394.4598 governs the discharge of the guardian advocate if the patient's competency to consent to treatment has been restored.

- (c) At any time a person who is subject to an order for involuntary outpatient placement or continued involuntary outpatient placement, or the guardian, guardian advocate, health care surrogate or proxy, or attorney representing the person, believes any one of the criteria for involuntary outpatient placement are no longer met, a petition for termination of an involuntary outpatient placement order may be filed with the circuit court having jurisdiction. Recommended form CF-MH 3170, Feb. 05, "Petition for Termination of Involuntary Outpatient Placement Order," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or other form adopted by the court may be used for this purpose. If the court determines to conduct a hearing on the petition, notice of the hearing shall be provided by the clerk of court, pursuant to Section 394.4599, F.S.

See Appendix K for extensive
information on Involuntary
Outpatient Placement

Involuntary outpatient placement

394.467 Involuntary inpatient placement.

- (1) **CRITERIA.** A person may be placed in involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:

(a) He or she is mentally ill and because of his or her mental illness:

1. a. He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or

b. He or she is unable to determine for himself or herself whether placement is necessary; and

2. a. He or she 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 himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or

b. There is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and

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

- (2) **ADMISSION TO A TREATMENT FACILITY.** A patient may be retained by a receiving facility or involuntarily placed in a treatment facility upon the recommendation of the administrator of the receiving facility where the patient has been examined and after

65E-5.290 Involuntary Inpatient Placement.

- (1) If a person is retained involuntarily after an involuntary examination is conducted, a petition for involuntary inpatient placement or involuntary outpatient placement shall be filed with the court by the facility administrator within the 72-hour examination period, or if the 72 hours ends on a weekend or legal holiday, the petition shall be filed no later than the next court working day thereafter. Recommended form CF-MH 3032, "Petition for Involuntary Inpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)1., F.A.C., or recommended form CF-MH 3130, "Petition for Involuntary Outpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., or other forms adopted by the court may be used for this purpose. A copy of the completed petition shall be retained in the person's clinical record.
- (2) Each criterion alleged must be substantiated by evidence.
- (3) Use of recommended form CF-MH 3021, Feb. 05, "Notice of Petition for Involuntary Placement," as referenced in subparagraph 65E-5.285(1)(b)7., F.A.C., or other form used by the court, when properly completed, will satisfy the requirements of Section 394.4599, F.S. A copy of that completed form, or its equivalent, shall be retained in the person's clinical record. Whenever potential involuntary inpatient placement in a state treatment facility is proposed, a copy of the completed notice form shall also be provided to the designated community mental health center or clinic for purposes of conducting a transfer evaluation.
- (4) Recommended form CF-MH 3113, Feb. 05, "Notice to Court – Request for Continuance of Involuntary Placement Hearing," as referenced in paragraph 65E-5.285(2)(b), F.A.C., may be used by the counsel representing a person in requesting a continuance. A completed copy of the form used shall be provided to the facility administrator for retention in the person's clinical record.
- (5) Recommended form CF-MH 3022, Feb. 05, "Application for Appointment of Independent Expert Examiner," as referenced in paragraph 65E-5.285(2)(c), F.A.C., may be used to request the expert examiner.
- (6) Recommended form CF-MH 3033, Feb. 05, "Notification to Court of Withdrawal of Petition on

adherence to the notice and hearing procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary inpatient placement are met. However, in a county that has a population of fewer than 50,000, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental and nervous disorders or by a psychiatric nurse. Any second opinion authorized in this subsection may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation shall be entered on an involuntary inpatient placement certificate that authorizes the receiving facility to retain the patient pending transfer to a treatment facility or completion of a hearing.

(3) **PETITION FOR INVOLUNTARY INPATIENT PLACEMENT.** The administrator of the facility shall file a petition for involuntary inpatient placement in the court in the county where the patient is located. Upon filing, the clerk of the court shall provide copies to the department, the patient, the patient's guardian or representative, and the state attorney and public defender of the judicial circuit in which the patient is located. No fee shall be charged for the filing of a petition under this subsection.

(4) **APPOINTMENT OF COUNSEL.** Within 1 court working day after the filing of a petition for involuntary inpatient placement, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of such appointment. Any attorney representing the

Involuntary Inpatient or Outpatient Placement," as referenced in paragraph 65E-5.285(2)(d), F.A.C., may be used if the facility administrator seeks to withdraw the petition for involuntary placement prior to the hearing. The facility shall retain a copy in the person's clinical record. When a facility withdraws a petition for involuntary inpatient placement, it shall notify the court, state attorney, attorney for the person, and guardian or representative by telephone within 1 business day of its decision to withdraw the petition, unless such decision is made within 24 hours prior to the hearing. In such cases, the notification must be made immediately. In all cases involving potential involuntary inpatient placement in a state treatment facility, a copy of the notification form shall also be provided to the designated community mental health center or clinic responsible for conducting a transfer evaluation.

(7) If the court determines the person meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to Section 397.675, F.S., and issues an order, recommended form CF-MH 3114, Feb. 05, "Order Requiring Involuntary Assessment and Stabilization for Substance Abuse and for Baker Act Discharge of Person," as referenced in paragraph 65E-5.285(2)(g), F.A.C., or other order used by the court, may be used for this purpose.

(8) If at any time prior to the conclusion of the hearing on involuntary inpatient placement, the person instead meets the criteria for involuntary outpatient placement, the court may order the person evaluated for involuntary outpatient placement. Recommended form CF-MH 3115, Feb. 05, "Order Requiring Evaluation for Involuntary Outpatient Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, or other order adopted by the court, may be used.

(9) If the court concludes that the person meets the criteria for involuntary inpatient placement pursuant to Section 394.467, F.S., it shall prepare an order. Recommended form CF-MH 3008, "Order for Involuntary Inpatient Placement," as referenced in paragraph 65E-5.1302(1)(b), F.A.C., or other order used by the court, may be used for this purpose. This signed order shall be given to the person, guardian, guardian advocate or representative, counsel for

Statute

(Chapter 394.467 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.290 F.A.C.

patient shall have access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.

(5) CONTINUANCE OF HEARING.

The patient is entitled, with the concurrence of the patient's counsel, to at least one continuance of the hearing. The continuance shall be for a period of up to 4 weeks.

(6) HEARING ON INVOLUNTARY INPATIENT PLACEMENT.

(a) 1. The court shall hold the hearing on involuntary inpatient placement within 5 days, unless a continuance is granted. The hearing shall be held in the county where the patient is located and shall be as convenient to the patient as may be consistent with orderly procedure and shall be conducted in physical settings not likely to be injurious to the patient's condition. If the court finds that the patient's attendance at the hearing is not consistent with the best interests of the patient, and the patient's counsel does not object, the court may waive the presence of the patient from all or any portion of the hearing. The state attorney for the circuit in which the patient is located shall represent the state, rather than the petitioning facility administrator, as the real party in interest in the proceeding.

2. The court may appoint a general or special magistrate to preside at the hearing. One of the professionals who executed the involuntary inpatient placement certificate shall be a witness. The patient and the patient's guardian or representative shall be informed by the court of the right to an independent expert examination. If the patient cannot afford such an examination, the court shall provide for one. The independent expert's report shall be confidential and not discover-

the person, state attorney, and administrator of the receiving or treatment facility, with a copy of the order retained in the person's clinical record.

(10) In order for the department to implement the provisions of Section 394.463(2)(e), F.S., and to ensure that the Agency for Health Care Administration will be able to analyze the data it receives pursuant to that section, designated receiving facilities and treatment facilities shall forward copies of each recommended form CF-MH 3008, "Order for Involuntary Inpatient Placement," as referenced in paragraph 65E-5.1302(1)(b), F.A.C., or other order provided by the court, accompanied by mandatory form CF-MH 3118, "Cover Sheet to Agency for Health Care Administration," as referenced in subsection 65E-5.280(5), F.A.C., to: BA Reporting Center, FMHI-MHC 2637, 13301 Bruce B. Downs Boulevard, Tampa, Florida 33612-3807.

See Appendix J for extensive
information on Involuntary
Inpatient Placement

Statute

(Chapter 394.467 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5. F.A.C.

able, unless the expert is to be called as a witness for the patient at the hearing. The testimony in the hearing must be given under oath, and the proceedings must be recorded. The patient may refuse to testify at the hearing.

- (b) If the court concludes that the patient meets the criteria for involuntary inpatient placement, it shall order that the patient be transferred to a treatment facility or, if the patient is at a treatment facility, that the patient be retained there or be treated at any other appropriate receiving or treatment facility, or that the patient receive services from a receiving or treatment facility, on an involuntary basis, for a period of up to 6 months. The order shall specify the nature and extent of the patient's mental illness. The facility shall discharge a patient any time the patient no longer meets the criteria for involuntary inpatient placement, unless the patient has transferred to voluntary status.
- (c) If at any time prior to the conclusion of the hearing on involuntary inpatient placement it appears to the court that the person does not meet the criteria for involuntary inpatient placement under this section, but instead meets the criteria for involuntary outpatient placement, the court may order the person evaluated for involuntary outpatient placement pursuant to s. 394.4655. The petition and hearing procedures set forth in s. 394.4655 shall apply. If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to s. 397.675, then the court may order the person to be admitted for involuntary assessment for a period of 5 days pursuant to s. 397.6811. Thereafter, all proceedings shall be governed by chapter 397.
- (d) At the hearing on involuntary inpatient placement, the court shall consider testimony and evidence regarding the patient's competence to consent to treatment. If the court finds that the patient

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Involuntary inpatient placement

is incompetent to consent to treatment,
it shall appoint a guardian advocate as
provided in s. 394.4598.

- (e) The administrator of the receiving facility shall provide a copy of the court order and adequate documentation of a patient's mental illness to the administrator of a treatment facility whenever a patient is ordered for involuntary inpatient placement, whether by civil or criminal court. The documentation shall include any advance directives made by the patient, a psychiatric evaluation of the patient, and any evaluations of the patient performed by a clinical psychologist, a marriage and family therapist, a mental health counselor, or a clinical social worker. The administrator of a treatment facility may refuse admission to any patient directed to its facilities on an involuntary basis, whether by civil or criminal court order, who is not accompanied at the same time by adequate orders and documentation.

(7) PROCEDURE FOR CONTINUED INVOLUNTARY INPATIENT PLACEMENT.

- (a) Hearings on petitions for continued involuntary inpatient placement shall be administrative hearings and shall be conducted in accordance with the provisions of s. 120.57(1), except that any order entered by the administrative law judge shall be final and subject to judicial review in accordance with s. 120.68. Orders concerning patients committed after successfully pleading not guilty by reason of insanity shall be governed by the provisions of s. 916.15.
- (b) If the patient continues to meet the criteria for involuntary inpatient placement, the administrator shall, prior to the expiration of the period during which the treatment facility is authorized to retain the patient, file a petition requesting authorization for continued involuntary inpatient placement. The request shall be accompanied by a statement from the patient's physician or

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65E-5.300 Continued Involuntary Inpatient Placement at Treatment Facilities.

- (1) In order to request continued involuntary inpatient placement, the treatment facility administrator shall, prior to the expiration of the period during which the treatment facility is authorized to retain the person, file a request for continued placement. Recommended form CF-MH 3035, Feb. 05, "Petition Requesting Authorization for Continued Involuntary Inpatient Placement," 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 as documentation of that request. The petition shall be filed with the Division of Administrative Hearings within 20 days prior to the expiration date of a person's authorized period of placement or, in the case of a minor, the date when the minor will reach the age of majority. The petition shall contain the signed statement of the person's physician or clinical psychologist justifying the request and shall be accompanied by the following additional documentation:
- (a) Evidence justifying the request by the physician or clinical psychologist for involuntary inpatient

Statute

(Chapter 394.467 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.300 F.A.C.

clinical psychologist justifying the request, a brief description of the patient's treatment during the time he or she was involuntarily placed, and an individualized plan of continued treatment. Notice of the hearing shall be provided as set forth in s. 394.4599. If at the hearing the administrative law judge finds that attendance at the hearing is not consistent with the best interests of the patient, the administrative law judge may waive the presence of the patient from all or any portion of the hearing, unless the patient, through counsel, objects to the waiver of presence. The testimony in the hearing must be under oath, and the proceedings must be recorded.

- (c) Unless the patient is otherwise represented or is ineligible, he or she shall be represented at the hearing on the petition for continued involuntary inpatient placement by the public defender of the circuit in which the facility is located.
- (d) If at a hearing it is shown that the patient continues to meet the criteria for involuntary inpatient placement, the administrative law judge shall sign the order for continued involuntary inpatient placement for a period not to exceed 6 months. The same procedure shall be repeated prior to the expiration of each additional period the patient is retained.
- (e) If continued involuntary inpatient placement is necessary for a patient admitted while serving a criminal sentence, but whose sentence is about to expire, or for a patient involuntarily placed while a minor but who is about to reach the age of 18, the administrator shall petition the administrative law judge for an order authorizing continued involuntary inpatient placement.
- (f) If the patient has been previously found incompetent to consent to treatment, the administrative law judge shall consider testimony and evidence regarding the

- placement, including how the person meets each of the statutorily required criteria;
- (b) A brief summary of the person's treatment during the time he or she was placed; and
- (c) An individualized treatment plan.
- (2) Each criterion alleged must be substantiated by evidence.
- (3) The administrative law judge shall provide notice of the hearing. Recommended form CF-MH 3024, Feb. 05, "Notice of Petition for Continued Involuntary Placement," 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 for this purpose. Copies shall be provided to the person, attorney, and guardian, guardian advocate or representative, with a copy of the notice filed in the person's clinical record.
- (4) If the administrative law judge finds evidence that the person has regained his or her competency to consent to treatment, the administrative law judge shall notify the court appointing the guardian advocate. Recommended form CF-MH 3116, Feb. 05, "Findings and Recommended Order Restoring Person's Competence to Consent to Treatment and Discharging the Guardian Advocate," 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 for this purpose.
- (5) Based on the findings of the hearing, the administrative law judge may return the person to involuntary placement pending the next statutorily required periodic hearing, release the person from placement, or find the person eligible for voluntary status. Recommended form CF-MH 3031, Feb. 05, "Order for Continued Involuntary Inpatient Placement or for Release," 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 for this purpose. A copy of the completed order shall be filed in the person's clinical record and a copy shall be provided to the person, attorney, facility administrator, and guardian, guardian advocate or representative.
- (6) In order for the department to implement the provisions of Section 394.463(2)(e), F.S., and to ensure that the Agency for Health Care Administration will be able to analyze the data it receives pursuant to that section, designated receiving facilities and treatment facilities shall

Involuntary inpatient placement

patient's competence. If the administrative law judge finds evidence that the patient is now competent to consent to treatment, the administrative law judge may issue a recommended order to the court that found the patient incompetent to consent to treatment that the patient's competence be restored and that any guardian advocate previously appointed be discharged.

- (8) **RETURN OF PATIENTS.** When a patient at a treatment facility leaves the facility without authorization, the administrator may authorize a search for the patient and the return of the patient to the facility. The administrator may request the assistance of a law enforcement agency in the search for and return of the patient.

394.46715 Rulemaking authority.

The Department of Children and Family Services shall have rulemaking authority to implement the provisions of ss. 394.455, 394.4598, 394.4615, 394.463, 394.4655, and 394.467 as amended or created by this act. These rules shall be for the purpose of protecting the health, safety, and well-being of persons examined, treated, or placed under this act.

394.4672 Procedure for placement of veteran with federal agency.

- (1) Whenever it is determined by the court that a person meets the criteria for involuntary placement and it appears that such person is eligible for care or treatment by the United States Department of Veterans Affairs or other agency of the United States Government, the court, upon receipt of a certificate from the United States Department of Veterans Affairs or such other agency showing that facilities are available and that the person is eligible for care or treatment therein, may place that person with

forward copies of each recommended form CF-MH 3031, "Order for Continued Involuntary Inpatient Placement or Release," as referenced in subsection 65E-5.300(5), F.A.C., accompanied by mandatory form CF-MH 3118, "Cover Sheet to Agency for Health Care Administration," as referenced in subsection 65E-5.280(5), F.A.C., to: BA Reporting Center, FMHI-MHC 2637, 13301 Bruce B. Downs Boulevard, Tampa, Florida 33612-3807.

N/A

N/A

VETERANS

- the United States Department of Veterans Affairs or other federal agency. The person whose placement is sought shall be personally served with notice of the pending placement proceeding in the manner as provided in this part, and nothing in this section shall affect his or her right to appear and be heard in the proceeding. Upon placement, the person shall be subject to the rules and regulations of the United States Department of Veterans Affairs or other federal agency.
- (2) The judgment or order of placement by a court of competent jurisdiction of another state or of the District of Columbia, placing a person with the United States Department of Veterans Affairs or other federal agency for care or treatment, shall have the same force and effect in this state as in the jurisdiction of the court entering the judgment or making the order; and the courts of the placing state or of the District of Columbia shall be deemed to have retained jurisdiction of the person so placed. Consent is hereby given to the application of the law of the placing state or district with respect to the authority of the chief officer of any facility of the United States Department of Veterans Affairs or other federal agency operated in this state to retain custody or to transfer, parole, or discharge the person.
- (3) Upon receipt of a certificate of the United States Department of Veterans Affairs or such other federal agency that facilities are available for the care or treatment of mentally ill persons and that the person is eligible for care or treatment, the administrator of the receiving or treatment facility may cause the transfer of that person to the United States Department of Veterans Affairs or other federal agency. Upon effecting such transfer, the committing court shall be notified by the transferring agency. No person shall be transferred to the United States Department of Veterans Affairs or other federal agency if he or she is confined pursuant to the conviction of any felony or misdemeanor or if he or she has been acquitted of the charge

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solely on the ground of insanity, unless prior to transfer the court placing such person enters an order for the transfer after appropriate motion and hearing and without objection by the United States Department of Veterans Affairs.

- (4) Any person transferred as provided in this section shall be deemed to be placed with the United States Department of Veterans Affairs or other federal agency pursuant to the original placement.

394.468 Admission and discharge procedures.

Admission and discharge procedures and treatment policies of the department are governed solely by this part. Such procedures and policies shall not be subject to control by court procedure rules. The matters within the purview of this part are deemed to be substantive, not procedural.

394.4685 Transfer of patients among facilities.

(1) TRANSFER BETWEEN PUBLIC FACILITIES.

- (a) A patient who has been admitted to a public receiving facility, or the family member, guardian, or guardian advocate of such patient, may request the transfer of the patient to another public receiving facility. A patient who has been admitted to a public treatment facility, or the family member, guardian, or guardian advocate of such patient, may request the transfer of the patient to another public treatment facility. Depending on the medical treatment or mental health treatment needs of the patient and the availability of appropriate facility resources, the patient may be transferred at the discretion of the department. If the department approves the transfer of an involuntary patient, notice according to the

N/A

65E-5.310 Transfer of Persons Among Facilities.

- (1) Recommended form CF-MH 3046, Feb. 05, "Application for and Notice of Transfer to Another 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 request the transfer of a person to another receiving or treatment facility. This application, or its equivalent, shall be completed and filed with the facility administrator or designee. A copy of the completed application shall be retained in the person's clinical record.
- (2) The administrator of the facility or designee at which the person resides shall, without delay, submit an application for transfer to the administrator of the facility to which a person has requested transfer. Upon acceptance of the person by the facility to which the transfer is sought, the administrator of the transferring facility or his or her designee shall mail the statutorily required notices to the person, the person's attorney, guardian, guardian advocate or representative, retaining a copy in the person's clinical record. Recommended

Statute

(Chapter 394.4685 F.S.)

Current and accurate as of date of printing September 2013

Rule

65E-5.310 F.A.C.

provisions of s. 394.4599 shall be given prior to the transfer by the transferring facility. The department shall respond to the request for transfer within 2 working days after receipt of the request by the facility administrator.

- (b) When required by the medical treatment or mental health treatment needs of the patient or the efficient utilization of a public receiving or public treatment facility, a patient may be transferred from one receiving facility to another, or one treatment facility to another, at the department's discretion, or, with the express and informed consent of the patient or the patient's guardian or guardian advocate, to a facility in another state. Notice according to the provisions of s. 394.4599 shall be given prior to the transfer by the transferring facility. If prior notice is not possible, notice of the transfer shall be provided as soon as practicable after the transfer.

(2) TRANSFER FROM PUBLIC TO PRIVATE FACILITIES.

A patient who has been admitted to a public receiving or public treatment facility and has requested, either personally or through his or her guardian or guardian advocate, and is able to pay for treatment in a private facility shall be transferred at the patient's expense to a private facility upon acceptance of the patient by the private facility.

(3) TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.

- (a) A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.
- (b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

form CF-MH 3046, "Application for and Notice of Transfer to Another Facility," as referenced in subsection 65E-5.310(1), F.A.C., may be used for this documentation.

- (3) If the proposed transfer of a person originates with the administrator of the facility or his or her designee or with the treating physician a notice of transfer is required. The notice shall be completed by the administrator or designee of the transferring facility, after acceptance of the person by the facility to which he or she will be transferred, with copies provided prior to the transfer to those required by law, with a copy retained in the person's clinical record. Recommended form CF-MH 3046, "Application for and Notice of Transfer to Another Facility," as referenced in subsection 65E-5.310(1), F.A.C., may be used for this purpose.
- (4) All relevant documents including a copy of the person's clinical record, shall be transferred prior to or concurrent with the person to the new facility.
- (5) Each facility shall develop and implement policies and procedures for transfer that provide for safety and care during transportation.

Transfers from hospitals must comply with federal EMTALA law.

(c) A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.

- (4) **TRANSFER BETWEEN PRIVATE FACILITIES.** A patient in a private facility or the patient's guardian or guardian advocate may request the transfer of the patient to another private facility at any time, and the patient shall be transferred upon acceptance of the patient by the facility to which transfer is sought.

394.469 Discharge of involuntary patients.

- (1) **POWER TO DISCHARGE.** At any time a patient is found to no longer meet the criteria for involuntary placement, the administrator shall:
- (a) Discharge the patient, unless the patient is under a criminal charge, in which case the patient shall be transferred to the custody of the appropriate law enforcement officer;
 - (b) Transfer the patient to voluntary status on his or her own authority or at the patient's request, unless the patient is under criminal charge or adjudicated incapacitated; or
 - (c) Place an improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.
- (2) **NOTICE.**—Notice of discharge or transfer of a patient shall be given as provided in s. 394.4599.

394.473 Attorney's fee; expert witness fee.

- (1) In the case of an indigent person for whom an attorney is appointed pursuant to the provisions of this part, the attorney shall be compensated by the state pursuant to s. 27.5304. In the case of an indigent person, the court may appoint a public defender. The public defender

65E-5.320 Discharge of Persons on Involuntary Status.

A receiving or treatment facility administrator shall provide prompt written notice of the discharge of a person on involuntary status to the person, guardian, guardian advocate, representative, initiating professional, and circuit court, with a copy retained in the person's clinical record. Recommended form CF-MH 3038, "Notice of Release or Discharge," as referenced in paragraph 65E-5.280(7)(e), F.A.C., may be used as documentation of such notice. If the discharge occurs while a court hearing for involuntary placement or continued involuntary placement is pending, all parties including the state attorney and attorney representing the person, shall be given telephonic notice of the discharge by the facility administrator or his or her designee.

N/A

- shall receive no additional compensation other than that usually paid his or her office.
- (2) In the case of an indigent person for whom expert testimony is required in a court hearing pursuant to the provisions of this act, the expert, except one who is classified as a full-time employee of the state or who is receiving remuneration from the state for his or her time in attendance at the hearing, shall be compensated by the state pursuant to s. 27.5304.

394.475 Acceptance, examination, and involuntary placement of Florida residents from out-of-state mental health authorities.

- (1) Upon the request of the state mental health authority of another state, the department is authorized to accept as a patient, for a period of not more than 15 days, a person who is and has been a bona fide resident of this state for a period of not less than 1 year.
- (2) Any person received pursuant to subsection (1) shall be examined by the staff of the state facility where such patient has been accepted, which examination shall be completed during the 15-day period.
- (3) If upon examination such a person requires continued involuntary placement, a petition for a hearing regarding involuntary placement shall be filed with the court of the county wherein the treatment facility receiving the patient is located or the county where the patient is a resident.
- (4) During the pendency of the examination period and the pendency of the involuntary placement proceedings, such person may continue to be held in the treatment facility unless the court having jurisdiction enters an order to the contrary.

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394.4784 Minors; access to outpatient crisis intervention services and treatment.

For the purposes of this section, the disability of nonage is removed for any minor age 13 years or older to access services under the following circumstances:

(1) OUTPATIENT DIAGNOSTIC AND EVALUATION SERVICES.

When any minor age 13 years or older experiences an emotional crisis to such degree that he or she perceives the need for professional assistance, he or she shall have the right to request, consent to, and receive mental health diagnostic and evaluative services provided by a licensed mental health professional, as defined by Florida Statutes, or in a mental health facility licensed by the state. The purpose of such services shall be to determine the severity of the problem and the potential for harm to the person or others if further professional services are not provided. Outpatient diagnostic and evaluative services shall not include medication and other somatic methods, aversive stimuli, or substantial deprivation. Such services shall not exceed two visits during any 1-week period in response to a crisis situation before parental consent is required for further services, and may include parental participation when determined to be appropriate by the mental health professional or facility.

(2) OUTPATIENT CRISIS INTERVENTION, THERAPY AND COUNSELING SERVICES

When any minor age 13 years or older experiences an emotional crisis to such degree that he or she perceives the need for professional assistance, he or she shall have the right to request, consent to, and receive outpatient crisis intervention services including individual psychotherapy, group therapy, counseling, or other forms of verbal therapy provided by a licensed mental health professional, as defined by Florida Statutes, or in a mental health facility licensed by the state. Such services shall not include medication and other somatic treatments, aversive stimuli, or

N/A

Outpatient Services for Minors.

See Appendix D for issues addressing consent for admission and treatment for minors

substantial deprivation. Such services shall not exceed two visits during any 1-week period in response to a crisis situation before parental consent is required for further services, and may include parental participation when determined to be appropriate by the mental health professional or facility.

(3) LIABILITY FOR PAYMENT.

The parent, parents, or legal guardian of a minor shall not be liable for payment for any such outpatient diagnostic and evaluation services or outpatient therapy and counseling services, as provided in this section, unless such parent, parents, or legal guardian participates in the outpatient diagnostic and evaluation services or outpatient therapy and counseling services and then only for the services rendered with such participation.

(4) PROVISION OF SERVICES.

No licensed mental health professional shall be obligated to provide services to minors accorded the right to receive services under this section. Provision of such services shall be on a voluntary basis. 394.4785 Children and adolescents; admission and placement in mental

394.4785 Children and adolescents; admission and placement in mental facilities.

- (1) A child or adolescent as defined in s. 394.492 may not be admitted to a state-owned or state-operated mental health treatment facility. A child may be admitted pursuant to s. 394.4625 or s. 394.467 to a crisis stabilization unit or a residential treatment center licensed under this chapter or a hospital licensed under chapter 395. The treatment center, unit, or hospital must provide the least restrictive available treatment that is appropriate to the individual needs of the child or adolescent and must adhere to the guiding principles, system of care, and service planning provisions contained in part III of this chapter.

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**Inpatient Services for
Minors.**

- (2) A person under the age of 14 who is admitted to any hospital licensed pursuant to chapter 395 may not be admitted to a bed in a room or ward with an adult patient in a mental health unit or share common areas with an adult patient in a mental health unit. However, a person 14 years of age or older may be admitted to a bed in a room or ward in the mental health unit with an adult if the admitting physician documents in the case record that such placement is medically indicated or for reasons of safety. Such placement shall be reviewed by the attending physician or a designee or on-call physician each day and documented in the case record.

394.47891 Military veterans and service members court programs.

The chief judge of each judicial circuit may establish a Military Veterans and Servicemembers Court Program under which veterans, as defined in s. 1.01, and servicemembers, as defined in s. 250.01, who are convicted of a criminal offense and who suffer from a military-related mental illness, traumatic brain injury, substance abuse disorder, or psychological problem can be sentenced in accordance with chapter 921 in a manner that appropriately addresses the severity of the mental illness, traumatic brain injury, substance abuse disorder, or psychological problem through services tailored to the individual needs of the participant. Entry into any Military Veterans and Service members Court Program must be based upon the sentencing court's assessment of the defendant's criminal history, military service, substance abuse treatment needs, mental health treatment needs, amenability to the services of the program, the recommendation of the state attorney and the victim, if any, and the defendant's agreement to enter the program.

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N/A

**New!!
Veterans and service
members court programs**

Online Baker Act Training

<http://www.bakeracttraining.org>

FREE!

On demand!

CEC's offered at low cost!

Also see 65E-5.180(7)(b)
FAC for additional training
required regarding restraint
and seclusion

65E-5.330 Training.

- (1) In order to ensure the protection of the health, safety, and welfare of persons treated in receiving and treatment facilities, required by Section 394.457(5)(b), F.S., the following is required:
 - (a) Each designated receiving and treatment facility shall develop policies and procedures for abuse reporting and shall conduct training which shall be documented in each employee's personnel record or in a training log.
 - (b) All staff who have contact with persons served shall receive training in verbal de-escalation techniques and the use of bodily control and physical management techniques based on a team approach. Less restrictive verbal de-escalation interventions shall be employed before physical interventions, whenever safety conditions permit.
 - (c) All staff who have contact with persons served shall receive training in cardiopulmonary resuscitation within the first six months of employment if not already certified when employed and shall maintain current certification as long as duties require direct contact with persons served by the facility.
 - (d) A personnel training plan that prescribes and assures that direct care staff, consistent with their assigned duties, shall receive and complete before providing direct care or assessment services, 14 hours of basic orientation training, documented in the employee's personnel record, in the following:
 1. Rights of persons served by the facility and facility procedures required under Chapter 394, Part I, F.S., and Chapter 65E-5, F.A.C.;
 2. Confidentiality laws including psychiatric, substance abuse, HIV and AIDS;
 3. Facility incident reporting;
 4. Restrictions on the use of seclusion and restraints, consistent with unit policies and procedures, and this chapter;
 5. Abuse reporting required by Chapter 415, F.S.;
 6. Assessment for past or current sexual, psychological, or physical abuse or trauma;
 7. Cross-training for identification of, and working with, individuals recently engaging in substance abuse;

Chapter 65E-14, FAC also governs funding.

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8. Clinical risk and competency assessment;
 9. Universal or standard practices for infection control;
 10. Crisis prevention, crisis intervention and crisis duration services;
 11. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, as referenced in subparagraph 65E-5.285(1)(a)2., F.A.C.; and
 12. Honoring preferences contained in advance directives prepared by persons served by the facility.
- (2) In addition to the training required in this rule, procedures must assure that mental health services staff shall annually receive 12 hours continuing training in the skills and knowledge employed in performing their respective responsibilities. Employees during their first year of employment shall undergo no less than the 14 hours of orientation, as described in paragraph (1)(c) above, and 12 hours of in-service training.
 - (3) Procedures shall require that individuals who deliver the staff training curriculum for mental health services shall be qualified by their experience and training in the content presented.
 - (4) A plan shall be developed and implemented providing for the mandatory training for employees, emergency room personnel and physicians in the Baker Act, relative to their positions and responsibilities, and any implementing local coordination agreements or protocols.

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.

Emergency Screening.

- 1 (2) **Baker Act Funding.**
2 (a) Only public receiving facilities, pursuant to
3 Section 394.455(25), F.S., and only the costs
4 of eligible Baker Act services provided to
5 diagnostically and financially eligible persons
6 may be paid with Baker Act appropriations.
7 (b) Baker Act services shall first be provided to
8 acutely ill persons who are most in need of
9 mental health services and are least able to pay.
10 (c) Persons receiving Baker Act funded services must
11 meet financial eligibility criteria as established
12 by the federal poverty guidelines. Public
13 receiving facilities may provide Baker Act funded
14 services to acutely ill persons who are financially
15 ineligible if the total number of days of service
16 paid for with Baker Act funds for financially
17 ineligible persons does not exceed 20 percent of
18 the total number of days paid for with Baker Act
19 funds.
20 (d) An individual's diagnostic and financial eligibility
21 shall be documented on mandatory form CF-
22 MH 3084, Feb. 05, "Baker Act Service Eligibility,"
23 which is incorporated by reference and may be
24 obtained pursuant to Rule 65E-5.120, F.A.C., of
25 this rule chapter.
26
27 (3) This section applies to all Baker Act funded
28 providers. All services including hospital inpatient
29 facilities, crisis stabilization units, short-term
30 residential treatment programs, and children's crisis
31 stabilization units providing services purchased
32 by the department under this chapter shall be
33 consistent with licensure requirements and must
34 comply with written facility policies and procedures.
35
36 (4) Training. The training required in Rule 65E-5.330,
37 F.A.C., is required for all direct service staff employed
38 by publicly funded Baker Act service providers.
39
40 (5) **Emergency Reception and Screening.**
41 (a) Providers authorized by the department
42 shall have a policy and procedure manual
43 for the specific service being provided. The
44 administration of the provider organization shall
45 ensure the completeness and accuracy of the
46 manual and that organizational operations are in
47 accordance with the manual. The manual must
48 be approved by the respective departmental
49 district or regional office for completeness and
50 consistency in implementing this chapter and
51 Chapter 394, Part I, F.S. The manual shall be
52 consistent with the provisions of Chapter 394,
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Part I, F.S., and with Chapter 65E-5, F.A.C., and must include the following:

1. Procedures for responding to requests for services that specify a prompt screening to determine the person's immediacy of need, and for prioritizing access to services with limited availability. Staff skills shall be specific to the unique needs of the persons to be served;
 2. A description of the services offered, recipient eligibility criteria, how eligible recipient facilities or individuals are informed of service availability, service locations, costs, criteria for response, hours of operation, staffing with staff qualifications and supervision, and organizational line of authority to the operating entity;
 3. Procedures to be utilized to implement and document staff training in accord with Rule 65E-5.330, F.A.C., staff proficiency or competency including the performance of any subcontractors employed to provide services, and how training will be used to effect remediable identified deficiencies;
 4. Procedures for a complaint and grievance system that provide a prompt response to the individuals served, and mechanisms to monitor and evaluate service quality, and the outcomes attained by individuals served. Facility personnel shall provide each person served with a listing of his or her rights and a telephone number to which complaints may be directed;
 5. Procedures to determine if the individual has a case manager from a mental health center or clinic, as well as notification and coordination of activities with the case manager;
 6. Procedures to maintain a clinical record for each individual served and its safeguarding in accordance with Section 394.4615, F.S.; and
 7. Procedures to inform the public of the availability of services.
- (b) Procedures must assure that a psychiatrist or a physician shall be available on-call for consultation at all times and hours during which emergency reception and screening services are operated.

**Mobile Crisis Response &
Mental Health Overlay defined
in 394.455 (17) & (19) F.S.**

(6) Mobile Crisis Response Service and Mental Health Overlay Program Requirements.

- (a) The criteria and operational requirements for a mobile crisis response service and a mental health overlay program is defined in Sections 394.455(19) and 394.455(17), F.S., respectively. The operation of these services is expressly limited to the program's contract with the department.
- (b) Providers authorized by the department to provide mobile crisis response services and mental health overlay programs shall have a policy and procedure manual for the specific service being provided. The administration of the provider organization shall ensure the completeness and accuracy of the manual and that organizational operations are in accordance with the manual. The manual must be approved by the departmental district or regional office in which the facility is located. The manual shall be consistent with the provisions of Chapter 394, Part I, F.S., and these rules, and shall include:
 1. A description of the services offered, eligibility criteria, how eligible recipient facilities or individuals are informed of service availability, criteria for response, hours of operation, staffing with staff qualifications and supervision, and organizational line of authority to the operating entity;
 2. Procedures to be utilized to implement the provisions of Section 394.4625, F.S., including staff training, proficiency or competency assessment instruments to be administered, credentialing, and distribution of results obtained;
 3. A description of on-site evaluation, educational, assistance or supportive services, if provided, to be rendered by mental health overlay programs. The extent and frequency of services offered must be described. Staff skills shall be specific to unique needs of the persons to be served;
 4. Procedures for the provision of a complaint and grievance procedure to be used by individuals served, and mechanisms to monitor and evaluate the service's quality and the outcomes attained by individuals served. Personnel shall provide each person served with a listing of his or her rights and a telephone number to which complaints may be directed;

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5. Procedures that require the provider's issuance of, and the employees wearing of identification badges including a photograph of employee, organization's name, and employees name and identification number, if full name is not used, for all employees responding to, or working in, off-site situations;
 6. Procedures that assure determination of whether the individual has a case manager from a mental health center or clinic, and require notification and coordination of activities with the case manager; and
 7. Procedures that require the maintenance of a clinical record for each individual served and safeguarding it in accordance with Section 394.4615, F.S.
- (c) Procedures must require employee's clinical activities and performance, as opposed to primarily administrative functions, are supervised by one of the following: a psychiatrist, physician, clinical psychologist, clinical social worker, mental health counselor, marriage and family therapist, or psychiatric nurse, as defined in Section 394.455, F.S.
- (d) Procedures must assure that a physician or psychiatrist shall be available on-call for consultation at all times and hours during which mental health overlay programs and mobile crisis response services are operated.
- (e) Procedures must be consistent with Section 394.462, F.S., and these rules, and must limit transportation of an involuntary person by the mental health overlay program or mobile crisis response service to only directly transporting individuals to the nearest designated receiving facility. In addition, the following provisions shall be met and described in the manual:
1. Liability insurance of no less than \$100,000 per person shall be provided.
 2. The vehicle shall be equipped with a Type 2A10BC fire extinguisher, seat belts, 2-way communication radio or cellular telephone with accompanying emergency telephone numbers, and a functioning air conditioner and heater.
 3. Staff having the responsibility for transporting people shall be trained and experienced in transporting people with mental illness and substance abuse who may become confused, volatile, or combative.

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4. At least 2 members shall be present to transport an individual. The total number of people in the vehicle at any time shall not exceed the legal seating capacity.
5. Firearms shall not be worn or carried in the vehicle.
6. Physical restraints, such as canvas cuffs, shall not be used except by personnel trained in their use, and only when necessary to protect the person being transported from injury to themselves or others. Any use of physical or mechanical restraints shall be fully and completely documented in the person's clinical record.
7. The vehicle used to transport people shall be unmarked, maintained and operated in accordance with Chapter 316, F.S., and in a manner that protects the individual's rights, dignity and physical safety.
8. Procedures must require the immediate reporting of any unusual incidents or injuries, upon arrival at the intended destination.

(7) **Requirements for Mental Health Overlay Programs in Nursing Homes, Assisted Living Facilities, Adult Day Care Centers, and Adult Family Care Homes.**

- (a) All plans, contracts and activities shall recognize that the primary responsibility for the care and treatment of individuals rests with the nursing home, assisted living facility, adult day care center, or adult family care home.
- (b) Activities representative of those services appropriate to be provided by a mental health overlay program include:
 1. Assisting in the development or implementation of individual care plans;
 2. Assessing and making recommendations for needed physical or psychiatric services to the facility administrator; and
 3. Providing training to facility staff or residents in various mental health skills or knowledge, such as anger management, psychotropic medications, depression, loss, physical and sexual trauma, and competency to consent determinations.
- (c) Personnel shall provide each person served with a list of his or her rights pursuant to Chapter 394, Part I, F.S.

Baker Act and Related Laws

Statutes governing the treatment of mental illness in Florida date back to 1874. Amendments to the law were passed many times over the years but in 1971 the Legislature enacted the Florida Mental Health Act. This Act brought about a dramatic and comprehensive revision of Florida's 97-year old mental health law. It substantially strengthened the due process and civil rights of persons in mental health facilities.

The Florida Mental Health Act, usually referred to as the "Baker Act," was named after Maxine Baker, former State representative from Miami who sponsored the Act, after serving as chairperson of the House Committee on Mental Health. Referring to the treatment of persons with mental illness before the passage of her bill, Representative Baker stated "In the name of mental health, we deprive them of their most precious possession – liberty."

It is important that the Baker Act only be used in situations where the person has a mental illness as defined in the Baker Act and meets all remaining statutory criteria for voluntary or involuntary admission. The Baker Act does not authorize provision of medical examination or medical treatment. Further, the legal definition of mental illness excludes intoxication, substance abuse impairment, any form of developmental disability, and antisocial behavior. For many persons, the use of other statutes may be more appropriate. Some alternative statutes may include:

Marchman Act

Chapter 397, F.S.

A person may voluntarily enter substance abuse treatment or undergo involuntary admission into a licensed substance abuse facility if found to be substance abuse impaired and meeting certain other criteria. This means a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behavior.

The involuntary assessment and treatment criteria under the Marchman Act requires a good faith reason to believe the person is substance abuse impaired and because of such impairment, has lost the power of self-control with respect to substance use and either has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on self or others or is in need of substance abuse services and, by reason of substance abuse impairment,

his judgment has been so impaired that he is incapable of appreciating his need for such services and of making a rational decision in regard thereto (mere refusal is insufficient).

Involuntary admission can be initiated in a number of ways:

- Protective Custody by a law enforcement officer
- Emergency Admission, requiring a physician's certificate
- Alternative Assessments for Minors by parent or legal guardian to a Juvenile Addiction Receiving Facility
- Assessment and Stabilization ordered by a Circuit Court Judge.

If the assessment conducted by a qualified professional under one of the above confirms criteria is met, a petition can be filed with the court and the judge can order up to 60 days of treatment if the person is accepted by a licensed treatment provider.

Developmental Disabilities

Chapter 393, F.S.

This statute governs disorders or syndromes that are attributable to intellectual disability, cerebral palsy, autism, spina bifida or Prader-Wili Syndrome that occur before the age of 18 and that constitute a substantial handicap that can reasonably be expected to continue indefinitely.

A person may be court ordered to undergo involuntary admission to residential services under Chapter 393.11, F.S. if he or she has intellectual disability, in order that the person may receive the care, treatment, habilitation, and rehabilitation which the person needs.

Emergency Examination and Treatment of Incapacitated Persons

s. 401.445, F.S.

This statute provides insulation from liability in cases where the person's emergency medical condition is a life-threatening one and treatment is provided without consent. A person is generally incapable of providing informed consent if he cannot understand the procedure, the medically acceptable alternatives, and the substantial risks and hazards inherent in the proposed treatment or procedures.

These conditions include when:

- (a) The patient at the time of examination or treatment is intoxicated, under the influence

of drugs, or otherwise incapable of providing informed consent;

- (b) The patient at the time of examination or treatment is experiencing an emergency medical condition; and
- (c) The patient would reasonably, under all the surrounding circumstances, undergo such examination, treatment, or procedure if he or she were advised by the emergency medical technician, paramedic, physician, advanced registered nurse practitioner, or physician assistant.

Examination and treatment is limited to reasonable examination of the patient to determine the medical condition of the patient and treatment reasonably necessary to alleviate the emergency medical condition or to stabilize the patient.

When examining or treating a person who is apparently intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent, an authorized professional acting under the direct medical supervision of a physician, shall proceed wherever possible with the consent of the person. If the person appears to be incapacitated and refuses his or her consent, the person may be examined, treated, or taken to a hospital or other appropriate treatment resource if he or she is in need of emergency attention, without his or her consent, but unreasonable force cannot be used. This doesn't limit medical treatment provided pursuant to a court order or treatment provided in accordance with the Baker Act or Marchman Act.

EMTALA

42 USC 1395dd

This federal statute titled Emergency Medical Treatment and Active Labor Act prohibits the delay and/or denial of emergency medical services, including psychiatric and substance abuse emergencies due to inability to pay for care. This law applies to all hospitals having emergency service capability, including freestanding psychiatric hospitals.

EMTALA governs access to emergency care, transfers between facilities, and penalties for violation by physicians and hospitals. Where the state Baker Act law conflicts with the federal EMTALA law, the federal law prevails. If the laws are not in conflict, both must be followed.

Access to Emergency Services and Care

s.395.1041, F.S.

This state statute is the equivalent of the federal EMTALA law. It prohibits the delay or denial of emergency services and care by hospitals and physicians and enforces the ability of persons to get all necessary and appropriate emergency care within the capability and capacity of each hospital. This statute governs access to care, transfers from one hospital to other facilities, and establishes penalties for violations by physicians and hospitals.

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.

(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...

This statute also requires that a hospital providing emergency services and care to a person who is being involuntarily examined under the Baker Act must adhere to all rights of patients and involuntary examination procedures provided by the Baker Act, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility, and regardless of whether the person is admitted to the hospital.

Adult Abuse, Neglect, and Exploitation

s. 415.1051, F.S.

This statute may be appropriate when a vulnerable adult is alleged to be a victim of abuse, neglect, or exploitation and lacks the capacity to consent to needed services and care. This means a mental impairment that causes a person to lack sufficient understanding or capacity to make or communicate responsible decisions concerning his person or property, including whether or not to accept protective services from the Department of Children and Families (DCF).

A **vulnerable adult** is defined in Chapter 415 as one whose ability to perform the normal activities of daily living or to provide for his/her own care or protection is impaired due to a mental, emotional, long-term physical or developmental disability, dysfunction, brain damage, or the infirmities of aging.

Where the person's condition is not a life-threatening emergency and no health care surrogate or proxy is available to consent, a report to the Department of Children and Families of the need for non-emergency protective service intervention is required. If the Department has reasonable cause to believe that a vulnerable adult is in need of protective services but lacks the capacity to consent to protective services, the Department must petition the court for an order authorizing the provision of protective services.

The Department of Children and Families and a law enforcement officer may forcibly enter and may remove a vulnerable adult who is likely to incur a risk of death or serious physical injury.

Emergency medical treatment (that doesn't violate an advance directive) may be provided without consent for a vulnerable adult after admission to a medical facility. Further treatment without informed consent is subject to a DCF petition and a court order.

Advance Directives

Chapter 765, F.S.

If a competent person has previously executed an advance directive designating a health care surrogate and a physician has now found the person to be incompetent or incapacitated to consent to his/her own treatment, the surrogate may instead be asked to provide such consent.

Incapacity or incompetent means the person is physically or mentally unable to communicate a willful and knowing health care decision.

In the absence of an advance directive, a health care proxy may be notified, if a person meeting the degree of relationship specified in Chapter 765, Part IV, F.S. is available to serve. A proxy can be:

1. A judicially appointed guardian of the person or the guardian advocate of the person having a developmental disability (totally different than under the Baker Act) who has been authorized to consent to medical treatment, if such guardian has previously been appointed;
2. The spouse;
3. An adult child, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation;
4. A parent;
5. The adult sibling or, if the patient has more than one sibling, a majority of the adult siblings who are reasonably available for consultation;
6. An adult relative of the patient who has exhibited special care and concern for the patient and who has maintained regular contact with the patient and who is familiar with the patient's activities, health, and religious or moral beliefs; or
7. A close adult friend of the patient who has exhibited special care and concern for the patient, and who presents an affidavit to the health care facility or to the attending or treating physician stating that he or she is a friend of the patient; is willing and able to become involved in the patient's health care; and has maintained such regular contact with the patient so as to be familiar with the patient's activities, health, and religious or moral beliefs.
8. A clinical social worker licensed pursuant to chapter 491, or who is a graduate of a court-approved guardianship program. Such a proxy must be selected by the provider's bioethics committee and must not be employed by the provider. If the provider does not have a bioethics committee, then such a proxy may be chosen through an arrangement with the bioethics committee of another provider.

Any health care decision made must be based on informed consent and on the decision the surrogate or proxy reasonably believes the person would have made under the circumstances (substitute judgement). If there is no indication what the patient would have chosen, the surrogate or proxy may consider the patient's best interest in deciding that proposed treatments are to be withheld or that treatments currently in effect are to be withdrawn.

The Baker Act requires that any person who has a health care surrogate or proxy making his/her treatment decisions be on involuntary status.

A health care facility must notify the surrogate or proxy in writing that his or her authority has begun. The surrogate or proxy has the authority to:

- Make written consent to health care decisions the principal would have made if capable of making such decisions (substitute judgement);
- Have access to clinical records;
- Authorize release of records for continuity of care;
- Authorize transfer of principal to or from a health care facility; and
- Apply for public benefits.

A sample mental health advance directive can be found in Appendix C of this handbook. However, any advance directive designating a health care surrogate which is prepared in accord with Florida law is acceptable.

Guardianship

Chapter 744, F.S.

Some persons, due to their incapacity, require either a limited or a plenary guardian to make many life decisions.

An incapacitated person is one who has been judicially determined to lack the capacity to manage at least some of his/her property or to meet at least some of the essential health and safety requirements of such person.

Both plenary and limited guardianship is initiated by a petition to the court. Any order of a circuit judge must state the nature of the guardianship as either plenary, where the guardian exercises all delegable rights, or limited where the guardian exercises only those removed from the ward in the order.

The Baker Act prohibits the voluntary admission of any person who has been adjudicated incapacitated. However, a plenary guardian or guardian of person may provide express and informed consent for the person's treatment while held under involuntary status.

*See chart comparing related statutes.

**Laws governing minors, including those who are dependent or delinquent, are addressed in Appendix D.

Specialized on-line Baker Act courses can be found at
<http://www.bakeracttraining.org>.

For further assistance visit: <http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml> to view DCF's most Frequently Asked Questions list.

Quick Reference Guide to Related Statutes (Does not substitute for consulting the statutes)

	Baker Act - The Florida Mental Health Act	Developmental Disabilities	Marchman Act	Emergency Medical Services & Transportation	Adult Abuse, Neglect, and Exploitation	Guardianship	Health Care Surrogate & Proxy
	Chapter 394.455 (18), Part 1, F.S.	s. 393.063(9), s. 393.0641(1), F.S.	Chapter 397, Part V, F.S.	s. 401.445, F.S.	s. 415.1051, F.S.	Chapter 744, F.S.	Chapter 765, F.S.
Definitions	<p>Mental illness means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.</p>	<p>Developmental disability is a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.</p> <p>Self Injurious behavior is any chronic behavior that results in injury to the person's own body, including, but not limited to, self-hitting, head banging, self-biting, scratching, and the ingestion of harmful or potentially harmful nutritive or nonnutritive substances.</p>	<p>Substance abuse Impaired: condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behavior.</p>	<p>EMS means the activities or services to prevent or treat a sudden critical illness or injury and to provide emergency medical care and pre-hospital emergency medical transportation to sick, injured, or otherwise incapacitated persons.</p> <p>A person is incapable of providing informed consent if he cannot generally understand the procedure, the medically acceptable alternatives, and the substantial risks and hazards inherent in the proposed treatment or procedures.</p>	<p>A vulnerable adult is one whose ability to perform the normal activities of daily living or to provide for his/her own care or protection is impaired due to a mental, emotional, long-term physical or developmental disability, dysfunctional, brain damage, or the infirmities of aging.</p> <p>Neglect by caregiver or vulnerable adult to provide care, supervision, food, clothing, shelter and medical services essential for well being.</p>	<p>An incapacitated person is one who has been judicially determined to lack the capacity to manage at least some of his/her property or to meet at least some of the essential health and safety requirements of such person.</p>	<p>Incapacity or incompetent means the person is physically or mentally unable to communicate a willful and knowing health care decision.</p> <p>A health care surrogate is any competent adult expressly designated by a person to make health care decisions on behalf of the person upon the principal's incapacity.</p> <p>A health care proxy is a competent adult who has not been expressly designated to make health care decisions for a particular incapacitated person, but who, is one of the designated authorized persons eligible to make health care decision for the individual.</p>

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	Baker Act - The Florida Mental Health Act	Developmental Disabilities	Marchman Act	Emergency Medical Services & Transportation	Adult Abuse, Neglect, and Exploitation	Guardianship	Health Care Surrogate & Proxy
	Chapter 394, Part 1, F.S.	s. 393., 11, F.S.	Chapter 397, Part V, F.S.	s. 401.445, F.S.	s. 415.1051, F.S.	Chapter 744, F.S.	Chapter 765, F.S.
Involuntary Criteria	A person may be taken to a receiving facility for involuntary examination if there is reason to believe that he or she has a mental illness and because of his or her mental illness the person has refused or is unable to consent to voluntary examination and treatment, the person is likely to suffer from neglect or refuse to care for self; such neglect or refusal poses a real and present threat of substantial harm to his well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or there is a substantial likelihood that without care or treatment the person will cause serious bodily harm to self or others in the near future, as evidenced by recent behavior.	Suffers from intellectual disabilities, in need of residential services, lacks the capacity to give express and informed consent to voluntary admission, and either lacks the basic survival and self-care skills to provide for one's well-being or is likely to physically injure others if allowed to remain at liberty.	Good faith reason to believe the person is substance abuse impaired, and, because of such impairment has lost the power of self-control with respect to substance use and either has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on self or others or is in need of substance abuse services and, by reason of impairment, his judgment has been so impaired that he is incapable of appreciating his need for such services and of making a rational decision in regard thereto (mere refusal insufficient).	Presence of an emergency medical condition in a person who is intoxicated, under influence or drugs or otherwise incapable of providing informed consent. Emergency personnel may take with or without consent if incapacitated to a hospital or other appropriate treatment resources, but unreasonable force shall not be used.	Vulnerable adult alleged to be a victim of abuse, neglect, or exploitation, who lacks capacity to consent. This means a mental impairment that causes a person to lack sufficient understanding or capacity to make or communicate responsible decisions concerning his person or property, including whether or not to accept protective services from DCF. If risk of death or serious physical injury, DCF with law enforcement may forcibly enter and may remove person to a medical or protective services facility.	Criteria differs for various types of guardians, including: <ul style="list-style-type: none"> ■ Natural Guardians ■ Guardians of minors ■ Emergency Temporary Guardians ■ Standby Guardians ■ Pre-Need Guardians ■ Foreign Guardians ■ Resident Guardians ■ Guardian Advocates 	Determination of incapacity or incompetence of a person needing medical treatment.

	Baker Act - The Florida Mental Health Act	Developmental Disabilities	Marchman Act	Emergency Medical Services & Transportation	Adult Abuse, Neglect, and Exploitation	Guardianship	Health Care Surrogate & Proxy
	Chapter 394, Part 1, F.S.	s. 393. 11, F.S.	Chapter 397, Part V, F.S.	s. 401.445, F.S.	s. 415.1051, F.S.	Chapter 744, F.S.	Chapter 765, F.S.
Initiation	<ul style="list-style-type: none"> Ex parte order of a circuit judge State Certified law enforcement officer acting in his or her official capacity Specified professional (MD, DO, clinical psychologist, LCSW, LMHC, LMFT or psychiatric nurse – all as defined in 394). 	Petitioning Commission of 3 persons, one must be a physician, file petition with circuit court.	2 forms of court involved initiation and 3 forms of non-court. Protective custody by LEO or emergency admission with physician's certificate, or petition to circuit court. See Appendix N for details	EMS personnel may treat without informed consent if the patient at the time of exam or treatment has an emergency medical condition and is intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent.	<p>Court order upon petition by DCF in non-emergency cases.</p> <p>DCF and LEO may forcibly enter and may remove incapacitated person who is likely to incur a risk of death or serious physical injury.</p>	<p>Petition to the court to determine incapacity filed by an adult.</p> <p>Order of a circuit judge stating the nature of the guardianship as either plenary or limited. If limited, order states the rights that have been removed and delegated to the guardian.</p>	<p>Determination by attending physician, that the principal lacks capacity to make health care decisions for himself.</p> <p>Health care facility notifies surrogate or proxy in writing that his or her authority under the advance directive has begun.</p>
Authority of Substitute Decision Maker	Guardian Advocate may be appointed by the court for any person found to be incompetent to consent to treatment. This means that a person's judgment is so affected by his or her mental illness that he lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.	Guardian Advocate is a person appointed by the Circuit Court for a person with developmental disabilities in any proceedings brought pursuant to 393.12 and excludes the use of the same term as applied to a guardian advocate for persons with a mental illness in Chapter 394.	<p>Guardian Advocate can be appointed for the person during the court hearing if person cannot attend. Otherwise, no substitute decision-maker provided in 397 other than the parent of a minor.</p> <p>A Guardian ad litem must be appointed for a minor unrepresented by an attorney in an involuntary hearing.</p>		<p>Emergency medical treatment (that doesn't violate an advance directive) without consent for incapacitated person, after admission to a medical facility.</p> <p>Further treatment without informed consent is subject to a DCF petition and a court order.</p>	<p>Limited to authority granted by Circuit Court: in Letters of Guardianship. Plenary Guardian shall exercise all delegable rights while Limited Guardian exercises only those removed from the ward in the order. Must file reports, plans, inventory, and accounting.</p>	<p>Make written consent to health care decisions the principal would have made if capable of making such decisions. (Substitute Judgement)</p> <p>Have access to clinical records, authorize release of records for continuity of care, authorize transfer of principal to or from a health care facility, and apply for public benefits.</p>

	Baker Act - The Florida Mental Health Act	Developmental Disabilities	Marchman Act	Emergency Medical Services & Transportation	Adult Abuse, Neglect, and Exploitation	Guardianship	Health Care Surrogate & Proxy
Authorizing Statute	Chapter 394, Part 1, F.S.	s. 393.11, F.S.	Chapter 397, Part V, F.S.	s. 401.445, F.S.	s. 415.1051, F.S.	Chapter 744, F.S.	Chapter 765, F.S.
Limitations of Authority of Substitute Decision Makers	Guardian Advocate cannot authorize voluntary admission or consent to treatment for a voluntary person. Cannot consent to medical treatment unless authorized by the court. Cannot consent to ECT and certain other extraordinary procedures without authority given by the court.					Guardian is prohibited from having ward placed voluntarily in psychiatric facility but may consent to treatment for a ward on involuntary status. Guardians may consent to treatment but not to admission.	May not consent to voluntary admission of person to psychiatric facility or to the psychiatric treatment of a person on voluntary status. May not provide consent for abortion, sterilization, ECT, psychosurgery, experimental treatment without Court approval or express authority in an advance directive.
See Also	65E-5, FAC 65E-12, FAC		65E-30, FAC	395.1041, F.S. 42USC 1395dd.	Chapter 825, F.S.	s. 394.4625 (1)(e), F.S.	s. 394.4625 (1)(e), F.S. and 65E-5.2301

Voluntary Admissions

s. 394.4625, F.S. Chapter 65E-5.270, F.A.C.

The Baker Act encourages the voluntary admission of persons for psychiatric care, but only when they are able to fully understand the decision and its consequences and are able to fully exercise their rights for themselves. When this is not possible due to the severity of the person's condition, the law requires that the person be extended the due process rights assured for those under involuntary status. This is further supported by the U.S. Supreme court case of *Zinerman v. Burch* (1990).

Each person entering a facility, regardless of age, must be asked to give express and informed consent for admission and treatment. If the person is a minor, express and informed consent for admission and treatment must also be requested from the person's guardian. Express and informed consent for admission and treatment of a person under 18 years of age is required from the person's guardian. See Appendix D for extensive information about consent for admission and treatment of minors.

Selected Definitions

s. 394.455, F.S.

“Mental illness” means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology. For the purposes of this part, the term does not include a developmental disability as defined in Chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment. (18)

“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. (9)

“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. (15)

Criteria

s. 394.4625(1)(a), F.S. s. 394.459(3)(a), F.S.

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. A person age 17 or under can be admitted only after a hearing to verify the voluntariness of the consent.

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.

Exclusions

s. 394.4625(1), F.S.

- A facility **may not** admit a person on a voluntary basis who has been adjudicated incapacitated and has a guardian appointed by the court.
- The health care surrogate or proxy of a person on voluntary status **may not** consent to mental health treatment for the person. Therefore, such a person must be discharged from the facility or involuntary placement procedures initiated.
- Certain individuals residing in or served by long-term care facilities such as nursing homes and assisted living facilities (licensed under Chapter 400 and 429, F.S.), **may not** be removed from their residence for voluntary examination unless previously screened by an authorized independent mental health professional and found to be able to provide express and informed consent to treatment (able to make well-reasoned, willful, and knowing decisions about their medical or mental health treatment) (CF-MH 3099). See Appendix E for additional information about long-term care facilities
- A person on voluntary status who is unwilling or unable to provide express and informed consent to mental health treatment must either be discharged from a receiving/treatment facility or transferred to involuntary status.

Within 24 hours after a voluntary admission, the admitting physician must document in the person's clinical record that the person is able to give express and informed consent for admission and treatment (CF-MH 3104). If the person is not able to give express and informed consent, the facility must either discharge the person or transfer the person to involuntary status.

Right to Discharge

s. 394.4625(3), F.S.

B

At the time of admission and at least every six months thereafter, a person on voluntary status must be notified in writing of his or her right to apply for a discharge. (CF-MH 3051)

Transfer from Involuntary to Voluntary Status

s. 394.4625(4), F.S.

A person on involuntary status who applies to be transferred to voluntary status must be transferred to voluntary status, unless the person has been charged with a crime, or has been involuntarily placed for treatment by a court and continues to meet the criteria for involuntary placement.

Before the transfer to voluntary status is processed, the mandatory initial involuntary examination must be performed by a physician or clinical psychologist and a certification of the person's competence to provide express and informed consent to treatment must be completed by a physician. In addition, the competent person must have formally applied for voluntary admission, without any coercion.

Such a transfer is contingent on the person meeting the criteria for voluntary status found above which should be documented by an Application for Voluntary Admission (CF-MH 3040, 3097, or 3098) and a Certification of Person's Competence to Provide Express and Informed Consent (CF-MH-3104).

When transfer to voluntary status occurs, notice must be provided to the person and the person's guardian advocate, attorney, and representative.

If a physician has determined the individual transferring from involuntary to voluntary status is of imminent danger to self or others, notification to the Clerk of Court regarding prohibition of firearm purchase or to obtain/retain a concealed weapon permit may be required (See Appendix S).

Transfer from Voluntary to Involuntary Status

s. 394.4625(5), F.S.

At any time a person on voluntary status is determined not to have the capacity to make well-reasoned, willful, and knowing decisions about his or her mental health or medical care, he/she must be transferred to involuntary status.

When a person on voluntary status, or an authorized individual acting on the person's behalf, makes a request for his/her 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 person meets the criteria for involuntary inpatient placement, the administrator of the facility must file a petition for involuntary placement (CF-MH 3032) or may file a petition for involuntary outpatient placement (CF-MH 3130), with the court within two court working days after the request for discharge is made. If the petition is not filed within two court working days, the person must be discharged.

Discharge of Persons on Voluntary Status

s.394.4625(2), F.S.

A facility must discharge a person on voluntary status:

1. Who has ***sufficiently improved*** so that retention in the facility is no longer clinically appropriate. A person may also be discharged to the care of a community facility.
2. Who ***requests discharge***. A person on voluntary status or a relative, friend, or attorney of the person may request discharge either orally or in writing at any time following admission to the facility. (CF-MH 3051)

If the person, or another acting on the person's behalf, makes an oral request for discharge to a staff member, such request must be immediately entered in the person'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 person.

The person must be discharged within 24 hours of the request, unless the request is rescinded or the person is transferred to involuntary status. The 24-hour time period may be extended by a treatment facility (which generally is a state hospital) when necessary for adequate discharge planning, but must not exceed three days exclusive of weekends and holidays.

3. A person on voluntary status who has been admitted to a facility and who ***refuses to consent to or revokes consent to treatment*** (CF-MH 3105) must be discharged within 24 hours after such refusal or revocation unless transferred to involuntary status or unless the refusal or revocation is freely and voluntarily rescinded by the person.

Elopement of a Person on Voluntary Status

If a person on voluntary status elopes or leaves the facility against medical advice, law enforcement should only be notified to return the person to the receiving facility if the person is under a criminal charge or it appears the person meets the criteria for involuntary examination or placement. A minor's guardian must be notified as soon as possible that the minor has eloped or left against advice. The notification must be documented in the person's record.

Specialized on-line Baker Act courses can be found at
<http://www.bakeracttraining.org>.

For further assistance visit: <http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml> to view DCF's most Frequently Asked Questions list.

Voluntary Admissions

Quick Reference Guide for Receiving and Treatment Facilities

The person being admitted must:

Have a mental illness, as defined in the law, and

Be suitable for treatment, and

Be competent to provide express and informed consent to the voluntary admission and to treatment as well as being willing and able to sign an Application for Voluntary Admission (CF-MH 3040 for adults at receiving facilities, CF-MH 3097 for minors, and CF-MH 3098 for State Treatment Facilities)

Prior to admission of a person meeting certain criteria from a long-term care facility licensed under Chapter 400 or 429, F.S. he or she has been assessed by an authorized service or independent professional as able to provide express and informed consent to admission and treatment (CF-MH 3099). _____ yes _____ no _____ not applicable

At the time of admission, the facility must open a clinical record containing the following information and may include the following completed recommended forms:

- _____ Application for Voluntary Admission (CF-MH 3040, or 3097 or 3098)
- _____ Notice of Right to Release (CF-MH 3051a for receiving facility and CF-MH 3051b for treatment facility) completed and given to the person at the time of admission and every 6 months thereafter.
- _____ General Authorization for Treatment Except Psychotropic Medications (CF-MH 3042a)
- _____ Inventory of Personal Effects (CF-MH 3043) documenting property brought by the person to the facility, signed by the person, if able, and witnessed by two staff members.
- _____ Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances (CF-MH 3036)
- _____ Documentation of providing explanation and copy of Rights of Persons in Mental Health Facilities or Programs (CF-MH 3103)
- _____ Intake Interview
- _____ Baker Act Service Eligibility Form (CF-MH 3084) for an indigent person at a CSU or other public receiving facility.

Subsequent to the person's admission, the following should be completed:

- _____ Documentation by the admitting physician that the person is able to give express and informed consent for admission. (CF-MH 3104) If not, the person must be discharged or transferred to involuntary status.
- _____ Documentation of a physical examination by an authorized health practitioner within 24 hours of arrival.
- _____ Personal Safety Plan (CF-MH 3124)
- _____ Completion of a "Specific Authorization for Psychotropic Medications" (CF-MH 3042b) prior to the administration of any psychotropic medications, after a complete disclosure to the person and to the guardian of a minor of the following:
 - _____ An individualized treatment plan completed within five days of the person's admission in which the person has had the opportunity to assist in preparing, including space for the person's comments and a copy of which has been provided to the person and to a minor's guardian.

<input type="checkbox"/> Reason for Admission	<input type="checkbox"/> Specific dosage range for medications
<input type="checkbox"/> Proposed treatment, including proposed psychotropic medications	<input type="checkbox"/> Frequency and method of administration
<input type="checkbox"/> Purpose of treatment	<input type="checkbox"/> Common risks, benefits and common short-term and long-term side effects
<input type="checkbox"/> Alternative treatments	<input type="checkbox"/> Any contraindications which may exist

- | | |
|--|--|
| <input type="checkbox"/> Clinically significant interactive effects with other medications
<input type="checkbox"/> Similar information on alternative medication which may have less severe or serious side effects
<input type="checkbox"/> Potential effects of stopping treatment
<input type="checkbox"/> Approximate length of care | <input type="checkbox"/> How treatment will be monitored, and that
<input type="checkbox"/> Any consent for treatment may be revoked orally or in writing before or during the treatment period if the person legally authorized to make health care decisions on behalf of the person. |
|--|--|

The following forms shall be included only if applicable:

- _____ Authorization for Release of Information (CF-MH 3044) completed and signed only when such release is to take place.
- _____ Authorization for Electroconvulsive Treatment (CF-MH 3057)
- _____ Refusal or Revocation of Consent to Treatment (CF-MH 3105)
- _____ Restriction of Communication or Visitors (CF-MH 3049)
- _____ Restriction of Person's Access to Own Record (CF-MH 3110)
- _____ Petition for Writ of Habeas Corpus or for Redress of Grievances (CF-MH 3090)
- _____ Application for and Notice of Transfer to Another Facility (CF-MH 3046)
- _____ Packet of forms to Clerk of Court on firearms prohibition if of imminent danger to self/others

Request for Discharge: If the person, or an authorized person acting on his/her behalf, makes an oral or written request for discharge, facility staff must:

- _____ Immediately enter the oral or written request for release in the person's clinical record.
- _____ Notify the physician, psychiatrist, or clinical psychologist within 12 hours of the request for discharge.
- _____ Discharge the person within 24 hours of the request unless a petition for involuntary placement (CF-MH 3032 or 3130) has been initiated. (State hospitals have 3 working days in which to discharge such persons)

If a person **requesting discharge** meets criteria for involuntary inpatient placement, the facility must (Or in cases of involuntary outpatient placement, the facility may):

- _____ Initiate proceedings for involuntary placement within 24 hours by having the first expert opinion documented on the petition form.
- _____ File the Petition for Involuntary Placement (CF-MH 3032 or 3130) with the circuit court within two court working days of the request for discharge.

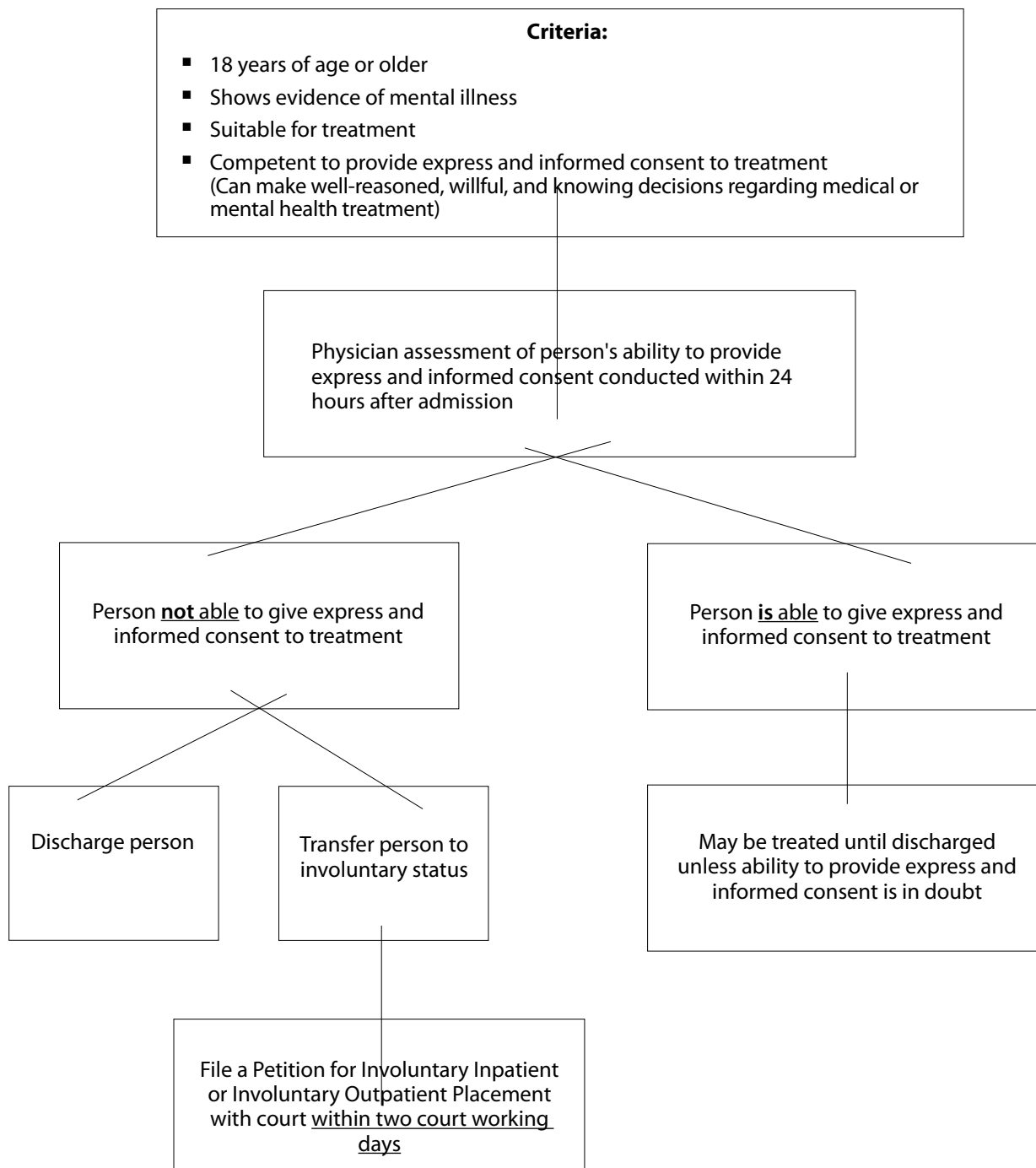
State Mental Health Facility: If voluntary placement in a state mental health facility is sought for the person, the following must be completed:

- _____ Transfer Evaluation (CF-MH 3089)
- _____ State Mental Health Facilities Admission Form (CF-MH 7000)
- _____ Physician to Physician Transfer Form (CF-MH 7002)

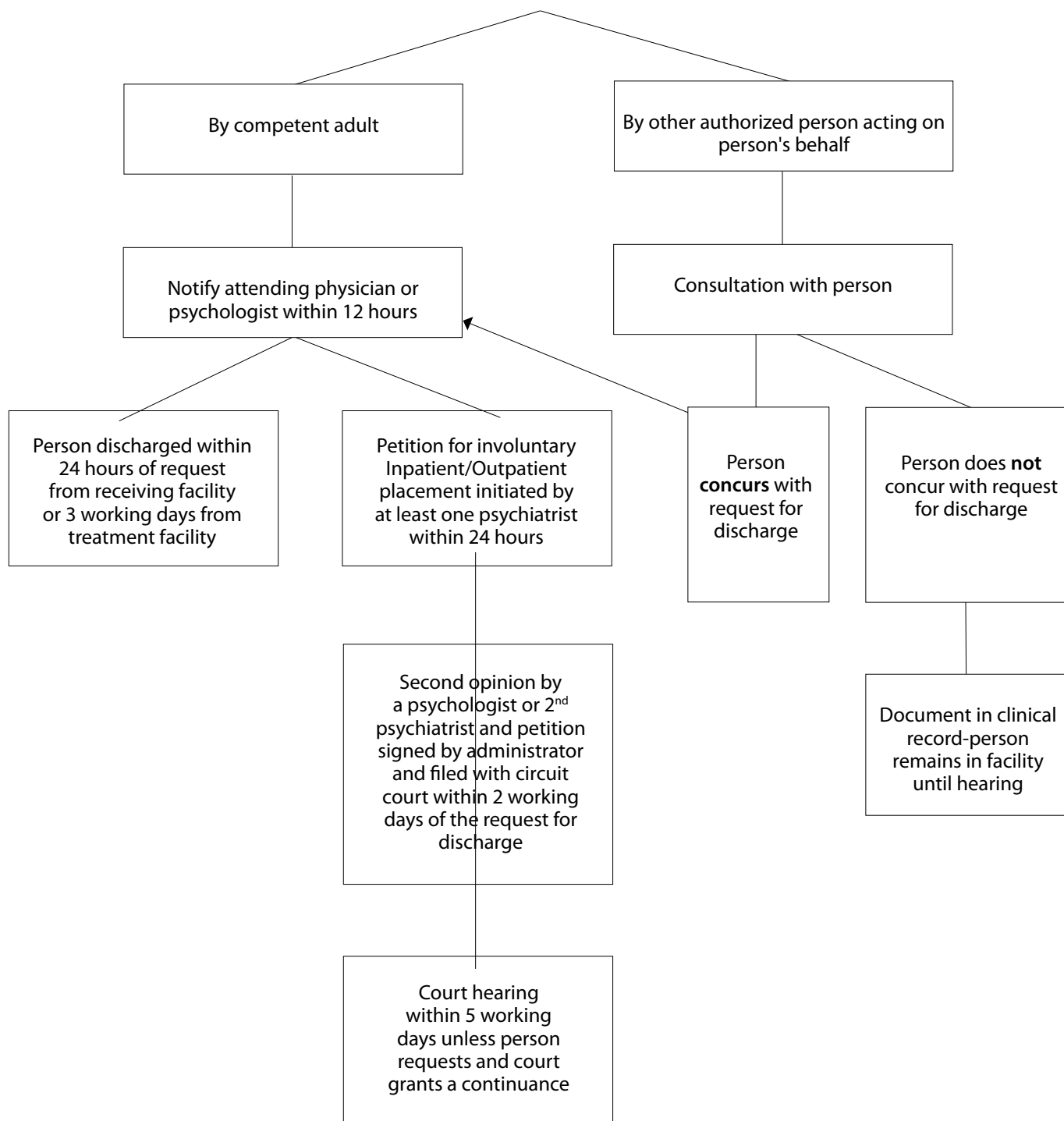
Recommended forms are those which are not required by the department, but which have been determined to satisfy the specific requirements for which the form has been developed. Alteration of recommended forms may jeopardize this status. Mandatory forms may not be altered. No blank forms should be signed by staff, the person, or substitute decision-maker.

Adult Seeking Voluntary Admission

(other than from a facility licensed under Chapter 400/429, F.S.)



Request for Discharge of Person on Voluntary Status



Express and Informed Consent

s. 394.459(3), F.S. Chapter 65E-5.170, F.A.C.

Consent in the mental health treatment context is simply the agreement of one person to accept the actions or decisions of another as his/her own. Consent must be voluntary, by a person who is competent to choose, and who is fully informed and understands the consequences of that choice. Individuals competent to consent to treatment are also competent to refuse or revoke consent to treatment. When a person is not competent to choose, he or she must be transferred to involuntary status. There are legally prescribed methods for obtaining substitute decision-making in such circumstances.

Express and Informed Consent is defined in the Baker Act as consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

A person is **incompetent to consent** to treatment, as defined in the Baker Act, as one whose judgment is so affected by mental illness that he or she lacks the capacity to make a well-reasoned, willful, and knowing decision concerning medical or mental health treatment.

Each person entering a facility, other than those who are incapacitated or incompetent to consent to treatment, must be asked to give express and informed consent for admission and treatment. If the person is a minor, express and informed consent for admission and treatment is required from the guardian.

No person can be administered treatment in a receiving or treatment facility without express and informed consent to the treatment having first been provided by a person legally authorized to give that consent, except in documented cases of imminent danger when a physician orders emergency treatment.

Prior to seeking such consent, the person and/or guardian (if incapacitated or a minor), or guardian advocate or health care surrogate/proxy must be given at least the following information and the clinical record should reflect that the person or substitute decision-maker clearly understood the information, had an opportunity to ask questions / get answers about the information, and understood the consequences of providing or withholding consent:

- Reason for admission or treatment
- Proposed treatment, including proposed psychotropic medications
- Purpose of treatment to be provided
- Alternative treatments
- Specific dosage range for medication
- Frequency and method of administration
- Common risks, benefits and common short-term and long-term side effects
- Any contraindications which may exist
- 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
- Notification 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 on behalf of the person.

Documentation of Competence to Provide Express and Informed Consent

The admitting physician must determine whether a person being admitted to a receiving or treatment facility is competent to provide express and informed consent to his/her admission and treatment.

- An adult admitted on a **voluntary** basis or transferred from involuntary to voluntary status must be competent to provide his or her own consent. The guardian of a minor must be willing to provide express and informed consent for the minor.
- A person admitted on an **involuntary** status may or may not be competent to provide express and informed consent for his/her own treatment.

In any case, when an adult is permitted to provide consent for his/her own treatment, the physician must document in the clinical record the adult's competence to make well-reasoned, willful, and knowing mental health and

medical decisions. If not competent to consent, as defined above, the facility administrator must release the person or petition the court for appointment of a guardian advocate, unless the person already has a court-appointed guardian. **Only** when the safety of the person or others is in imminent danger, may the physician order emergency treatment.

Emergency psychiatric treatment (ETO) may be 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 person or others and express and informed consent from an authorized person is unavailable. If the person has not had a guardian appointed by the court, a petition for a guardian advocate must be initiated within 24 hours and submitted to the court within two court working days (unless only one ETO is ordered within a two day period).

Drugs used as a restraint are medications used to control behavior or to restrict the person's freedom of movement and are not a standard treatment for the person's medical or psychiatric condition. Chemical restraints are also regulated by federal conditions of participation and accrediting organizations.

The administrator of a receiving or treatment facility may, upon the recommendation of the person's attending physician, authorize emergency medical treatment, including a surgical procedure, if such treatment is deemed lifesaving, or if the situation threatens serious bodily harm to the person, and informed consent of the person or the person's guardian or guardian advocate cannot be obtained. See Appendix I for more information about emergency treatment orders.

Electroconvulsive treatment (ECT) may be authorized by a competent person, or by a guardian, or by a guardian advocate who has been given express court authority to consent to electroconvulsive treatment. [s. 394.459(3)(b), F.S.] Section 458.325, F.S. requires that electroconvulsive treatment be agreed to by a second physician not directly involved with the responsibility for the person's care. Such agreement must be documented in the person's treatment record and must be signed by both physicians.

Persons Determined Incompetent to Consent to Treatment

s. 394.4598, F.S. Chapter 65E-5.230, F.A.C.

The administrator of a receiving or treatment facility may petition the court for the appointment of a guardian advocate based upon the opinion of a psychiatrist that the person is incompetent - unable to make well-reasoned, willful and knowing decisions about his or her medical or mental health treatment.

Before giving consent to treatment, the guardian advocate must meet and talk with the individual and the individual's physician in person, if at all possible, and by telephone, if not. The guardian advocate must certify that such communication with the individual and physician has taken place before authorizing treatment. The guardian advocate must also complete court-ordered training. See the Guardian Advocate Training & Resource Manual for extensive information about the duties of a guardian advocate. The Manual can be found on the DCF website <http://www.dcf.state.fl.us/>. A specialized web-based training course for Guardian Advocates can be found at <http://flguardianadvocate.org/>.

Persons Adjudicated Incapacitated

Chapter 394.4625(1)(d) F.S.

The Baker Act prohibits the voluntary admission of any person who has been adjudicated by a court as incapacitated even though the guardianship law [744.3725, FS] defines specific steps the court must follow before granting a guardian the authority to do so. The first District Court of Appeals has ruled that where the Baker Act and the guardianship law conflict on least restrictive alternatives, the Baker Act prevails (*Hanley v. Dennis*).

The court order adjudicating the person as incapacitated will designate who is the guardian. Letters of guardianship are issued to the guardian and specify whether the guardianship pertains to the person, or to the property, or both, of the ward. The letters will state whether the guardianship is plenary or limited, and, if limited, the letters must state the powers and duties of the guardian. [s. 744.345, F.S.] The guardian can only be permitted to perform those responsibilities that have been expressly removed from the ward and delegated to the guardian.

Persons with Health Care Surrogates / Proxies

Chapter 765, F.S. Chapter 65E-5.2301, F.A.C.

Any competent adult may execute an advance directive designating any other adult to make his/her health-related decisions should he/she ever become incompetent to make these decisions. If the person has not executed an advance directive or the surrogate selected by the person is not available, health care decisions may be made by a proxy chosen from a statutorily authorized prioritized list of persons: guardian, spouse, adult child, parent, adult sibling, adult relative, close friend, or independent licensed clinical social worker.

If a person's capacity to make health care decisions for oneself or provide express and informed consent is in question, the attending physician should evaluate the person's capacity. If the attending physician concludes that the person lacks such capacity to make mental health care decisions, the facility must enter the physician's evaluation in the person's clinical record and notify the surrogate or proxy in writing that his/her authority to act has commenced (recommended form "Certification of Person's Incompetence to Consent to Treatment and Notification of Health Care Surrogate/Proxy" CF-MH 3122 may be used). The authority thus activated remains in effect until a determination that the person has regained his/her capacity. When a healthcare proxy is designated, the proxy should also complete an affidavit (CF-MH 3123).

A specialized Mental Health Advance Directive has been developed for optional use and can be found at the end of this appendix.

During the interim period between the time a person is determined by a physician to be incompetent to consent to treatment and the time a guardian advocate is appointed by a court to provide express and informed consent to the person's treatment, the health care surrogate or proxy may provide such consent to treatment.

A petition for adjudication of incompetence to consent to treatment and appointment of a guardian advocate must be filed with the court within two court working days of the determination by the physician of the person's incompetence to consent to treatment. Recommended form "Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate," (CF-MH 3106) may be used.

The facility must immediately provide to the health care surrogate or proxy the same information required by statute

to be provided to the guardian advocate. In order to protect the safety of the person, the facility must make available to the health care surrogate or proxy the same training required of guardian advocates and ensure that the surrogate or proxy communicates with the person and person's physician prior to giving express and informed consent to treatment.

The surrogate or proxy may only provide consent for treatment for persons on involuntary status. The surrogate or proxy has the authority to:

- Make any and all health care decisions, but must make those decisions based upon what he or she believes the principal would have decided if that principal was capable of making such decisions, (substitute judgment). Only if the surrogate/proxy doesn't know what the person would have wanted can a "best interest" standard be used;
- Access the person's clinical record;
- Authorize the release of information and clinical records to appropriate persons to ensure the continuity of the person's health care;
- Apply for private, public, governmental, or veteran's benefits to defray the cost of health care and to have access to financial information of the principal and;
- Authorize transfers to and from other facilities.

Summary of Consent Issues

A person who is competent to provide express and informed consent to admission or to treatment is competent to refuse or revoke such consent. A mere refusal or revocation of consent does not justify a transfer to involuntary status without clear documentation of other behaviors by the person that satisfy the involuntary placement criteria.

However, a person who has been adjudicated incapacitated or found to be incompetent to consent to treatment by a court is incapable of refusing treatment that has been authorized, by express and informed consent, by a legally authorized substitute decision-maker.

Specialized on-line Baker Act courses can be found at
<http://www.bakeracttraining.org>.

For further assistance visit: <http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml> to view DCF's most Frequently Asked Questions list.

Summary Reference on Substitute Decision Making

(Does not substitute for Statutes or Legal Advice)

	Guardian	Guardian Advocate	Representative	Health Care Surrogate (HCS)	Health Care Proxy (HCP)
Statutory Citation	Chapter 744, F.S.	s. 394.4598, F.S.	s. 394.4597, F.S.	Chapter 765, Part II, F.S.	Chapter 765, Part IV, F.S.
Initiation	Petition to determine incapacity filed by an adult.	Determination by a psychiatrist that the person is incompetent to provide express and informed consent to treatment.	Conversion from voluntary to involuntary status or admission to a receiving or treatment facility on involuntary status.	Determination by attending physician, that principal lacks capacity to make health care decisions for him/her self.	Same as Health Care Surrogate
Appointment	Order of a Circuit Judge stating the nature of the guardianship as either plenary or limited. If limited, order states the rights which have been removed and delegated to the guardian.	Circuit judge upon petition of Receiving or Treatment Facility Administrator and adjudication of incompetence to consent to treatment.	Selected by the person if possible; if not, designated by the facility from a prioritized list specified in law.	Healthcare facility notifies Surrogate in writing that authority under the advance directive has commenced.	Health care facility notifies Proxy in writing that authority has commenced.
Qualifications	Competent adult; if non-resident, must be related by blood or adoption. Preference given to wishes of ward, to a relative, and to a person with ability to perform. Prohibits a felon, an incapacitated person, creditor, or other unsuitable person, or one with a conflict of interest. If providing any professional or business services, must be a close relative. Prohibits a judge unless related to ward. See law for other limitations.	Same as guardian but gives preference to HCS followed by spouse, adult child, parent, adult next of kin, adult friend, or trained adult. Prohibits MH professional, facility employee, or DCF, from serving.	Any competent adult selected by the person. Otherwise preference given to HCS, followed by spouse, adult child, parent, adult next of kin or adult friend. Prohibits licensed professional, facility employee, DCF staff, creditor, or other person providing substantial services from serving.	Any competent adult selected by the principal through an advance directive.	Designated by law from a prioritized list of persons including guardian, spouse, adult child, parent, adult sibling, adult relative, close friend*, or clinical social worker*. *Friend is defined in law and LCSW limits provided in law.
Requirements	40 hours training on duties, rights of ward, local resources, and plans/reports within 1 year of appointment. Professional and public guardian must take oath and file a bond (unless waived).	Agreement to serve, undergo 4 hour training course, meet with person and physician prior to providing consent.	No prerequisites or training required.	No prerequisites or training required by law. 65E-5.2301 FAC requires HCS to be given same information required to be given to guardian advocate.	Same as Health Care Surrogate

	Guardian	Guardian Advocate	Representative	Health Care Surrogate (HCS)	Health Care Proxy (HCP)
Tenure	While person is incapacitated.	While person is incompetent to consent to treatment.	While person is on involuntary status in a receiving or treatment facility.	While principal is physically or mentally unable to communicate a willful and knowing health care decision.	Same authority as a Health Care Surrogate.
Authority	Limited to authority granted by Circuit Court in Letters of Guardianship. Plenary Guardian shall exercise all delegable rights while Limited Guardian exercises only those removed from the ward in the order. Must file reports, plans, inventory, and accounting.	Consent to psychiatric treatment, access client record, and release of information for continuity of care. Consent to medical care, ECT, abortion, sterilization, psychosurgery, and experimental treatment only upon Court approval. Receives all notices and may file Habeas petition.	Receives notices of proceedings and any restrictions during the time a person is held in or admitted to a receiving or treatment facility. Has standing to file a Petition for Habeas Corpus if it is believed the person is being held illegally or to file a petition if person is unjustly denied a right or privilege.	Make written consent to health care decisions the principal would have made if capable of making such decisions. Have access to clinical records, authorize release of records for continuity of care, authorize transfer of principal to or from a health care facility, and apply for public benefits.	Same as Health Care Surrogate.
Limitations	Prohibited from having ward admitted on a voluntary basis for psychiatric examination or treatment. May only consent to treatment of ward if on involuntary status.	Medical, ECT, and other extraordinary interventions are prohibited without Court approval.	Has no authority other than described above.	May not consent to psychiatric treatment for a person on a voluntary status. May not provide consent for abortion, sterilization, ECT, psychosurgery, or experimental treatment without Court approval or express authority in an advance directive.	Same authority as a Health Care Surrogate.
Termination	Upon resignation of guardian and appointment of successor guardian; upon restoration of capacity; or removal of guardian by the Court.	Persons' restoration of competency, discharge from involuntary inpatient/outpatient placement, or transfer to voluntary status.	Transfer to voluntary status or discharge from receiving or treatment facility.	Upon revocation of the advance directive by a competent principal, upon the principal's gaining capacity to consent, or removal by court.	Same as Health Care Surrogate.

Mental Health Advance Directive

If you believe you may be hospitalized for mental health care in the future and that your doctor may think you aren't able to make good decisions about your treatment, then completing a mental health advance directive will ensure that your treatment choices are known. It is important that you decide NOW what types of treatment you do or do not want and to appoint a friend or family member to make the mental health care decisions that you want carried out. You may always change your preferences or surrogate later.

You can use the following Advance Directive form to direct your future care.

- Read each section of the form carefully and talk about your choices with someone you trust.
- The person you choose to be your health care surrogate and alternate must be a competent adult whose civil rights have not been taken away. The person you choose should not be a mental health professional, an employee of a facility that might provide services to you, or an employee of the Department of Children & Family Services.
- You should sign the form in front of two witnesses.
- Make sure your surrogate understands your wishes and is willing to accept the responsibility. Your surrogate (and a back-up alternate surrogate if you wish) should sign this form now or at a later time to show they are aware you have chosen them to be your surrogate.
- Have copies made and give them to your surrogate, your case manager, your doctor, the hospital or crisis unit at which you are most likely be treated, your family and anyone else who might be involved in your care. Discuss your choices with each of them.
- The document should be available quickly if you need it. If you travel, be sure to take a copy with you.

Your advance directive will not take effect unless a physician decides that you are not competent to make your own treatment decisions. If you are in a psychiatric facility on an involuntary basis, you will have an attorney appointed to represent your interests and a hearing will be conducted in front of a judge or magistrate. A health care surrogate is not authorized to consent to treatment for a person on voluntary status.

I, _____, being of sound mind, willfully and voluntarily execute this mental health advance directive to assure that if I should be found incompetent to consent to my own mental health treatment, my choices regarding my treatment will be carried out despite my inability to make informed decisions for myself.

If a guardian, guardian advocate or other decision maker is appointed by a court to make health care or mental health decisions for me, I intend this document to take precedence over all other means of determining my intent while competent. This document represents my wishes, and it should be given the greatest possible legal weight and respect. If the surrogate(s) named in this directive are not available, my wishes shall be binding on whoever is appointed to make such decisions.

If I become incompetent to make decisions about my own mental health treatment, I have authorized a mental health care surrogate to make certain treatment decisions for me. My surrogate is also authorized to apply for public benefits to defray the cost of my health care, to release information to appropriate persons and to authorize my transfer from a health care facility.

My mental health care surrogate is:

Name: _____
 Address: _____
 Day Telephone: _____ Evening Telephone: _____

If the person named above is unable or unavailable to serve as my mental health care surrogate, I hereby appoint and request immediate notification of my alternate mental health care surrogate as follows:

Name of Alternate: _____
 Address: _____
 Day Telephone: _____ Evening Telephone: _____

Complete the following or Initial in the blank marked yes or no:

A. If I become incompetent to give consent to mental health treatment, I give my mental health care surrogate full power and authority to make mental health care decisions for me. This includes the right to consent, refuse consent or withdraw consent to any mental health care, treatment, service or procedure consistent with any instructions and/or limitations I have stated in this advance directive. If I have not expressed a choice in this advance directive, I authorize my surrogate to make the decision that (s)he determines is the decision I would make if I were competent to do so. ____ Yes ____ No

B. My choices of treatment facilities are as follows:

1. In the event my psychiatric condition is serious enough to require 24-hour care, I would prefer to receive this care in this/these facilities:

Facility: _____ Facility: _____

2. I do not wish to be admitted to the following facilities for psychiatric care (optional):

Facility: _____ Facility: _____

C. My choice of a treating physician is:

First choice of physician: _____ Second choice of physician: _____

I do not wish to be treated by the following physicians: (optional)

Name of physician: _____ Name of Physician: _____

D. My wishes about confidentiality of my admission to a facility and my treatment while there are as follows:

1. My representative may be notified of my involuntary admission ____ Yes ____ No
2. Any person who seeks to contact me while I am in a facility may be told I am there. ____ Yes ____ No
3. I consent to release of information about my condition and treatment plan ____ Yes ____ No

To the following persons: _____

4. If I am incompetent to give consent, I want staff to immediately notify the following persons that I have been admitted to a psychiatric facility.

Name: _____ Relationship: _____
 Address: _____
 Day Phone: _____ Evening Phone: _____

Name: _____ Relationship: _____
 Address: _____
 Day Phone: _____ Evening Phone: _____

E. If I am not competent to consent to my own treatment or to refuse medications relating to my mental health treatment, I have initialed one of the following, which represents my wishes:

1. ☐ I wish to take the medications that Dr. _____ recommends.
2. ☐ I wish to take the medications agreed to by my mental health care surrogate after consulting with my treating physician and any other individuals my surrogate deems appropriate, with the exceptions found in #3 below.
3. ☐ I specifically do not wish to take and I do not authorize my mental health care surrogate to consent to the administration of the following medications or their respective brand name, trade name or generic equivalents: (list name of drug): _____

4. ☐ I am willing to take the medications excluded in #3 above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.
5. I have the following other preferences about psychiatric treatment and medications: _____

F. Florida law prohibits a mental health care surrogate from consenting to experimental treatments that have not been approved by a federally approved institutional review board without my prior written consent or the express approval of the court.

- ☐ I wish to participate in experimental drug studies or drug trials
- ☐ I do not wish to participate in experimental drug studies or drug trials

G. My wishes regarding Electroconvulsive Therapy (ECT) are as follows:

- 1 ☐ My surrogate may not consent to ECT without express court approval.
2. ☐ I authorize my surrogate to consent to ECT, but only (initial one of the following):
 - a. ☐ with the number of treatments the attending psychiatrist thinks is appropriate; OR
 - b. ☐ with the number of treatments that Dr. _____ thinks is appropriate; OR
 - c. ☐ for no more than the following number of ECT treatments: _____.
3. Other instructions and wishes regarding ECT are as follows: _____

H. I ☐ have / ☐ have not attached to this advance directive a Personal Safety Plan, regarding my preferences.

I. Other instructions I wish to make about my mental health care are (use additional pages if needed): _____

_____ Check here (☐) if other pages are used

Signature

By signing here I indicate that I fully understand that this advance directive will permit my mental health care surrogate to make decisions and to provide, withhold or withdraw consent for my mental health treatment.

Printed Name (Declarant): _____

Signature: _____ Date: _____

Witnesses

This advance directive was signed by _____ in our presence. At his/her request, we have signed our names below as witnesses. We declare that, at the time this advance directive was signed, the Declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence. We further declare that we are both adults, are not designated in this advance directive as the mental health care surrogate, and at least one of us is neither the person's spouse nor blood relative.

Dated at _____ This _____ day of _____, _____.
(County & State) (Day) (Month) (Year)

Witness 1:

Witness 2:

Signature of witness 1

Signature of witness 2

Printed name of witness 1

Printed name of witness 2

Address of witness 1

Address of witness 2

City, State, Zip Code of witness 1

City, State, Zip Code of witness 2

Acknowledgement of Health Care Surrogate/Alternate

I, _____, mental health care surrogate designated by _____
_____, hereby accept the designation.

(Signature of Mental Health Care Surrogate)

(Date)

I, _____, alternate mental health care surrogate designated by _____
_____, hereby accept the designation.

(Signature of Alternate Mental Health Care Surrogate)

(Date)

Consent for Admission and Treatment for Minors

(Baker Act, Marchman Act/Substance Abuse, and Medical-related Statutes)

Cautionary Note:

Many statutes, case law, and rules govern how minors are to be treated in Florida. Some of these legal requirements regarding mental health differ, based on whether the minor lives with his/her own family or is in the custody of the Department of Children & Families or Department of Juvenile Justice, whether the minor is on voluntary or involuntary status, whether the issue relates to admission or to treatment, and whether the issue relates to inpatient, residential or outpatient settings. Mental health requirements applying to minors are different than those applying to substance abuse and general medical examination/treatment. Consult with an attorney for legal advice.

The Baker Act makes only a few distinctions between adults and minors. Where distinctions are not made, adults and minors have the same rights and are to be treated the same. Specific reference to the admission and treatment of minors in the Baker Act and other statutes are summarized here, with the corresponding statutory references.

Since the Baker Act contains so few specific references to minors, and since this law must be carried out in the context of other coexisting statutes and case law, it is important for each professional and mental health agency to involve legal counsel in reviewing policies and procedures for properly carrying out one's responsibilities. Legal consultation on an on-going basis is necessary to assure responsible and lawful conduct. In each circumstance in which consent to admission and/or treatment is sought for a minor, it is essential that the professional consider the nature and context of the consent in determining whether the consent is legally sufficient.

A specialized on-line Baker Act course for persons dealing with minors can be found at www.bakeracttraining.org.

Minority/Non-Age

The Baker Act considers all persons under the age of 18 to be minors. However, for other purposes, the following may apply:

"Minor" means a person under 18 years of age whose disabilities have not been removed by marriage or otherwise. [s. 744.102(13), F.S.]

Removal of Disabilities of Non-Age:

- **Married minors.** The disability of nonage of a minor who is married or has been married or subsequently becomes married, including one whose marriage is dissolved, or who is widowed, or widowed, is removed.

The minor may assume the management of his or her estate, contract and be contracted with, sue and be sued, and perform all acts that he or she could do if not a minor. [s.743.01, F.S.]

- **Unwed Pregnant Minors or Minor Mothers.** An unwed pregnant minor may consent to the performance of medical or surgical care or services relating to her pregnancy by a hospital or clinic or by a physician licensed under chapter 458 or chapter 459, and such consent is valid and binding as if she had achieved her majority. She may consent to the performance of medical or surgical care or services for her child by a hospital or clinic or by a physician licensed under chapter 458 or chapter 459, and such consent is valid and binding as if she had achieved her majority. However, this doesn't affect the provisions of s. 390.0111 which governs Termination of Pregnancy. [s.743.065, F.S.]
- **Circuit Court.** A circuit court has jurisdiction to remove the disabilities of nonage of a minor age 16 or older residing in this state upon a petition filed by the minor's natural or legal guardian or, if there is none, by a guardian ad litem. The court shall consider the petition and, if satisfied that the removal of the disabilities is in the minor's best interest, shall remove the disabilities of nonage; and shall authorize the minor to perform all acts that the minor could do if he or she were 18 years of age. [s.743.015, F.S.]
- **Minors adjudicated as adults.** The disability of nonage of a minor adjudicated as an adult and in the custody or under the supervision of the Department of Corrections is removed, as such disability relates to health care services, except in regard to medical services relating to abortion and sterilization. [s.743.066, F.S.]

Rights, privileges, and obligations of persons 18 years of age or older [s.743.07, F.S.]

- The disability of nonage is hereby removed for all persons in this state who are 18 years of age or older, and they shall enjoy and suffer the rights, privileges, and obligations of all persons 21 years of age or older except as otherwise excluded by the State Constitution immediately preceding the effective date of this section and except as otherwise provided in the Beverage Law.
- This section shall not prohibit any court of competent jurisdiction from requiring support for a dependent person beyond the age of 18 years when such dependency is because of a mental or physical incapacity which began prior to such person reaching majority or if the person is dependent in fact, is between the ages of 18 and 19, and is still in high school, performing in good faith with a reasonable expectation of graduation before the age of 19.

Consent to Treatment

Generally, persons under the age of 18 cannot consent to their own treatment because they are presumed to be legally incompetent as a result of their age or presumed immaturity of judgment. When needed, parents usually provide consent on their children's behalf, except where parental consent is not required. The mother and father jointly are natural guardians of their own biological children and of their adopted children during minority. [s.744.301, (1) F.S.] However:

- If one parent dies, the natural guardianship passes to the surviving parent, and the right continues even though the surviving parent remarries.
- If the marriage between the parents is dissolved, the natural guardianship belongs to the parent to whom the responsibility of the child is given. (See Chapter 61, F.S., governing dissolution of marriage.)
- If the parents share parental responsibility, then both continue as natural guardians.
- If the marriage is dissolved and neither the father nor the mother is given parental responsibility of the child, neither can act as natural guardian of the child.
- The mother of a child born out of wedlock is the natural guardian of the child and is entitled to primary residential care and custody of the child unless a court enters an order stating otherwise.
- Upon petition of a parent, brother, sister, next of kin, or other person interested in the welfare of a minor, a guardian for a minor may be appointed by

the court without appointing an examining committee or adjudicating the child incapacitated. A guardian appointed for a minor, whether of the person or property, has the authority of a plenary guardian. [s. 744.302(1) and s.744.342, F.S.] The court must consider the preference of a minor who is age 14 or over as to who should be appointed guardian. [s. 744.312(3) (b), F.S.]

“Legal custody” means a legal status created by a court which vests in a custodian of the person or guardian, whether an agency or an individual, the right to have physical custody of the child and the right and duty to protect, nurture, guide, and discipline the child and to provide him or her with food, shelter, education, and ordinary medical, dental, psychiatric, and psychological care. [s. 39.01(35), F.S.]

A guardian appointed by the court does not have the power to admit the minor to a facility, institution, or licensed service provider without formal placement proceeding, pursuant to Chapter 393, Chapter 394, or Chapter 397 without first obtaining specific authority from the court, as described in s. 744.3725. [s. 744.3215(4)(a), F.S.]

The 2008 Florida Legislature extensively rewrote state laws (chapter 61, F.S.) governing the dissolution of marriage (SB2532). This action substantially changed terms used as well as the relationship among the parties of a divorce as it pertained to children. It removed the term “divorce,” exchanged the term “custody” with “parental responsibility” and changed the term “visitation” for “time sharing.” Some of these terms are as follows:

- **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.** Treatment records are available to either parent unless the court specifically revokes this right.

Consent to Mental Health Admission

Admission

A facility may receive for observation, diagnosis or treatment any person age 17 or under and for whom such application is made by his or her guardian, only after a hearing to verify the voluntariness of the consent. [s. 394.4625(1), F.S.]

A facility is defined in the Baker Act as:

Any hospital, community facility under contract with the department, public or private facility, or receiving or treatment facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who appear to have a mental illness or have been diagnosed as having a mental illness.

Each person, regardless of age, who enters treatment must be asked to give express and informed consent for admission and for treatment. If the person is a minor, express and informed consent for admission and treatment must also be requested from the guardian, but such consent is required from the guardian. [394.459(3)(a) F.S.]

Hospitals

A minor *under the age of 14* who is admitted to any hospital licensed pursuant to Chapter 395, F.S. may not be admitted to a bed in a room or ward with an adult in a mental health unit or share common areas with an adult in a mental health unit. However, a *minor 14 years of age or older* may be admitted to a bed in a room or ward in the mental health unit with an adult if the admitting physician documents in the case record that such placement is medically indicated or for reasons of safety. Such placement must be reviewed by the attending physician or a designee or on-call physician each day and documented in the case record. [s. 394.4785(2), F.S.]

In addition, all hospitals are required to ensure full compliance with the Baker Act as a condition of licensure, as follows:

- 395.003(5)(a), F.S. 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.”
- 395.003(5)(b), F.S. states that “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), F.S. governing Rights Of Persons Being Treated states that “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), F.S. 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.”

Children’s Crisis Stabilization Units

Minors *under the age of 14 years* cannot be admitted to a bed in a room or ward with an adult. They may share common areas with an adult only when under direct visual observation by unit staff. Minors who are *14 years of age and older* may be admitted to a bed in a room or ward in the mental health unit with an adult, if the clinical record contains documentation by a physician that such placement is medically indicated or for reasons of safety. This must be reviewed and documented by the physician on a daily basis. [Chapter 65E-12.106(22), F.A.C.]

Consent to Psychiatric Treatment

Inpatient Treatment

Each person entering a facility must be asked to give express and informed consent for admission and treatment. If the person is a minor, express and informed consent for admission and treatment must also be requested from the person’s guardian. Express and informed consent for admission and treatment of a person under 18 years of age is required from the person’s guardian, unless the minor is seeking outpatient crisis intervention services (see below). [s. 394.459(3)(a), F.S.]

Residential Treatment Centers

All rights, specified in s. 394.459, F.S., must be safeguarded for minors in residential treatment centers as well as receiving facilities. Children must be informed of their legal and civil rights, including the right to legal counsel and all other requirements of due process. Therefore, the Baker

Act describes the rights of children in residential treatment centers. [Chapter 65E-10.021(3)(e), F.A.C.]

Outpatient Crisis Intervention Services

The disability of nonage is removed for any minor age *13 years or older* to access services under the following circumstances (s. 394.4784, F.S.):

■ Outpatient Diagnostic and Evaluation Services

When any minor age *13 years or older* experiences an emotional crisis to such degree that he or she perceives the need for professional assistance, he or she shall have the right to request, consent to, and receive mental health diagnostic and evaluative services provided by a licensed mental health professional, as defined by Florida Statutes, or in a mental health facility licensed by the state. The purpose of such services shall be to determine the severity of the problem and the potential for harm to the person or others if further professional services are not provided. Outpatient diagnostic and evaluative services shall not include medication and other somatic methods, aversive stimuli, or substantial deprivation. Such services shall not exceed two visits during any 1-week period in response to a crisis situation before parental consent is required for further services, and may include parental participation when determined to be appropriate by the mental health professional or facility.

■ Outpatient Crisis Intervention, Therapy and Counseling Services

When any minor age *13 years or older* experiences an emotional crisis to such degree that he or she perceives the need for professional assistance, he or she shall have the right to request, consent to, and receive outpatient crisis intervention services including individual psychotherapy, group therapy, counseling, or other forms of verbal therapy provided by a licensed mental health professional, as defined by Florida Statutes, or in a mental health facility licensed by the state. Such services shall not include medication and other somatic treatments, aversive stimuli, or substantial deprivation. Such services shall not exceed two visits during any 1-week period in response to a crisis situation before parental consent is required for further services, and may include parental participation when determined to be appropriate by the mental health professional or facility.

■ Liability for Payment

The parent, parents, or legal guardian of a minor shall not be liable for payment for any such outpatient diagnostic and evaluation services or outpatient therapy

and counseling services, as provided in this section, unless such parent, parents, or legal guardian participates in the outpatient diagnostic and evaluation services or outpatient therapy and counseling services and then only for the services rendered with such participation.

■ Provision of Services

No licensed mental health professional shall be obligated to provide services to minors accorded the right to receive services under this section. Provision of such services shall be on a voluntary basis.

Substance Abuse (Marchman Act) Admission and Treatment

The disability of minority for persons under 18 years of age is removed solely for the purpose of obtaining *voluntary* substance abuse impairment services from a licensed service provider, and consent to such services by a minor has the same force and effect as if executed by an individual who has reached the age of majority. Such consent is not subject to later disaffirmance based on minority. [s. 397.601(4)(a), F.S.]

Criteria

A minor may be taken to a detox facility, hospital or an addictions receiving facility (ARF) for involuntary admission if there is a good faith reason to believe the minor suffers from a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behavior, and who, because of such condition [s. 397.311(14) and s. 397.675, F.S.):

1. Has lost the power of self-control with respect to substance use; and either:
2. Inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; or
3. Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto; however, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services.

Initiation

Protective custody may be initiated through law enforcement [s. 397.677, F.S.]. A parent/guardian may apply for a minor's emergency admission if a physician's certificate has been

obtained [397.6791(2) F.S.], as well as for admission to a Juvenile Addiction Receiving Facility [397.6798, F.S.]. A parent/guardian or a licensed service provider can also petition the court for an involuntary assessment and stabilization order. [397.6811, F.S.]

Disposition

Release of the minor from protective custody, emergency admission, involuntary assessment, involuntary treatment, and alternative involuntary assessment of a minor, upon approval of a qualified professional in a hospital, a detoxification facility, addictions receiving facility, or any less restrictive treatment component must be to the minor's parent, legal guardian, or legal custodian or the authorized designee thereof or to the department. [s. 397.6758, F.S.]

Parental Participation in Treatment

A parent, legal guardian, or legal custodian who seeks involuntary admission of a minor is required to participate in all aspects of treatment as determined appropriate by the director of the licensed service provider. [397.6759, F.S.]

Release of Information

Since a minor acting alone has the legal capacity to voluntarily apply for and obtain substance abuse treatment, any written consent for disclosure may be given only by the minor. This restriction includes, but is not limited to, any disclosure of identifying information to the parent, legal guardian, or custodian of a minor for the purpose of obtaining financial reimbursement. When the consent of a parent, legal guardian, or custodian is required under this chapter in order for a minor to obtain substance abuse treatment, any written consent for disclosure must be given by both the minor and the parent, legal guardian, or custodian. [ss. 397.501(7)(e) 1 and 2, F.S.]

Parental Participation/Payment

A parent or legal guardian of a minor is required to contribute toward the cost of substance abuse services in accordance with his ability to pay, unless otherwise provided by law. The parent, legal guardian or legal custodian of a minor is not liable for payment for any voluntary substance abuse services provided to the minor without parental consent, unless the parent, legal guardian, or legal custodian participates or is ordered to participate in the services, and only for the substance abuse services rendered. If the minor is receiving services as a juvenile offender, the obligation to pay is governed by the law relating to juvenile offenders. [s. 397.431(2)(3), F.S.]

See Appendix N for more information on Florida's Marchman Act.

Consent for General Medical Care & Treatment

Power to Consent

Persons who have the power to consent for a minor's medical care and treatment includes a natural or adoptive parent, legal custodian, or legal guardian.

There must be maintained in treatment provider's records of the minor documentation that a reasonable attempt was made to contact the person who has the power to consent. Any of the following persons, in order of priority listed, may consent to the "medical care or treatment" of a minor who is not committed to the Department of Children and Families or the Department of Juvenile Justice when, after a reasonable attempt, a person who has the power to consent as otherwise provided by law cannot be contacted by the treatment provider and actual notice to the contrary has not been given to the provider by that person [ss. 743.0645(1) and (2), F.S.]:

1. A person who possesses a power of attorney to provide medical consent for the minor
2. The stepparent
3. The grandparent
4. An adult brother or sister
5. An adult aunt or uncle

"Medical care or treatment" includes ordinary and necessary medical and dental examinations and treatment, *but does not include* surgery, general anesthesia, provision of *psychotropic medication* or other extraordinary procedures for which a separate court order, power of attorney, or informed consent as provided by law is required. [743.0645(1)(b), F.S.]

Emergency Care

The absence of parental consent notwithstanding, a physician licensed under chapter 458 or an osteopathic physician licensed under chapter 459 may render emergency medical care or treatment to any minor who has been injured in an accident or who is suffering from an acute illness, disease, or condition if, within a reasonable degree of medical certainty, delay in initiation or provision of emergency medical care or treatment would endanger the health or physical wellbeing of the minor, and provided such emergency medical care or treatment is administered in a hospital licensed by the state under chapter 395 or in a college health service. Emergency medical care or treatment may also be rendered in the prehospital setting by paramedics, emergency medical technicians, and other emergency medical services personnel,

provided such care is rendered consistent with the provisions of chapter 401.

This section applies only when parental consent cannot be immediately obtained for one of the following reasons [ss. 743.064(1) and (2), F.S.]:

- The minor's condition has rendered him or her unable to reveal the identity of his or her parents, guardian, or legal custodian, and such information is unknown to any person who accompanied the minor to the hospital.
- The parents, guardian, or legal custodian cannot be immediately located by telephone at their place of residence or business.
- Notification shall be accomplished as soon as possible after the emergency medical care or treatment is administered.

The hospital records shall reflect the reason such consent was not initially obtained and shall contain a statement by the attending physician that immediate emergency medical care or treatment was necessary for the patient's health or physical wellbeing. The hospital records shall be open for inspection by the person legally responsible for the minor. [s. 743.064(3), F.S.]

Emergency Care of Youth in DCF or DJJ Custody

The Department of Children and Family Services or the Department of Juvenile Justice caseworker, juvenile probation officer, or person primarily responsible for the case management of the child, the administrator of any facility licensed by the department under s. 393.067, s. 394.875, or s. 409.175, or the administrator of any state-operated or state-contracted delinquency residential treatment facility may consent to the medical care or treatment of any minor committed to it or in its custody under chapter 39, chapter 984, or chapter 985, when the person who has the power to consent as otherwise provided by law cannot be contacted and such person has not expressly objected to such consent. There shall be maintained in the records of the minor documentation that a reasonable attempt was made to contact the person who has the power to consent as otherwise provided by law. [s.743.0645(3), F.S.]

The medical provider shall notify the parent or other person who has the power to consent as otherwise provided by law as soon as possible after the medical care or treatment is administered pursuant to consent given under this section. The medical records shall reflect the reason consent as otherwise provided by law was not initially obtained and shall be open for inspection by the parent or other person who has the power to consent as otherwise provided by law. [s.743.0645(4), F.S.]

The person who gives consent; a physician, dentist, nurse, or other health care professional licensed to practice in this state; or a hospital or medical facility, including, but not limited to, county health departments, shall not incur civil liability by reason of the giving of consent, examination, or rendering of treatment, provided that such consent, examination, or treatment was given or rendered as a reasonable prudent person or similar health care professional would give or render it under the same or similar circumstances. [s.743.0645(5), F.S.]

Delinquent Youth

(Chapter 985, F.S.)

Medical, psychiatric, psychological, substance abuse, and educational examination and treatment

After a detention petition or a petition for delinquency has been filed, the court may order the child named in the petition to be examined by a physician. The court may also order the child to be evaluated by a psychiatrist or a psychologist. If it is necessary to place a child in a residential facility for such evaluation, the criteria and procedures established in chapter 393, chapter 394, or chapter 397, whichever is applicable, shall be used. [s.985.18(1), F.S.]

Whenever a child has been found to have committed a delinquent act, or before such finding with the consent of any parent or legal custodian of the child, the court may order the child to be treated by a physician. The court may also order the child to receive mental health, substance abuse services for intellectual disabilities from a psychiatrist, psychologist, or other appropriate service provider. If it is necessary to place the child in a residential facility for such services, the procedures and criteria established in chapter 393, chapter 394, or chapter 397, whichever is applicable, shall be used. [s.985.18(2), F.S.]

A physician shall be immediately notified by the person taking the child into custody or the person having custody if there are indications of physical injury or illness, or the child shall be taken to the nearest available hospital for emergency care. A child may be provided mental health, substance abuse, or intellectual disabilities services, in emergency situations, pursuant to chapter 393, chapter 394, or chapter 397, whichever is applicable. After a hearing, the court may order the custodial parent or parents, guardian, or other custodian, if found able to do so, to reimburse the county or state for the expense involved in such emergency treatment or care. [s.985.18(6), F.S.]

Nothing eliminates the right of the parents or the child to consent to examination or treatment for the child, except that consent of a parent shall not be required if the physician determines there is an injury or illness requiring immediate treatment and the child consents to such treatment or an ex parte court order is obtained authorizing treatment. [985.18(7), F.S.]

Dependent Youth

(Chapter 39, F.S.) (Chapter 65C-35, F.A.C.)

Medical, psychiatric, and psychological examination and treatment of child in DCF Custody

Parents or legal guardians retain the right to consent to or decline the administration of psychotropic medications for children taken into state care until such time as their parental rights, or court ordered guardianship or custodial rights, have been terminated.

If the parents' or guardians' legal rights have been terminated; their identity or location is unknown; or they decline to approve administration of psychotropic medications, and any party believes that administration of the medication is in the best interest of the child and medically necessary, then authorization to treat with psychotropic medication must be pursued through a court order via Children's Legal Services.

In no case may the dependency case manager, child protective investigator, the child's caregiver, representatives from DJJ, or staff from residential treatment centers provide express and informed consent for a child in out-of-home care to be prescribed a psychotropic medication.

When any child is removed from the home and maintained in an out-of-home placement, the department is authorized to have a medical screening performed on the child without authorization from the court and without consent from a parent or legal custodian. Such medical screening shall be performed by a licensed health care professional and shall be to examine the child for injury, illness, and communicable diseases and to determine the need for immunization. The department shall by rule establish the invasiveness of the medical procedures authorized to be performed under this subsection. In no case does this subsection authorize the department to consent to medical treatment for such children. [s.39.407(1), F.S.]

- When DCF has performed the medical screening or when it is otherwise determined by a licensed health care professional that a child who is in an out-of-home placement, but who has not been committed to the department, is in need of medical treatment,

including the need for immunization, consent for medical treatment shall be obtained from a parent or legal custodian of the child, or a court order for such treatment shall be obtained (2).

- If a parent or legal custodian of the child is unavailable and his or her whereabouts can't be reasonably ascertained, and it is after normal working hours so that a court order cannot reasonably be obtained, an authorized agent of the department has the authority to consent to necessary medical treatment, for the child. DCF authority to consent to medical treatment in this circumstance is limited to the time reasonably necessary to obtain court authorization (2)(b).
- If a parent or legal custodian of the child is available but refuses to consent to the necessary treatment, a court order is required unless the situation meets the definition of an emergency in s. 743.064 or the treatment needed is related to suspected abuse, abandonment, or neglect of the child by a parent, caregiver, or legal custodian. In such case, DCF can consent to necessary medical treatment. This authority is limited to the time reasonably necessary to obtain court authorization (2)(c).

Psychotropic Medications

(Chapter 65C-35, F.A.C.)

Before DCF provides psychotropic medications to a child in its custody, the prescribing physician must attempt to obtain express and informed consent from the child's parent or legal guardian. DCF must take steps necessary to facilitate the inclusion of the parent in the child's consultation with the physician. However, if the parental rights of the parent have been terminated, the parent's location or identity is unknown or cannot reasonably be ascertained, or the parent declines to give express and informed consent, the department may, after consultation with the prescribing physician, seek court authorization to provide the psychotropic medications to the child. Unless parental rights have been terminated and if it is possible to do so, the department shall continue to involve the parent in the decision-making process regarding the provision of psychotropic medications. If, at any time, a parent whose parental rights have not been terminated provides express and informed consent to the provision of a psychotropic medication, the requirements of this section that DCF seek court authorization do not apply to that medication until such time as the parent no longer consents.

- Any time DCF seeks a medical evaluation to determine the need to initiate or continue a psychotropic medication for a child, DCF must provide to the evaluating physician all pertinent medical information

known to the department concerning that child.

- If a child who is removed from the home under s. 39.401 is receiving prescribed psychotropic medication at the time of removal and parental authorization to continue providing the medication cannot be obtained, the department may take possession of the remaining medication and may continue to provide the medication as prescribed until the shelter hearing, if it is determined that the medication is a current prescription for that child and the medication is in its original container.
- If DCF continues to provide the psychotropic medication to a child when parental authorization cannot be obtained, the department shall notify the parent or legal guardian as soon as possible that the medication is being provided to the child. The child's official departmental record must include the reason parental authorization was not initially obtained and an explanation of why the medication is necessary for the child's well-being.
- If DCF is advised by a licensed physician that the child should continue the psychotropic medication and parental authorization has not been obtained, DCF must request court authorization at the shelter hearing to continue to provide the psychotropic medication and must provide to the court any information in its possession in support of the request. Any authorization granted at the shelter hearing may extend only until the arraignment hearing on the petition for adjudication of dependency or 28 days following the date of removal, whichever occurs sooner.
- Before filing the dependency petition, DCF must ensure that the child is evaluated by a licensed physician to determine whether it is appropriate to continue the psychotropic medication. If, as a result of the evaluation, DCF seeks court authorization to continue the psychotropic medication, a motion for such continued authorization shall be filed at the same time as the dependency petition, within 21 days after the shelter hearing.

DCF must file a motion seeking the court's authorization to initially provide or continue to provide psychotropic medication to a child in its legal custody. The motion must be supported by a written report prepared by the department which describes the efforts made to enable the prescribing physician to obtain express and informed consent for providing the medication to the child and other treatments considered or recommended for the child. In addition, the motion must be supported by the prescribing

physician's signed medical report providing:

1. The name of the child, the name and range of the dosage of the psychotropic medication, and that there is a need to prescribe psychotropic medication to the child based upon a diagnosed condition for which such medication is being prescribed.
2. A statement indicating that the physician has reviewed all medical information concerning the child which has been provided.
3. A statement indicating that the psychotropic medication, at its prescribed dosage, is appropriate for treating the child's diagnosed medical condition, as well as the behaviors and symptoms the medication, at its prescribed dosage, is expected to address.
4. An explanation of the nature and purpose of the treatment; the recognized side effects, risks, and contra indications of the medication; drug-interaction precautions; the possible effects of stopping the medication; and how the treatment will be monitored, followed by a statement indicating that this explanation was provided to the child if age appropriate and to the child's caregiver.
5. Documentation addressing whether the psychotropic medication will replace or supplement any other currently prescribed medications or treatments; the length of time the child is expected to be taking the medication; and any additional medical, mental health, behavioral, counseling, or other services that the prescribing physician recommends.

Chapter 65C-35, F.A.C., ADOPTED on March 17, 2010, governs Psychotropic Medications for Children in Out of home Care. Several of the many Definitions included in this rule include:

Assent means a process by which a provider of medical services helps the patient achieve a developmentally appropriate awareness of the nature of his or her condition; informs the patient of what can be expected with tests and treatment; makes a clinical assessment of the patient's understanding of the situation and the factors influencing how he or she is responding; and solicits an expression of the patient's willingness to accept the proposed care.

Express and Informed Consent means voluntary written consent from a competent person who has received full, accurate, and sufficient information and explanation about a child's medical condition, medication and treatment to enable the person to make a knowledgeable decision without being subjected to

any deceit or coercion. Express and informed consent for the administration of psychotropic medications may only be given by a parent whose rights have not been terminated, or a legal guardian of the child. Sufficient explanation includes but is not limited to the following information, provided and explained in plain language by the prescribing physician to the consent giver: the medication, reason for prescribing it, and its purpose or intended result; side effects, risks, and contraindications, including effects of stopping the medication; method for administering the medication, and dosage range when applicable; potential drug interactions; alternative treatments; and the behavioral health or other services used to complement the use of medication, when applicable.

Legal guardian means a permanent guardian as described in Section 39.6221, F.S., or a “guardian” as defined in Section 744.102, F.S., or a relative with a court order of temporary custody under Chapter 751, F.S. Dependency case managers and Guardians ad Litem do not meet the definition of legal guardian.

Medical report means a report prepared by the prescribing physician that includes information required by Section 39.407(3)(c), F.S. The form for the medical report is “Medical Report” (form CF-FSP 5339 dated January 2010) which is hereby incorporated by reference and is available by contacting the Family Safety Program Office at 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700, or at <http://www.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx>.

Psychotropic medications means, for the purpose of this rule, any chemical substance prescribed with the intent to treat psychiatric disorders; and those substances, which though prescribed with the intent to treat other medical conditions, have the effect of altering brain chemistry or involve any of the medications in the categories listed below. The medications include, without limitation, the following major categories:

- Antipsychotics
- Antidepressants
- Sedative Hypnotics
- Lithium
- Stimulants
- Non-stimulant Attention Deficit Hyperactivity Disorder medications
- Anti-dementia medications and cognition enhancers
- Anticonvulsants and alpha-2 agonists
- Any other medication used to stabilize or improve mood, mental status, behavior, or mental illness

Psychotropic medications may be administered in advance of a court order or parental authorization under two circumstances including:

- If the prescribing physician certifies in writing on the Medical Report form that delay in providing the prescribed psychotropic medication would more likely than not cause significant harm to the child, or
- In hospitals, crisis stabilization units, and in psychiatric Residential Treatment programs.

In the above two circumstances, the dependency case manager or child protective investigator must assist the prescribing physician in obtaining express and informed consent and must take steps to include the parent or legal guardian in the child’s consultation with the prescribing physician. If express and informed consent hasn’t been obtained, the dependency case manager or child protective investigator must obtain a completed/signed copy of the Medical Report and provide it to Children’s Legal Services in time for a motion to be filed within 3 business days after the medication is begun.

Examination, Treatment, & Placement

- A judge may order a child in an out-of-home placement to be **examined** by a licensed health care professional. The judge may also order such child to be evaluated by a psychiatrist or a psychologist or, if a developmental disability is suspected or alleged, by the developmental disability diagnostic and evaluation team of the department. If it is necessary to place a child in a residential facility for such evaluation, the criteria and procedure established in s. 394.463(2) or chapter 393 shall be used, whichever is applicable. [s. 39.407 (4), F.S.]
- A judge may order a child in an out-of-home placement to be **treated** by a licensed health care professional based on evidence that the child should receive treatment. The judge may also order such child to receive mental health or developmental disabilities services from a psychiatrist, psychologist, or other appropriate service provider. If it is necessary to place the child in a residential facility for such services, the procedures and criteria established in s. 394.467 shall be used. A child may be provided mental health services in emergency situations, pursuant to the procedures and criteria contained in s. 394.463(1). [s. 39.407(5), F.S.]
- Children who are in the legal custody of the department

may be *placed* by DCF, without prior approval of the court, in a residential treatment center licensed under s. 394.875 or a hospital licensed under chapter 395 for residential mental health treatment or may be placed by the court in accordance with an order of involuntary examination or involuntary placement entered pursuant to s. 394.463 or s. 394.467. All children placed in a residential treatment program under this subsection must have a guardian ad litem appointed. [s.39.407 (6), F.S.]

A specialized on-line Baker Act course for persons dealing with minors can be found at www.bakeracttraining.org.

For further assistance visit: <http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml> to view DCF's most Frequently Asked Questions list.

Baker Act and Long-Term Care Facilities Licensed Under Chapter 400 and 429

Introduction

The 1996 legislative reform of the Baker Act has had a significant impact on long-term care facilities and programs licensed by the Agency for Health Care Administration under the authority of Chapter 400/429, F.S. such as nursing homes, assisted living facilities, adult day care centers, and adult family care homes. Failure to follow the criteria and procedures provided under the Baker Act relating to the transportation, voluntary admission, and involuntary examination of a resident by a facility or its employee are grounds for action by the Agency for Health Care Administration against a licensed long-term care facility or program.

Before referring any resident or client to a Baker Act receiving facility on a voluntary or involuntary basis, the staff of the long-term care facility must make every effort to provide appropriate psychiatric interventions to avoid such referrals. However, if all appropriate on-site interventions prove ineffective and are fully documented in a resident's record, a referral to a Baker Act receiving facility may be necessary. In such cases, the resident may be sent for either a voluntary admission or for an involuntary examination, following the provisions in the Baker Act. A person may not be sent for "assessment" at a Baker Act receiving facility, without first making the on-site determination through legal means of either voluntary or involuntary status. Referral of the resident to an emergency room or other site for this psychiatric assessment is contrary to the law.

The role of a Baker Act receiving facility is to provide psychiatric evaluations and short-term psychiatric treatment for persons in acute mental health emergencies. If the resident requires something different than psychiatric examination or short-term psychiatric treatment, he/she should **not** be sent to a receiving facility simply because of behavioral problems or to evade federal and state discharge/transfer requirements. Instead, the resident should be directly transferred to a more appropriate type of facility.

***A specialized on-line Baker Act course
for staff of long-term care facilities can be found at:
<http://www.bakeracttraining.org>***

Voluntary Admissions

s. 394.4625, F.S. Chapter 65E-5.270, F.A.C.

A person may go to a Baker Act receiving facility for **voluntary** psychiatric examination from a facility licensed under Chapter 400/429, F.S. only if the person is:

- Over the age of 18,
- Has a mental illness, as defined in the statute,
- Competent to provide express and informed consent to his or her own treatment, and
- Suitable for treatment.

Express and informed consent requires that a person on voluntary status be competent to make well-reasoned, willful, and knowing decisions concerning his or her medical or mental health treatment.

Consent must be voluntarily given in writing after sufficient explanation of the need for admission so that the person can make a knowing and willful decision without any element of force or deceit.

If residents cannot meet these criteria, they cannot be on voluntary status in a Baker Act receiving facility, and instead, must be handled under the involuntary provisions of the law if they meet the involuntary criteria.

The Baker Act specifically states that the following persons **cannot** be sent on a **voluntary** basis to a receiving facility until after an initial assessment of the resident's ability to give express and informed consent is conducted at the sending facility by an authorized independent professional. These residents include:

1. A person 60 years of age or older for whom an emergency transfer is being sought from a nursing home pursuant to s. 400.0255, F.S.
2. A person 60 years of age or older with a diagnosis of dementia for whom transfer is being sought from a:
 - Nursing home,
 - Assisted-living facility,
 - Adult day care center, or
 - Adult family care home.
3. A person for whom all decisions concerning medical treatment are currently being lawfully made by a health care surrogate or proxy designated under Chapter 765, F.S.

The initial assessment, documented on recommended form CF-MH 3099, can only be performed by one of the following [see definition of each of the following in s 394.455(6), (17), and (19), F.S.] as specified by the circuit office of the Department of Children and Families:

1. A mental health overlay program,
2. A mobile crisis response team, or
3. A licensed professional who is authorized to initiate an involuntary examination and is employed by a publicly funded community mental health center.

If none of the above services exist in the locale, or if the service cannot respond within two hours of being called, the facility may contact a licensed professional authorized to initiate an involuntary examination who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the Baker Act receiving facility to which the transfer may be made to conduct and document this assessment.

Involuntary Examinations

s. 394.463, F.S. Chapter 65E-5.280, F.A.C.

A person may be taken to a Baker Act receiving facility for involuntary examination if there is reason to believe that he or she has a mental illness, as defined in the law, *and* because of his or her mental illness:

The person has refused examination *or* is unable to determine whether examination is necessary; *and*

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

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

There are only three methods to initiate an involuntary examination. They are:

1. *A physician, clinical psychologist, psychiatric nurse, clinical social worker, licensed mental health counselor or licensed marriage and family therapist.* (See definitions in Baker Act) may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears

to meet the criteria for involuntary examination and stating the professional's *observations* upon which that conclusion is based. These observations and conclusions should be those of the professional signing the certificate, rather than those of persons who are not legally authorized to initiate the involuntary examination. The professional should complete the form entitled "Certificate of Professional Initiating Involuntary Examination" (CF-MH 3052b). The professional's observations should focus on the resident's overt behavior supporting the findings rather than just a diagnosis and specifically relate to the statutory criteria for involuntary examination.

2. If no legally authorized mental health professional is available to personally conduct an examination and complete the professional's certificate, a *court* may issue an Ex Parte Order for Involuntary Examination of the resident. To obtain such an order, one or more persons including facility staff, guardian or family members who have personally observed the resident's behavior must go the office of the Clerk of the Circuit Court (usually the Probate Division) at the Courthouse to file a petition(s). The petition must contain a sworn statement of the facts and circumstances that the petitioner(s) believe justify an involuntary examination of the person. The petition must be signed under oath by those who have personal knowledge of the person's behavior.
3. In an emergency, *law enforcement* may be called to complete the "Report of a Law Enforcement Officer Initiating an Involuntary Examination," (CF-MH 3052a).

Transportation

s. 394.462, F.S. Chapter 65E-5.260, F.A.C.

Regardless of which of these three methods is used to initiate the involuntary examination, law enforcement is responsible for transporting the person to the nearest receiving facility for the examination. A law enforcement agency *may decline* to transport the person to a receiving facility *only if*:

1. The county has contracted for transportation, at the sole cost to the county, and the law enforcement officer and medical transport service agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others.
2. In cases where the officer requests assistance from emergency medical personnel for the safety of the officer or the person in custody or the officer believes the person has an emergency medical condition.
3. When a transportation exception plan has been approved by the Board of County Commissioners and the Secretary of the Department of Children and Families.

The law enforcement officer must complete the form entitled “Transportation to Receiving Facility,” (CF-MH 3100) describing the circumstances under which the person was taken into custody.

The Baker Act forbids the removal of a person from any program or residential placement licensed under Chapter 400/429, F.S. and transport to a receiving facility for involuntary examination unless a Professional’s Certificate, a court’s Ex Parte Order, or a Law Enforcement Officer’s Report is first prepared. If the client’s condition is such that preparation of a Law Enforcement Officer’s Report is not practical before removal, the Report must be completed as soon as possible after removal, but in any case before the person is transported to a Baker Act receiving facility. If the sending facility fails to properly initiate an involuntary examination, the Baker Act receiving facility must report such failure to the Agency for Health Care Administration by certified mail on the next working day.

Florida Health Care Association Recommendations

The Florida Health Care Association has developed through its Quality First Credentialing Program a Best Practice Tool for Behavior Management, Aggression Control, and Baker Act Guidelines. This tool was developed to provide guidelines for redirecting a resident who exhibits aggressive behavior that may present as a risk to self or others. The tool recommends:

1. Attempt to identify triggers for the adverse behavior such as:
 - Being touched
 - Noise
 - Yelling
 - Contact with person that is unfamiliar or upsetting
 - Restraint
 - Isolation
 - Perception of threat
2. Through the facility assessment and care planning process attempt to identify triggers as well as calming strategies. Integrate them, as appropriate, into the resident plan of care. Suggestions could include:
 - Identify preferences regarding daily routine and caregivers as possible: Male, female, language, ethnicity, culture, of a particular religion, etc.
 - Music, reading a book or being read to
 - Wrapping in a blanket
 - Watching TV or movies of preference
 - Quiet room, soft lighting
 - Talk with trusted person/staff
 - Go for a supervised walk
 - Outdoor activity, (supervised)
 - Take a bath or shower, (do not force care)
 - Massage, imagery, relaxation techniques, aroma therapy
 - Drink/snack
 - Stuffed animal or comfort article
 - Artwork
 - Diversion to preferred activity
 - Other as noted through assessment
3. Attempt to identify signals of distress as part of the MDS/RAI/Care plan process and daily systems of care before behavior accelerates such as: Sweating, crying, breathing hard, yelling, screaming or resisting care, accelerated pacing, injuring self, clenching teeth, running, clenching fists, swearing, not eating, potential self neglect, threats, other as noted.
4. If a resident in a nursing home demonstrates aggressive behavior, (verbal or physical) and a potential for being an imminent threat to themselves or others, the nursing staff are to notify the Director of Nursing or designee or the Unit Manager and/or RN of record for assistance with further assessment of the situation and the current health status of the resident.
5. Be certain that the Administrator/designee is aware of the possibility of an involuntary admission for psychiatric examination (Baker Act). Keep the primary physician and responsible party (RP) notified and kept informed throughout the course of the treatment, and until the situation has resolved.
6. Notify Social Services for therapeutic intervention, and direct involvement of the behavioral management plan for the resident.
7. Provide for the safety of all other facility residents. Provide 1: 1 staff oversight as possible. Enlist the help of staff that are familiar with the resident, and have successfully redirected behavior(s) in the past.
8. Gather and re-evaluate behavioral data to include behavioral flow records and documentation of the behavior within the clinical record.

9. Verbally redirect and assist the resident to a quiet area of the facility that is free from all stimuli, and is away from other residents. Time outs are utilized for behaviors, which place others in potential danger due to the negative behavior of the resident. As such, these are specific timed activities, followed with appropriate praise for compliance.
10. Review/revise the current plan of care as indicated. Notify the RP, and if they are available, suggest their assistance in calming the resident. Offer comfort measures that might include: toileting, offering food and fluids, providing warmth, repositioning, rest, music, reminiscence therapy, aroma therapy, supervised activity outdoors in a safe secure area, or known diversions that may have worked with the resident in the past. Document the effectiveness of all interventions.
11. Interact with the resident in a calm, non-threatening way. Assure the resident has the use of adaptive devices such as hearing aids and/or glasses so that communication efforts are maximized.
12. Be kind and direct when addressing the resident. Do not force care. If the resident escalates, do not proceed. Back away and notify the nurse immediately.
13. Review the resident history and diagnoses. Identify medical conditions, disabilities, and related medical problems. Review the record for identification of recent falls, lab work, or tests that will be helpful information for the assessment.
14. Assess for signs and symptoms of an acute onset of infection. Monitor vital signs every shift or as warranted by nursing assessment. Do not proceed if the resident is resistant. Notify the physician if attempts to monitor clinical symptoms are unsuccessful due to resident's behavior/resistance.
15. Assess for signs of acute pain. Notify the physician as warranted for tests, treatments, or alterations to the current pain management plan. Medicate for pain as indicated after checking to be certain there are no drug allergies. Document the effectiveness of the intervention.
16. Review the medication profile. Check for recent medication changes, e.g. omission, additions, or dosing adjustments. If time allows, request that the Pharmacist provide a review of the medication plan as warranted.
17. Medicate the resident with a sedative if required, as ordered by the physician. Document the reasons for the medication, frequency and method of administration, and monitor for any side effects or contraindications that may exist. Be sure that the legally authorized substitute decision maker has been notified.
18. Discuss with the physician the possibility of lab work to rule out physiological causes. Consider asking for a chemical profile, CBC, UA, Thyroid profile, and pertinent medication levels e.g. Digoxin, Dilantin, etc. If labs are ordered, request a STAT report to the facility as warranted per resident assessment.
19. Keep the physician/RP notified of the status of the resident and the need for further interventions/orders.
20. Inform the physician and RP, (responsible party), that the goal of the facility is to keep the resident within their known home environment as long as it remains a medically safe option for the resident, staff, and other residents.
21. The primary role of a Baker Act receiving facility is to perform psychiatric evaluations and provide short term psychiatric treatment. If a person has behavioral conditions that may have resulted from non-psychiatric conditions, the person should not be sent to a psychiatric facility.
22. Residents cannot be sent out for psychiatric examinations unless the voluntary or involuntary provisions of the Baker Act are followed. Residents should never be sent out to ER's for "altered mental status" if staff believes the person's symptoms are related to a mental illness.
23. If the above noted interventions are not successful, notify the primary physician and implement one of the following options:
 - As authorized by s394.463(2)(a)3, F.S., the physician may elect to personally evaluate the resident on site to determine if the resident meets the criteria for involuntary examination, and will complete the form CF-MH3052b.
 - As authorized by s394.463(2)(a)3, F.S., the physician may elect to have the involuntary examination (Baker Act), coordinated through the services of a clinical psychologist, licensed clinical social worker or licensed psychiatric nurse. The requirements specify that the clinical social worker be licensed, or psychiatric nurse have a Masters or doctorate degree in psychiatric nursing with two years experience under the supervision of a physician, as defined in the Baker Act. A licensed mental health counselor and licensed marriage and family therapist are also authorized by law to initiate an involuntary Baker Act examination. In any case, the licensed professional initiating the examination must base the conclusion that the person meets criteria on his/her own evaluation and observations.
 - A person may not be removed from any program or residential placement under Chapter 400/429, FS, and transported for involuntary examination unless an ex parte order (CF-MH 3001), a law enforcement officer's report, (CF-MH 3052a), or a Professional's Certificate, (CF-MH 3052b) is first prepared.

- In an emergency situation the police may be called for on-site evaluation, but a law enforcement officer should not be expected to initiate an involuntary examination in a nursing home except in cases of imminent danger. Instead, the facility's physician, or other legally authorized professionals as noted above should be called to initiate the examination.
- A police officer must be notified for coordination of transport to the receiving facility. The officer must execute a written report detailing the circumstances under which the person is taken into custody (CF-MH 3100). The report and a copy of the certificate should be copied and made to be part of the resident's clinical record.
- Law enforcement transportation is required for any person for whom an involuntary examination has been initiated, whether by the court, mental health professional, or law enforcement officer. The officer can make the determination to consign a person to medical transportation at any time that the officer determines that emergency medical personnel are needed or for the safety of the officer or others. This consignment can take place once the officer and EMS have agreed that the continued presence of law enforcement personnel is not necessary for the safety of the person or others. In this case, the decision needs to be reflected within the clinical record.
- A law enforcement officer may decline to transport a resident if the county has contracted for transportation at the sole cost to the county and the law enforcement officer and medical transport service agree that the continued presence of law enforcement personnel is not expected to be necessary for the safety of the person to be transported or others. The statute requires that the law enforcement officer report to the scene, assess the risk circumstances, and if appropriate, to "consign" the person to the care of the transport company.
- If law officers refuse to respond to a facility's request for transporting a resident for whom an involuntary examination has been initiated, it is recommended that the facility administrator contact the supervisor of the officer refusing to transport. If that fails, it is recommended that the facility ask to speak to the attorney for the law enforcement agency. If that intervention fails, contact the local DCF mental health program office and/or the local AHCA field office. If it is at night or on a weekend, and none of the above is available and the need for transport is urgent, the facility should seek EMS assistance to transport the resident to the nearest receiving facility. On the next working day, contact DCF and AHCA to seek long-term resolution.

Document your actions in the resident record.

- The facility is responsible for assuring that appropriate notice of transfer is issued at the time of transfer.
It is expected that the resident will be accepted back to the facility after the provision of examination and treatment at a receiving facility. The facility should re-evaluate the resident prior to making a determination that it is no longer able to meet the individual needs of the resident.

Nursing Homes Psychotropic Medication Usage Issues

The use of psychotropic medications in nursing homes, particularly anti-psychotic medications, is under close review due to potential adverse effects.

Nursing home staff and related medical personnel must follow the federal regulations governing use of psychotropic medications to protect the health and safety of residents

The following are some, but not all, of the federal regulations governing this issue:

- Federal Regulation **FO329, FO320, FO425, and FO428** regulate anti psychotic medications.
- Federal Regulation **FO386** governs physicians' active role including medication regime (see also FO425 and FO428).
- Federal Regulation **FO319** regulates assessment and adjustment.
- Federal Regulation **FO425** requires routine and emergency drugs and biological and other pharmaceutical services including accurate acquiring, receiving, dispensing, and administering of all drugs to meet the needs of residents.

All facility and medical staff should refer to the most current regulations for appropriate use of medications in a nursing home setting.

A specialized on-line Baker Act course for long-term care facility personnel can be found at
<http://www.bakeracttraining.org>.

For further assistance visit: <http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml> to view DCF's most Frequently Asked Questions list.

Person Seeking Voluntary Admission

(from a facility licensed under Chapter 400/429, F.S.)

All possible interventions have been tried, documented, and found to be ineffective (See model policy and procedures developed by the Florida Health Care Association)

Determined by referring facility to meet voluntary admission criteria:

These extraordinary protections apply to persons:

- 60 years of age or older for whom an emergency transfer is being sought from a nursing home, or
- 60 years of age or older with a diagnosis of dementia for whom transfer is being sought from a nursing home, assisted-living facility, adult day care center, or adult family care home.
- For whom all decisions concerning medical treatment are currently being lawfully made by the health care surrogate or proxy.

Notified publicly funded mobile crisis response service, mental health overlay program or authorized professional employed by Community Mental Health Center

Publicly funded service responds within 2 hours

Assessed by service for ability to provide express and informed consent to treatment

Publicly funded service does not exist or informs facility it will be unable to respond within 2 hours

Contacts independent authorized licensed professional to perform assessment of ability to provide express and informed consent to treatment who is not employed by, under contract with, or has no financial interest in the sending or receiving facility

Able to give express and informed consent to treatment

May be transported by any safe method to facility of patient's choice

Unable to give express and informed consent to treatment

May **not** be transported except after involuntary examination is initiated

If the person does not meet the criteria for voluntary admission, see flow chart for "Involuntary Examination" in Appendix F. A person may not be removed from any program or residential placement licensed under Chapter 400/429, F.S. and transported to a receiving facility for involuntary examination unless an ex parte order, a professional's certificate, or a law enforcement officer's report is first prepared. A receiving facility admitting a person for involuntary examination who is not accompanied by such documentation shall notify AHCA of such admission by certified mail no later than the next working day.

Quality First Credentialing Program Best Practices Tools

Title: Behavior Management/Aggression Control /Involuntary Baker Act Guidelines

Latest Revision: 3-27-07

Regulatory:

of Pages: 4

Approved By: Quality First Credentialing Foundation Board/Subcommittee

The Quality First Credentialing Foundation disclaims responsibility for any adverse effects resulting directly or indirectly from the use of the sample Best Practices Tools from any undetected errors, And from the reader's misunderstanding of the text. The Quality First Credentialing Foundation exerted every effort to ensure that any Tools set forth in this text were in accord with current regulations, recommendations, and practice at the time of publication.



MISSION: This protocol is intended to comply with Federal and State statutes.

PURPOSE: To provide guidelines pertaining to the redirection of a resident exhibiting aggressive behavior that may present as a risk to self or others.

1. Attempt to identify triggers for the adverse behavior such as:

- Being touched
- Noise
- Yelling
- Contact with person that is unfamiliar or upsetting
- Restraint
- Isolation
- Perception of threat

2. Through the facility assessment and care planning process attempt to identify triggers as well as calming strategies. Integrate them, as appropriate, into the resident plan of care.

3. Suggestions could include:

- Identify preferences regarding daily routine and caregivers as possible: Male, female, language, ethnicity, culture, of a particular religion, etc.
- Music, reading a book or being read to
- Wrapping in a blanket
- Watching TV or movies of preference
- Quiet room, soft lighting
- Talk with trusted person/staff
- Go for a supervised walk
- Outdoor activity, (supervised)
- Take a bath or shower, (do not force care)
- Massage, imagery, relaxation techniques, aroma therapy
- Drink/snack
- Quiet room
- Stuffed animal or comfort article
- Artwork
- Diversion to preferred activity
- Other as noted through assessment

4. Attempt to identify signals of distress as part of the MDS/RAI/Care plan process and daily systems of care before behavior accelerates such as: Sweating, crying, breathing hard, yelling, screaming or resisting care, accelerated pacing, injuring self, clenching teeth, running, clenching fists, swearing, not eating, potential self neglect, threats, other as noted.

5. If a resident in a nursing home demonstrates aggressive behavior, (verbal or physical) and a potential for being an imminent threat to themselves or others, the nursing staff are to:
- a. Notify the Director of Nurses or designee, the Unit Manager and/or RN of record for assistance with further assessment of the situation and the current health status of the resident.
 - b. Be certain that the Administrator/designee is aware of the possibility of an involuntary admission for psychiatric examination, (Baker Act). Keep the primary physician and RP, (responsible party) notified and kept informed throughout the course of the treatment, and until the situation has resolved.
 - c. Notify Social Services for therapeutic intervention, and direct involvement of the behavioral management plan for the resident.
 - d. Provide for the safety of all other facility residents. Provide 1: 1 staff oversight as possible. Enlist the help of staff that are familiar with the resident, and have successfully redirected behavior(s) in the past.
 - e. Gather and re-evaluate behavioral data to include behavioral flow records and documentation of the behavior within the clinical record.
 - f. Verbally redirect and assist the resident to a quiet area of the facility that is free from all stimuli, and is away from other residents. Time outs are utilized for behaviors, which place others in potential danger due the negative behavior of the resident. As such these are specific timed activities, followed with appropriate praise for compliance.
 - g. Review/revise the current plan of care as indicated. Notify the RP, and if they are available, suggest their assistance in calming the resident. Offer comfort measures that might include: Toileting, offering food and fluids, providing warmth, repositioning, rest, music, reminiscence therapy, aroma therapy, supervised activity outdoors in a safe secure area, or known diversions that may have worked with the resident in the past. Document the effectiveness of all interventions.
 - h. Interact with the resident in a calm, non-threatening way. Assure the resident has the use of adaptive devices such as hearing aides and/or glasses so that communication efforts are maximized.
 - i. Be kind and direct when addressing the resident. Do not force care. If the resident accelerates, do not proceed. Back away and notify the nurse immediately.
 - j. Review the resident history and diagnoses. Identify medical conditions, disabilities, and related medical problems. Review the record for identification of recent falls, lab work, or tests that will be helpful information for the assessment?
 - k. Assess for signs and symptoms of an acute onset of infection. Monitor vital signs every shift or as warranted by nursing assessment. Do not proceed if the resident is resistant. Notify the physician if attempts to monitor clinical symptoms are unsuccessful due to resident's behavior/ resistance.
 - l. Assess for signs of acute pain. Notify the physician as warranted for tests, treatments, or alterations to the current pain management plan. Medicate for pain as indicated after checking to be certain there are no drug allergies. Document the effectiveness of the intervention.

Quality First Credentialing Program Best Practices Tools (continued)

- m. Review the medication profile. Check for recent medication changes, e.g. omission, additions, or dosing adjustments. If time allows, request that the Pharmacist provide a review of the medication plan as warranted.
- n. Medicate the resident with a sedative if required, as ordered by the physician. Document the reasons for the medication, frequency and method of administration, and monitor for any side effects or contraindications that may exist. Be sure that the legally authorized substitute decision maker has been notified.
- o. Discuss with the physician the possibility of lab work to rule out physiological causes. Consider asking for a chemical profile, CBC, UA, Thyroid profile, and pertinent medication levels e.g. Digoxin, Dilantin, etc. If labs are ordered, request a STAT report to the facility as warranted per resident assessment.
- p. Keep the physician/RP notified of the status of the resident and the need for further interventions/orders.
- q. Inform the physician and RP, (responsible party), that the goal of the facility is to keep the resident within their known home environment as long as it remains a medically safe option for the resident, staff, and other residents.
- r. The primary role of a Baker Act receiving facility is to perform psychiatric evaluations and provide short term psychiatric treatment. If a person has behavioral conditions that are not psychiatric in nature they should not be sent to a psychiatric facility.
- s. Residents cannot be sent out for psychiatric examinations unless the voluntary or involuntary provisions of the Baker Act are followed. Residents should never be sent out to ER's for "altered mental status."
- t. If the above noted interventions are not successful, notify the primary physician and implement one of the following options:
 - i. As authorized by s394.463 (2)(a)3, F.S., the physician may elect to personally evaluate the resident on site to determine if the resident meets the criteria for involuntary examination, and will complete the form CF-MH3052b.
 - ii. As authorized by s394.463 (2)(a)3, F.S., the physician may elect to have the involuntary examination (Baker Act), coordinated through the services of a clinical Psychologist, clinical social worker or psychiatric nurse. The requirements specify that the clinical social worker be licensed, or psychiatric nurse have a Masters degree or doctorate in psychiatric nursing with two years experience under the supervision of a physician as defined in the Baker Act.
 - iii. A person may not be removed from any program or residential placement under Chapter 400, FS, and transported for involuntary examination unless an ex parte order (CF-MH 3001), a law enforcement officer's report, (CF-MH 3052a), or a Professional's Certificate, (CF-MH 3052b) is first prepared.
 - iv. In an emergency situation the police may be called for on site evaluation, but a law enforcement officer should not be expected to initiate an involuntary examination in a nursing home except in cases of imminent danger. Instead, the facility's physician, or other authorized parties as noted in ii. should be called to initiate the examination.

- v. A police officer must be notified for coordination of transport to the receiving facility. The officer shall execute a written report detailing the circumstances under which the person is taken into custody. The report and a copy of the certificate should be copied and made to be part of the resident's clinical record.
- vi. Law enforcement transportation is required for any person for whom an involuntary examination has been initiated, whether by the court, mental health professional, or law enforcement officer. The officer can make the determination to consign a person to medical transportation at any time that the officer determines that emergency medical personnel are needed or for the safety of the officer or others. This consignment can take place once the officer and EMS have agreed that the continued presence of law enforcement personnel is not necessary for the safety of the person or others. In this case, the decision needs to be reflected within the clinical record.
- vii. A law enforcement officer may decline to transport a resident if the county has contracted for transportation at the sole cost to the county and the law enforcement officer and medical transport service agree that the continued presence of law enforcement personnel is not expected to be necessary for the safety of the person to be transported or others. The statute requires that the law enforcement officer report to the scene, assess the risk circumstances, and if appropriate, to "consign" the person to the care of the transport company.
- viii. If law officers refuse to respond to a facility's request for transporting a resident for whom an involuntary examination has been initiated, it is recommended that the facility administrator contact the supervisor of the office refusing to transport. If that fails it is recommended that the facility ask to speak to the attorney for the law enforcement agency. If that intervention fails, contact the local DCF mental health program office and/or the local AHCA field office. If it is at night or on a weekend, and none of the above is available and the need for transport is urgent, the facility should seek EMS assistance to transport the resident to the nearest receiving facility. On the next working day, contact DCF and AHCA to seek long term resolution. Document your actions in the resident record.
- ix. The facility is responsible for assuring that appropriate notice of transfer is issued at the time of transfer. It is expected that the resident will be accepted back to the facility after the provision of treatment at a receiving facility. The facility should re-evaluate the resident prior to making a determination that they are no longer able to meet the individual needs of the resident.

Involuntary Examination

s. 394.463, F.S. Chapter 65E-5.280, F.A.C.

The Baker Act encourages the voluntary admission of persons for psychiatric care, but only when they are able to understand the decision and its consequences and are able to fully exercise their rights for themselves. When this is not possible due to the severity of the person's condition, the law requires that the person be extended the due process rights assured under the Baker Act's involuntary provisions.

The definition of "mental illness" is not a part of this section of the statute. However, because it is relevant to the content of this part of the statute it is being included on this page.

"Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment. [(F.S. 394.455 (18)]

Criteria

s. 394.463(1), F.S.

A person may be taken to a receiving facility for involuntary examination if there is reason to believe that he or she has a mental illness (as defined in the Baker Act) **and** because of his or her mental illness:

1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **or** the person is unable to determine whether examination is necessary; **and**
 - a. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **or**
 - b. There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to self or others in the near future, as evidenced by recent behavior.

Initiation

s. 394.463(2), F.S. 65E-5.280(1)(2)(3)F.A.C.

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

1. A **court may** enter an ex parte order (CF-MH 3001 or other order developed by the court) stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on sworn testimony, written or oral (CF-MH 3002 or other form developed by the court). No fee can be charged for the filing of a petition for an order for involuntary examination.

A law enforcement officer, or other designated agent of the court, must take the person into custody and deliver him or her to the nearest receiving facility for an involuntary examination. A law enforcement officer acting in accordance with an ex parte order may serve and execute such order on any day of the week, at any time of the day or night. A law enforcement officer acting in accordance with an ex parte order may use such reasonable physical force as is necessary to gain entry to the premises, and any dwellings, buildings, or other structures located on the premises, and to take custody of the person who is the subject of the ex parte order.

The officer must execute a written report entitled "Transportation to a Receiving Facility" (CF-MH 3100) detailing the circumstances under which the person was taken into custody, and the report must be made a part of the person's clinical record.

The ex parte order is valid only until executed or, if not executed, for the period specified in the order itself. If no time limit is specified in the order, the order is valid for seven days after the date that the order was signed. Once a person is picked up on the order and taken to a receiving facility for involuntary examination and released, the same order cannot be used again during the time period. The order of the court must be made a part of the person's clinical record.

2. A **law enforcement officer shall** take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to the nearest receiving facility for examination. (CF-MH 3052a) The officer must execute a written report (CF-MH 3100) detailing the **circumstances** under which the person was taken into custody, and the report must be made a part of the person's clinical record.

3. A **physician, clinical psychologist, clinical social worker, mental health counselor, marriage and family therapist or psychiatric nurse** (each as defined in the Baker Act) *may* execute a certificate (CF-MH 3052b) stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and **stating the professional's observations** upon which that conclusion is based. A law enforcement officer must take the person named in the certificate into custody and deliver him or her to the nearest receiving facility for involuntary examination. The law enforcement officer must execute a written report detailing the circumstances (CF-MH 3100) under which the person was taken into custody. The report and certificate shall be made a part of the person's clinical record.

Definitions of Professionals

s. 394.455, F.S.

Physician means a medical practitioner licensed under Chapter 458 or Chapter 459 who has experience in the diagnosis and treatment of mental and nervous disorders or a physician employed by a facility operated by the United States Department of Veterans Affairs which qualifies as a receiving or treatment facility under this part. (21)

Psychiatrist means a medical practitioner licensed under Chapter 458 or Chapter 459 who has primarily diagnosed and treated mental and nervous disorders for a period of not less than three years, inclusive of psychiatric residency. (24)

Clinical Psychologist means a psychologist as defined in s. 490.003(3) 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 under this part. (2)

Clinical Social Worker means a person licensed as a clinical social worker under Chapter 491. (4)

Marriage and Family Therapist means a person licensed as a marriage and family therapist under Chapter 491. (36)

Mental Health Counselor means an individual who is licensed as a mental health counselor under Chapter 491, F.S. (37)

Psychiatric Nurse means a registered nurse licensed under Chapter 464 who has a master's degree or a doctorate in psychiatric nursing and two years of post-master's clinical experience under the supervision of a physician. (23)

The Florida Attorney General determined in May 2008 that **Physician Assistants** can, under certain conditions, initiate

an involuntary examination. The ruling did not extend any other authority granted to physicians.

Selected Procedures

Any receiving facility accepting a person based on a court's ex parte order, law enforcement officer's report or a professional's certificate must send a copy of the initiating document with the required cover sheet (3118) to the Agency for Health Care Administration on the next working day.

This must be mailed to:

Baker Act Reporting Center
FMHI
13301 Bruce B. Downs Blvd., MHC 2637
Tampa, Florida 33612-3807

A person cannot be removed from any long-term care program or residential placement licensed under Chapter 400 or 429, F.S. and transported to a receiving facility for involuntary examination unless an ex parte order (CF-MH 3001), a Law Enforcement Officer's report (CF-MH 3052a), or a Professional's Certificate (CF-MH 3052b), is first prepared. If the condition of the person is such that preparation of a law enforcement officer's report is not practical before removal, the report must be completed as soon as possible after removal, but in any case before the person is transported to a receiving facility. A receiving facility admitting a person for involuntary examination who is not accompanied by the required ex parte order, professional certificate, or law enforcement officer's report must notify AHCA of such admission by certified mail no later than the next working day. [CF-MH3119]

Examination

s. 394.463(2)(f), F.S. Chapter 65E-5.2801, F.A.C.

A person must receive a mandatory initial mandatory involuntary examination by a physician or clinical psychologist at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the person or others. This initial mandatory involuntary examination must include:

1. A thorough review of any observations of the person's recent behavior;
2. A review of the document initiating the involuntary examination and transportation form;
3. A brief psychiatric history; and
4. A face-to-face examination of the person in a timely manner to determine if the person meets criteria for release.

A physical examination, which must be conducted within 24 hours of a person's arrival at the facility, is intended to rule out mock

psychiatric symptoms caused by non-psychiatric medical illness, injury, metabolic disorders, and drug toxicity.

The person cannot be released by the receiving facility without the documented approval of a psychiatrist, clinical psychologist, or physician in the hospital's emergency department. However, a person may not be held in a receiving facility for involuntary examination longer than 72 hours. The person must be given prompt opportunity to notify others of his whereabouts. See Appendix H for circumstances involving persons having an emergency medical condition for whom an involuntary examination has been initiated.

Release

s. 394.463(2)(i), F.S.

Within the 72-hour examination period, one of the following actions must be taken, based on the individual needs of the person:

1. The person must be released, unless he or she is charged with a crime, in which case the person must be returned to the custody of a law enforcement officer;
2. The person must be released for outpatient treatment;
3. The person, unless he or she is charged with a crime, must be asked to give express and informed consent to placement on voluntary status, and, if such consent is given, the person shall be voluntarily admitted. Such transfer from involuntary to voluntary status must be conditioned on the certification by a physician that the person has the capacity to make well-reasoned, willful, and knowing decisions about mental health and medical issues; or
4. A petition for involuntary inpatient placement (CF-MH 3032) shall be filed or a petition for involuntary outpatient placement (CF/MH 3130) may be filed in the appropriate court by the facility administrator when treatment is deemed necessary within the 72 hours or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter.

If converted to voluntary status in lieu of seeking involuntary placement, it may be necessary under some circumstances to file documents with the Clerk of Court to prohibit firearm purchase (see appendix S).

Escape or Elopement of a Person from a Receiving or Treatment Facility

If a person being involuntarily examined or treated at a receiving or treatment facility elopes from the facility, the following procedures are recommended:

1. If the person is an adult on voluntary status and does not meet the criteria for involuntary placement, law enforcement will **not** be notified by the facility.

2. If the person is on voluntary status and does meet the criteria for involuntary placement, a certificate (Form CF-MH 3052b) may be initiated by an authorized professional at the facility and the appropriate law enforcement agency may be requested to take the person named in the certificate into custody and deliver him or her to the nearest receiving facility. A transfer of the person, if appropriate, will then be arranged using the procedure for transporting persons from facility to facility.
3. If the person is on involuntary examination status and within 72 hours of arrival at the facility appears to meet the criteria for involuntary placement, but prior to the Petition for Involuntary Placement being filed with the court, the appropriate law enforcement agency should be provided a copy of the original ex parte order, Law Enforcement Officer's Report (CF-MH 3052a), or Certificate of a Professional (CF-MH 3052b) and requested to take the person into custody and deliver him or her to the nearest receiving facility. A transfer of the person, if appropriate, will then be arranged from facility to facility.
4. If the person is on involuntary examination status and a Petition for Involuntary Inpatient Placement has already been filed with the court, the appropriate law enforcement agency will be provided a copy of the petition form (CF-MH 3032) and requested to return the person to the facility from which the petition was filed.
5. If a person is under a court's Order for Involuntary Inpatient Placement (CF-MH 3008) at a treatment facility leaves the facility without authorization, the administrator may authorize a search for the person and the return of the person to the facility. While the statute is silent with regard to receiving facilities, it is presumed that the court order itself would provide the required authority. The administrator of the facility may request the assistance of a law enforcement agency in the search for and return of the person and may provide a copy of the order (CF-MH 3008) to law enforcement.
6. If a person escapes/elopes from a hospital Emergency Department, he/she should be returned to the ED for an appropriate transfer as required by EMTALA.

Notice of Discharge or Release

s. 394.463(3), F.S. s. 394.469(2), F.S.

Notice of discharge or transfer of a person shall be given as provided in s. 394.4599, F.S. Notice of the release (CF-MH 3038) shall be given to the person's guardian or representative, to any person who executed a certificate admitting the person to the receiving facility, and to any court that ordered the person's evaluation.

Baker Act Involuntary Examination

Quick Reference Guide for Receiving Facilities

The person:

____ Has a mental illness, as defined in the Baker Act, and because of his or her mental illness:

____ Either ____ refused or is ____ unable to determine the need for voluntary examination, and either:

- ☐ Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; or
- ☐ There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

F

The facility must open a clinical record on the person containing the following information/mandatory forms and may include the recommended completed forms:

- ☐ Documentation initiating involuntary examination and any accompanying affidavits, which shall be one of the following three:
 - ____ Ex Parte Order for Involuntary Examination (CF-MH 3001) with the Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination (CF-MH 3002), **or**
 - ____ Report of Law Enforcement Officer Initiating Involuntary Examination (CF-MH 3052a); **or**
 - ____ Certificate of Professional Initiating Involuntary Examination (CF-MH 3052b) by one of the authorized professionals.
- ☐ Transportation to Receiving Facility (CF-MH 3100) if the involuntary examination was initiated at a location other than the receiving facility or hospital.
- ☐ Notification of person's representative or guardian of admission for involuntary examination by telephone or in person within 24 hours. Opportunity for the person to notify others of whereabouts is documented.
- ☐ General Authorization for Treatment Except Psychotropic Medications (CF-MH 3042a) for those persons appearing to be competent to consent to treatment or by their guardian or health care surrogate/proxy.
- ☐ Inventory of Personal Effects (CF-MH 3043) documenting property brought by the person to the facility signed by the person, if able, and witnessed by two staff members.
- ☐ Authorization for Release of Information (CF-MH 3044) completed and signed **only** when such release is to take place. No blank forms should be signed by the person or decision-maker.
- ☐ Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances (CF-MH 3036)
- ☐ Explanation and copy of Rights of Persons in Mental Health Facilities and Programs (CF-MH 3103)
- ☐ Intake Interview
- ☐ Baker Act Service Eligibility Form (CF-MH 3084) for persons admitted to public receiving facilities.

Subsequent to the person's admission, the following forms or documentation must be completed:

- ☐ Cover Sheet to Agency for Health Care Administration (CF-MH 3118) documenting the submission of the court order, law enforcement officer's report, or professional's certificate to AHCA (BA Reporting Center in Tampa).

- ☐ Documentation of a physical examination by an authorized health practitioner within 24 hours of arrival (medical stability and rule out non-psychiatric medical causes of symptoms]
- ☐ Documentation of the Initial Mandatory Involuntary Examination by a physician or clinical psychologist, including:
 1. A thorough review of any observations of the person's recent behavior;
 2. A review of the document initiating the involuntary examination and transportation form;
 3. A brief psychiatric history; and
 4. A face-to-face examination of the person in a timely manner to determine if the person meets criteria for release.
- ☐ Certification of Person's Competence to Provide Express and Informed Consent (CF-MH 3104) if the person was permitted to sign a General Authorization for Treatment Except for Psychotropic Medications (CF-MH 3042a) at the time of admission or if the person is to be permitted to sign a Specific Authorization for Psychotropic Medications (CF-MH 3042b).
- ☐ Completion of a Specific Authorization for Psychotropic Medications (CF-MH 3042b) by a qualified health care practitioner **prior** to the administration of any psychotropic medications, and only after a complete disclosure is made to the person, the guardian, guardian advocate, health care surrogate/proxy, and to the guardian of a minor as to the:

<ul style="list-style-type: none"> _____ Reason for admission or treatment _____ Proposed treatment, including proposed psychotropic medications _____ Purpose of treatment to be provided _____ Alternative treatments _____ Specific dosage range of medications _____ Frequency and method of administration _____ Common risks, benefits and common short-term and long-term side effects _____ Any contraindications which may exist _____ Clinically significant interactive effects with other medications 	<ul style="list-style-type: none"> _____ 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 _____ 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 on behalf of the person
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- ☐ Personal Safety Plan (CF-MH 3124)
- ☐ An individualized treatment plan completed within 5 days of the person's admission in which the person has had the opportunity to assist in preparing, including space for the person's comments and a copy of which has been provided to the person, guardian, guardian advocate, and a minor's guardian

The following forms shall be included only if applicable:

- ☐ If the person has been determined to be incompetent to consent to his or her own treatment, the following forms may be used:
 - _____ Certification of Person's Incompetence to Consent to Treatment and Notification of Health Care Surrogate/Proxy (CF-MH 3122)
 - _____ Affidavit of Health Care Proxy (CF-MH 3123)
 - _____ Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate (CF-MH 3106)
 - _____ Order Appointing Guardian Advocate (CF-MH 3107)
 - _____ Certification of Guardian Advocate Training Completion (CF-MH 3120)

____ Petition Requesting Court Approval for Guardian Advocate to Consent to Extraordinary Treatment (CF-MH 3108)

____ Order Authorizing Guardian Advocate to Consent to Extraordinary Treatment (CF-MH 3109)

- ☐ Request for Involuntary Examination after Emergency Medical Services (CF-MH 3102)
- ☐ Notification of a facility's Non-Compliance (CF-MH 3119)
- ☐ Authorization for Electroconvulsive Treatment (CF-MH 3057)
- ☐ Refusal or Revocation of Consent to Treatment (CF-MH 3105)
- ☐ Restriction of Communication or Visitors (CF-MH 3049)
- ☐ Restriction of Person's Access to Own Record (CF-MH 3110)
- ☐ Petition for Writ of Habeas Corpus or for Redress of Grievance (CF-MH 3090)
- ☐ Application for and Notice of Transfer to Another Facility (CF-MH 3046)

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If it is determined that the person **does not meet** the criteria for involuntary inpatient or outpatient placement and the person refuses voluntary admission, the facility must:

- ☐ Release the person within 72 hours with the documented approval of a psychiatrist, clinical psychologist, or emergency department physician using "Approval for Release of Person on Involuntary Status from a Receiving Facility" (CF-MH 3111)
- ☐ Send copies of "Notice of Release or Discharge" (CF-MH 3038) by first class mail to:
 - ____ Person's guardian or representative
 - ____ Any person executing certificate admitting person to a receiving facility
 - ____ Any court which ordered person's involuntary examination

If it is determined that the person meets the criteria for involuntary inpatient/outpatient placement and either refuses voluntary placement or is unable to determine that such placement is needed, the facility must (see Quick Reference Guide for Receiving and Treatment Facilities for Involuntary Inpatient Placement- Appendix J):

- ☐ File a Petition for Involuntary Inpatient Placement (CF-MH 3032) with the circuit court.
- ☐ Facility may file a petition for involuntary outpatient placement (CF-MH 3130) with the circuit court (Appendix K)

If involuntary inpatient placement in a state mental health facility is sought for the person:

- ☐ Transfer Evaluation (CF-MH 3089)
- ☐ State Mental Health Facilities Admission Form (CF-MH 7000)
- ☐ Physician to Physician Transfer Form (CF-MH 7002)

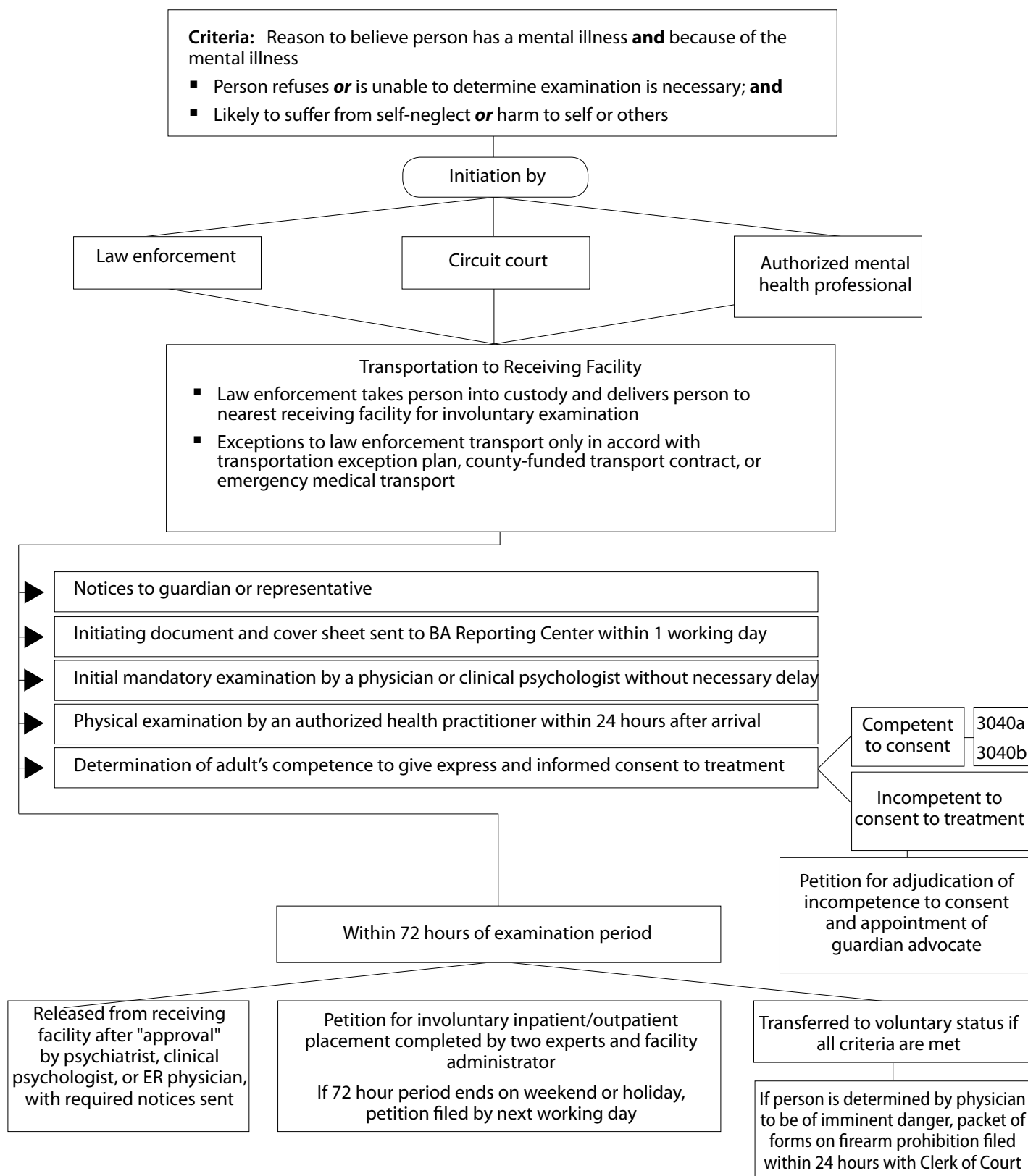
If at any time prior to the court hearing on involuntary inpatient placement, the facility determines that the person will be discharged, transferred to another facility, or transferred to voluntary status, it will immediately:

- ☐ Telephone, then submit in writing, a Notification to Court of Withdrawal of Petition for Hearing on Involuntary Placement (CF-MH 3033) and notify any persons expected to attend the hearing.
- ☐ File packet of forms for Firearm Prohibition with the Clerk of Court within 24 hours if person is found to be of imminent danger by a physician (per 790.065, F.S.)

Recommended forms are those which are not required by the department, but which have been determined to satisfy the specific requirements for which the form has been developed. Alteration of recommended forms may jeopardize this status. Mandatory forms may not be altered. No blank forms should be signed by staff, the person, or substitute decision-maker.

Involuntary Examination

s. 394.463, F.S. Chapter 65E-5.280, F.A.C.



Specialized on-line Baker Act courses can be found at
<http://www.bakeracttraining.org>.

For further assistance visit: <http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml> to view
DCF's most Frequently Asked Questions list.

Law Enforcement and the Baker Act

Initiation: s. 394.463, F.S. and s. 65E-5.280, F.A.C.

Transportation: s. 394.462, F.S. and 65E-5.260, F.A.C.

Introduction

Law enforcement officers often serve as the front line for many social and health problems of our communities. Although mental illness is a health problem, it is often a personal and a public safety issue as well. The Legislature in Florida has granted law enforcement certain authority and responsibilities under the Baker Act.

- The authority to initiate an involuntary examination of persons when they meet certain criteria and are unable or unwilling to consent to the examination themselves.
- The responsibility, with few exceptions, to transport persons to the nearest receiving facility for involuntary examination.

The Baker Act is Florida's Mental Health Act and cannot be used interchangeably with other statutes. Other related but different statutes include:

- Marchman Act, Chapter 397, F.S., which governs all issues related to intoxication or substance abuse impairment.
- Chapter 393, F.S., which governs all issues related to intellectual disability, autism, and other developmental disabilities.
- Chapter 401, F.S., which is the emergency medical services law containing provisions for the Emergency Examination & Treatment of Incapacitated Persons who cannot provide consent to Emergency Medical Services (EMS) personnel.
- Florida's hospital licensing statute, Chapter 395.1041, F.S., which governs Access to Emergency Services and Care in hospital emergency departments.
- The federal Emergency Medical Treatment and Active Labor Law, or EMTALA, that requires all licensed hospitals to accept persons for medical screening and stabilization, and makes those hospitals responsible for arranging safe and appropriate secondary transfers to other facilities.
- Chapter 415, F.S., the Adult Protective Services law that protects vulnerable adults (persons age of 60 or older and disabled adults) from abuse, neglect and exploitation.

Voluntary Admission

Adults can only be admitted to a facility on a voluntary basis if they have a mental illness as defined in the Baker Act, are willing to be admitted without any coercion, are competent to provide express and informed consent, and are suitable for treatment. A minor must meet the same criteria, including willingness to be admitted, but the application for admission must be made by his or her parent or legal guardian following a judicial hearing.

Law enforcement officers have no legal duty to transport any person for voluntary admission to a psychiatric facility.

Involuntary Examination

A person may be taken to a receiving facility for involuntary examination if there is reason to believe that he or she has a mental illness and because of his or her mental illness:

1. The person has *either* refused a voluntary examination *or* is unable to determine for himself or herself whether an examination is necessary; *and*
2. Either:
 - » The person is likely to suffer from *neglect* which poses a real and present threat of substantial harm to his or her well-being that can't be avoided through the help of willing family members or friends or the provision of other services; *or*
 - » There is substantial likelihood that without care or treatment the person will cause *serious bodily harm* to himself or herself or others in the near future, as evidenced by recent behavior.

Behaviors to Look For

Individuals with mental illness who may need further evaluation typically exhibit some combination of the following behaviors, or characteristics:

Behaviors: rapid speech, flight of thought, no eye contact, quick movements, disconnected speech patterns, constant movement, can't concentrate, swift and frequent mood changes, disorganized thoughts, disoriented to time and place, acts of violence, cutting self, combative/aggressive behavior, inappropriate dress or nudity.

Hallucinations: sees people who aren't there, hears voices telling them to hurt themselves or others, reports that the television is suggesting harm to others, turning the head as if listening to an unseen person.

Self-Care Issues: insomnia or increased sleep, has not eaten for days, not taking prescribed medications, home is in disarray, neglects household, property, or personal hygiene to the point of putting self/others at risk.

Feelings: low self-esteem with feelings of hopelessness or helplessness, flat affect, or not reacting with much feeling or interest.

Suicidal Risks: has weapons or access to weapons, speaks about previous attempts, makes direct comments about dying or hurting self, evidence of previous attempts such as scars on the wrists.

Elderly Issues: wandering at night, leaving things on stove unattended, not eating or sleeping or caring for personal needs, unrealistic fears, uncontrollable anxiety, confusion, quantity and age of unused foods in the home.

Substance Abuse: abuse of prescribed medications, use of alcohol or illegal substances while taking medications. (If substance abuse appears to be the only issue, the Marchman Act may be more appropriate.)

Initiation of Involuntary Examination

An involuntary examination under the Baker Act can be initiated by a circuit court judge, an authorized mental health professional or by a Florida certified law enforcement officer. The criteria is the same, regardless of which of the three methods is used to initiate.

A "law enforcement officer" is specifically defined in the Baker Act as a law enforcement officer as defined in s. 943.10, F.S. Therefore, as Chapter 943 is revised in future legislative sessions, the Baker Act will not have to be revised further. [s.394.455, F.S.] This definition includes a wide array of state certified law enforcement officers, but doesn't include probation officers who are licensed under chapter 943, but not as law enforcement officers.

943.10(1) "Law enforcement officer" means any person who is elected, appointed, or employed full time by any municipality or the state or any political subdivision thereof; who is vested with authority to bear arms and make arrests; and whose primary responsibility is the prevention and detection of crime or the enforcement of the penal, criminal, traffic, or highway laws of the state. This definition includes all certified supervisory and command personnel whose duties include, in whole or in part, the supervision, training, guidance, and

management responsibilities of full-time law enforcement officers, part-time law enforcement officers, or auxiliary law enforcement officers but does not include support personnel employed by the employing agency.

The Florida Attorney General has determined that "Federal law enforcement officers do not constitute law enforcement officers for purposes of Florida's Baker Act, and thus possess no authority under the act to initiate the involuntary examination of a person or to transport such person as law enforcement officers."

There are three important key points to remember for officers:

1. **Your role is not to diagnose.** However, if you have reason to believe that someone has a mental illness, you **can** decide whether or not that person may be putting himself/herself or others in active danger or self neglect, and therefore meet the criteria for a complete evaluation.
2. **You do not need to witness all of the behaviors personally.** You can consider credible eyewitness accounts from others as you determine the need for further assessment.
3. **Law enforcement officers must complete two state forms when initiating a Baker Act.** The two forms are Report of Law Enforcement Officer Initiating Involuntary Examination (CF-MH 3052a), and Transportation to a Receiving Facility-Part 1 (CF-MH 3100). Generally, officers also must complete their own department's Offense/Incident report.

While a circuit court judge or mental health professional may initiate an involuntary examination if they believe the criteria are met, the Baker Act requires a law enforcement officer to take a person who appears to meet the criteria for involuntary examination into custody.

The statute is silent as to whether the officer must personally see the person's behavior, but there is no expectation that the officer should be able to clinically diagnose mental illness or predict dangerousness. Evidence of likelihood of harm to self or others is defined solely by the person's "recent behavior." The law requires that the law enforcement officer's report detail the "circumstances" under which the person was taken into custody, not personal observations. As the Baker Act is a civil law, not a criminal one, "probable cause" is not required.

Since the officer is rarely on site when the event prompting the Baker Act call occurs, his or her judgment may often be based upon the statements by the person or the credibility of the witnesses to the event. For example, one can usually presume a relative contacting law enforcement about a

family member has their loved one's best interest in mind, unless the officer believes that the call to law enforcement may be a retaliatory act. It is not the officer's job to conduct an examination, only to initiate the examination when the criteria appears to be met by taking the person to a designated receiving facility where an expert must perform the involuntary examination.

The Baker Act states that "any person who acts in good faith in compliance with the provisions of this part is immune from civil or criminal liability for his or her actions in connection with the admission, diagnosis, treatment, or discharge of a patient to or from a facility. However, this section does not relieve any person from liability if such person commits negligence." Law enforcement officers should consult with their department's legal counsel in determining whether there is greater liability in:

- Acting to protect a person even though a skilled clinician may ultimately determine that the person does not meet the more stringent statutory criteria for involuntary placement, or
- Failing to act when credible witnesses allege passive or active danger and the person ultimately suffers harm or commits an act of violence.

Most attorneys would gauge the seriousness of the consequences of the above decisions and suggest that the examination be initiated by law enforcement, leaving it to mental health experts to confirm whether the criteria have been met. While common sense should always prevail, each law enforcement department needs to develop explicit policies and procedures to reflect the actions which should be taken in such circumstances.

Initiation of Involuntary Examination by Others

If the involuntary examination has been initiated by the **circuit court**, a court order will be given to the law enforcement officer to deliver with the person to the nearest receiving facility where it will be made a part of the person's clinical record.

A law enforcement officer acting in accordance with an ex parte order may serve and execute such order on any day of the week, at any time of the day or night, and may use such reasonable physical force as is necessary to gain entry to the premises and any dwellings, buildings, or other structures located on the premises and to take custody of the person who is the subject of the ex parte order.

The court order for involuntary examination, along with the petition(s) seeking the order, will be delivered by the

law enforcement officer to the facility to be placed in the person's clinical record along with the "Transportation to a Receiving Facility" form (CF-MH 3100) completed by the law enforcement officer. [ss. 394.463(2)(a), (c) and (d), F.S.]

If the involuntary examination has been initiated by a **physician, clinical psychologist, psychiatric nurse, clinical social worker, licensed mental health counselor or licensed marriage and family therapist**, a certificate must be completed by the professional stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the professional's observations upon which that conclusion is based.

The professional, if not already located at a receiving facility or hospital emergency room, will call the law enforcement agency designated by the Board of County Commissioners to execute such certificates to transport the person to the nearest receiving facility for examination. The mental health professional's certificate (CF-MH 3052b) and the "Transportation to a Receiving Facility" form (CF-MH 3100) completed by the law enforcement officer will be made a part of the person's clinical record.

Transportation of Persons for Involuntary Examination

The Baker Act requires law enforcement officers to transport any person for whom an involuntary examination has been initiated to the nearest receiving facility. Law enforcement officers have the responsibility to transport persons under involuntary examination status, instead of health or social service personnel, because the involuntary criteria requires that the person be refusing examination or be unable to determine that the examination is necessary. For anyone other than those authorized by statute to take a person against his or her will or without informed consent could be a criminal offense such as battery, false imprisonment, kidnapping, etc. In addition, law enforcement is specifically trained in the transportation of persons who are either violent, resisting transportation, or are otherwise unwilling to comply with directions. Others without that training are much more likely to either injure or be injured by the person.

Two appellate cases and a Florida Attorney General Opinion apply to law enforcement duty to transport:

- Administrator, Retreat Hospital v. Honorable W. Clayton Johnson of the Seventeenth Judicial Circuit In and For Broward County, FL, Alan Schreiber, Broward County Public Defender, and Fredrick A. Goldstein, Special Assistant Public Defender, Respondents, 660 So. 2d 333 (Fla. 4th DCA 1995). Individuals were

transported by private entities to a receiving facility for involuntary placement under the Baker Act. The Circuit Court Judge found that this did not comport with the requirements of section, 394.463(2), F.S. which requires that only law enforcement officer may transport persons on involuntary status to a receiving facility. The Fourth District Court of Appeals affirmed that only a law enforcement officer may transport a Baker Act patient to a receiving facility.

- Donald Pruessman v. Dr. John T. MacDonald Foundation, 589 So. 2d 948 (Fla. 3d DCA 1991). The 3rd DCA held that where a patient was discharged from a hospital and the patient refused to leave, and the hospital administrator contacted an outside doctor to evaluate the patient regarding Baker Acting the patient, the hospital was not legally responsible for any action taken by the outside doctor involved in Baker Acting the patient. The 3rd DCA also held that the actions of the city police officers who were called to the hospital to take the patient into custody, remove the patient from the hospital, and transport the patient to a Baker Act receiving facility based on a doctor's certification were not discretionary under the Baker Act and the city was not liable for the actions of the city police officers in transporting the patient to a receiving facility.
- AGO 2001-73 Regarding the responsibility for Transportation of Mentally Ill Person to Treatment Facility. If a person is the subject of an ex parte order or certificate requiring involuntary examination and treatment under Florida's Baker Act, the single law enforcement agency designated by the county for this purpose is responsible for transporting that person to the nearest receiving facility. If a person is taken into custody by a law enforcement officer for minor criminal behavior or non-criminal behavior that meets the statutory guidelines for involuntary examination under the Act, the law enforcement officer taking the person into custody is responsible for transporting the person to the nearest treatment facility. If a law enforcement officer arrests a person for commission of a felony and believes that the person meets the guidelines for involuntary examination or placement, the person shall be processed through the criminal justice system like any other criminal suspect and is entitled to examination and treatment in the facility where he or she is held.

While a law enforcement officer is responsible for transporting all persons for involuntary examination, there is no responsibility for an officer to transport persons for voluntary examinations since persons on voluntary status are by definition both willing and able to provide consent

to the examination. However, there is nothing to prohibit such transportation if an officer and their law enforcement department (including legal counsel) concur.

Memorandum of Understanding (MOU) Required

(394.462 (1),(K) F.S.) Each law enforcement agency is required by law to develop a MOU with each receiving facility within its jurisdiction reflecting a single set of protocols for the safe and secure transport, crisis intervention, and transfer of custody of a responsible individual at the facility. DCF has made available a template for the MOU to incorporate the requirements, but modifications to the format are allowed.

There are circumstances under which a law enforcement officer can delegate the responsibility to someone else to perform the transport. The Baker Act states that the designated ***law enforcement agency may decline to transport the person to a receiving facility only if:***

1. The jurisdiction designated by the county has contracted with an emergency medical transport service or private transport company for transportation of persons to Baker Act receiving facilities at the sole cost of the county; and the law enforcement agency and the transport service agree that the ***continued presence of law enforcement*** personnel is not necessary for the safety of the person or others.
2. When a law enforcement officer takes custody of a person under the Baker Act, the officer can request assistance from emergency medical personnel if such assistance is needed for the safety of the officer or the person in custody (person may be too frail, heavy, non-ambulatory, or medically involved to be placed in a cruiser). Further, if the officer believes that a person has an emergency medical condition, the person can be first transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated receiving facility. Once taken to a hospital for examination or treatment of an emergency medical condition, transportation of the patient to a Baker Act receiving facility is the responsibility of the sending hospital.
3. When a mental health overlay program or a mobile crisis response service evaluates a person and determines that transportation to a receiving facility is needed, it ***may*** transport the person to the facility ***or*** may call on the law enforcement agency or make other transportation arrangements best suited to the needs of the patient.
4. When a transportation exception plan has been approved by the Board of County Commissioners and the Secretary of the Department of Children and Family Services [s. 394.462(3), F.S.] permitting use of a "more humane method of transport.

Transportation for Medical Emergencies

Law enforcement officers are statutorily required to take persons to the nearest receiving facility for involuntary examinations. It is not appropriate to have law enforcement take individuals to a non-receiving facility for “medical clearance” first unless the officer believes the individual was in an emergency medical condition. An emergency medical condition is defined in Chapter 395, F.S. as a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that absence of immediate medical attention could reasonably be expected to result in serious jeopardy to patient health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Once a person is delivered by law enforcement to a hospital for emergency medical examination or treatment and the person is placed in the hospital’s care, the officer’s responsibility to the person is over, assuming there are no criminal charges pending.

Eventual safe and appropriate transfer of the person from the hospital offering emergency medical treatment to the designated receiving facility for an involuntary examination under the Baker Act is the responsibility of the referring hospital, unless other appropriate arrangements have been made.

Designation of Transportation Responsibility

The law enforcement agency responsible for transporting people for involuntary examinations under the Baker Act is determined by each county’s Board of County Commissioners. The 1984 Florida Legislature required that each county designate a single law enforcement agency within the county, or portions thereof, to take persons into custody upon entry of an ex parte order or the execution of a certificate for involuntary examination by an authorized professional and to transport that person to the nearest receiving facility for examination. This might result in the Sheriff’s Office being responsible for certain transportation and municipal police responsible for others. A copy of the formal action taken by the Board of County Commissioners should be available through the County Attorney’s office.

Nearest Receiving Facility

Law enforcement officers have to take persons to the nearest Baker Act receiving facility, regardless of whether the facility is public or private and regardless of whether a person has the ability to pay for care. Further, it cannot be to a different facility where the person, their caregiver, or mental health professional has asked they be taken. The only alternative

to this is when a Transportation Exception Plan has been approved by the Board of County Commissioners and the DCF Secretary that provides persons be taken to a central receiving facility or to facility that has specialized care for certain persons such as minors or elders. If a person is at a hospital or other receiving facility that can’t meet his/her medical or psychiatric needs or if the person’s age or financial status requires transfer, the federal EMTALA law and state Baker Act transfer provisions place responsibility on the sending hospital, not on law enforcement personnel.

The Baker Act requires that the person be taken to the nearest receiving facility, making no reference to remaining in an officer’s jurisdiction. However, if a transportation exception plan is approved by a Board of County Commissioners and the Secretary of the Department of Children and Families for a given county, the plan may result in jurisdictional boundaries.

Criminal Charges

The Baker Act requires a law enforcement officer who has custody of a person based on either non-criminal or minor criminal behavior that meets the statutory guidelines for involuntary examination to transport the person to the nearest receiving facility for examination, instead of to jail. [s. 394.462(1)(f), F.S.]

However, the transportation provisions of the Baker Act state that if the person meets the criteria for involuntary examination and has been arrested for a felony, the person must first be processed in the same manner as any other criminal suspect. [s. 394.462(1)(g) F.S.] Law enforcement officials must then contact the nearest *public* receiving facility which is then responsible for promptly arranging for the examination and treatment of the person. If the receiving facility can document that it cannot provide adequate security of a person with felony charges, it is required to provide the mental health examination and treatment to the person where he or she is held. The costs of transportation, evaluation, hospitalization, and treatment incurred by persons who have been arrested for violations of any state, county, or municipal law/ordinance can be recovered by the receiving facility as provided in s.901.35, F.S.

Use of Restraining Devices

The Baker Act states that the individual dignity of the person must be respected at all times, including any occasion when the person is taken into custody, held or transported. Procedures, facilities, vehicles, and restraining devices utilized for criminals or those accused of crime

may not be used in connection with persons who have a mental illness, *except* for the protection of the person or others. When the officer documents in his or her report that circumstances require such protection, restraints may be used in accordance with the law enforcement agency's written policies [s. 394.459(1), F.S.].

Procedures

1. **Facilities Must Accept.** The Baker Act states that the nearest receiving facility must accept persons brought by law enforcement officers for involuntary examination. If the receiving facility believes the person should be "medically cleared," the facility must arrange appropriate medical transport for this purpose. It would be inappropriate for a law enforcement officer to place a person at medical risk back into the cruiser. If the receiving facility is at capacity or otherwise cannot meet the person's needs due to age or financial need, it should accept the person and arrange an appropriate transfer to another receiving facility.
2. **Weapons.** The Baker Act prohibits firearms or deadly weapons from being brought onto the grounds of a hospital providing mental health services, including by law enforcement officers, unless specifically authorized by law or by the hospital administrator. Law enforcement officers may choose to lock their firearms in their vehicle prior to entering a facility or may place the weapons in a lock-box at the facility, if one exists. [s. 394.458(1), F.S.]
3. **Hospital Security.** A law enforcement officer does not have to wait at a hospital or other receiving facility for the person to be medically screened, treated, or to have their insurance verified. The officer's only duties are to present the person and the required completed paperwork and make a responsible handoff to the appropriate staff member. However, if the person is acting in a dangerous manner, beyond the ability of the facility staff to manage, the officer should stay to assist for a temporary period until hospital clinical or security staff can arrive. If the person has criminal charges, the officer's Department Policy should be followed.
4. **Transfers.** A law enforcement officer does not have to return to a hospital to transfer the person to another facility following medical clearance. Once the person is taken to the hospital, the state's Baker Act and the federal EMTALA law require the hospital to arrange for appropriate transfer, when necessary.

The federal Emergency Medical Treatment and Active Labor Act (EMTALA) preempts any state law with which it is in conflict. EMTALA requires that a hospital accept

any person who presents or is brought to the emergency room for the purpose of performing a medical screening. If the ED staff determine the person has an emergency medical condition (including psychiatric and substance abuse emergencies), the hospital is then responsible for the person until the emergency has been stabilized, including the person's discharge or transfer from the hospital to another facility that has the capability and capacity to manage the person's condition. This includes, among other responsibilities, the duty to arrange a safe and appropriate method of transportation to the destination facility.

5. **Paperwork.** A law enforcement officer has to present certain completed forms to the Baker Act receiving facility staff. The Baker Act form entitled "Transportation to a Receiving Facility" (CF-MH 3100) must be presented each time a law enforcement officer takes a person to a receiving facility for involuntary examination, regardless of whether the examination is initiated by a judge, a mental health professional, or by the officer. In addition, the Baker Act form entitled "Report of Law Enforcement Officer Initiating Involuntary Examination" (CF-MH 3052a) must be completed when the officer, as opposed to the judge or mental health professional, initiates the examination. These forms, as well as all other Baker Act forms can be obtained from the circuit office of the Department of Children and Families or can be downloaded from the DCF website. [Chapter 65E-5.280, F.A.C.]

The Mental Health Professional's Certificate form should go with the law enforcement officer to deliver with the person to the receiving facility. Many receiving facilities want the original, although they are required to accept the person from law enforcement regardless of whether the form is an original or a copy. The initiating professional should retain a copy of the initiation form in the person's record.

Law enforcement officers are required to complete the front side of the transportation form (CF-MH 3100). In addition, they should complete and sign the back of the form when delegating the transportation to medical transport. Then the transport form as well as the initiation form (BA 52a, BA 52b, or ex parte order) must be sent with the person to the receiving facility.

The Baker Act is very clear. The nearest receiving facility must accept any person brought by law enforcement officers for involuntary examination. [s.394.462(1)(j), F.S.]

Escape or Elopement of Persons from a Baker Act Receiving Facility

It is the responsibility of each Baker Act receiving facility and hospital emergency departments to retain persons safely and not allow them to elope or to depart against medical advice if they meet criteria for involuntary examination.

If a person being examined or treated at a receiving facility or ER elopes from the facility, the following procedures are recommended:

1. If an adult is on voluntary status and does not meet the criteria for involuntary placement, law enforcement should not be notified by the facility.
2. If the person is on voluntary status and does appear to meet the criteria for involuntary placement, a certificate of a professional should be initiated by an authorized person at the facility and the appropriate law enforcement agency should be requested to take the person named in the certificate into custody for delivery to the nearest receiving facility. A transfer of the person, if appropriate, will then be arranged between facilities.
3. If the person elopes while on involuntary examination status within 72 hours of arrival at the facility, but prior to the Petition for Involuntary Placement being filed with the court, the appropriate law enforcement agency will be provided a copy of the original CF-MH 3052a or 3052b and requested to take the person into custody for delivery to the nearest receiving facility. A transfer of the person, if appropriate, will then be arranged from facility to facility.
4. If the person is on involuntary examination status and a Petition for Involuntary Placement has already been filed with the court, the appropriate law enforcement agency will be provided a copy of the petition form (CF-MH 3032) and requested to return the person to the facility from which the petition was filed.
5. If a person under a court's Order for Involuntary Placement (CF-MH 3008) at a treatment facility leaves the facility without authorization, the administrator may authorize a search for the person and the return of the person to the facility. While the statute is silent with regard to receiving facilities, it is presumed that the court order itself would provide the required authority. The administrator of the facility may request the assistance of a law enforcement agency in the search for and return of the person and may provide a copy of the order to law enforcement.
6. If a person elopes from a hospital emergency department, he/she should be returned to the hospital for appropriate transfer as required by the federal EMTALA law.

Confidentiality of Clinical Records

Many state and federal laws govern the confidentiality of medical information and some even require mandatory reporting. For example:

- Law enforcement officers, in addition to many other identified persons, have a duty to report suspected abuse, neglect, or exploitation of children or vulnerable adults.
- The Vienna Convention and bilateral agreements the United States has with other countries require law enforcement to notify the consulate whenever a Foreign National (even those with dual citizenship) is detained in any manner, including under the Baker and Marchman Act. The officer is not required to inform the consulate of the reason for the detention, considering the privacy rights of the person.
- HIPAA doesn't apply to law enforcement officers, except the medical records of inmates in the jail.
- Laws governing confidentiality of information on people with communicable disease and substance abuse are different than those applying to other medical or mental health diagnoses.

Any person, agency, or entity receiving information pursuant to the Baker Act has to maintain such information as confidential and exempt from the provisions of Florida's public records law [s. 119.07(1), F.S.].

Therefore, any documents initiating an involuntary examination, reports resulting from transportation of the person to a receiving facility, responses to a person's elopement from a facility, or other information which could provide for the identification of the person, may not be released by law enforcement.

However, the Florida Attorney General has issued opinions that state the officers' incident reports are public records and can be released to the public, even if the reports have the same information as is contained in the official forms.

The Baker Act permits release of confidential information when a person has declared an intention to harm other persons. When such a declaration has been made, the facility administrator can authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the person. The law does not allow the release of confidential information to law enforcement about confessions the person may have made about past crimes he or she may have committed. In fact, the 9th US Circuit Court of Appeals has ruled that while therapists are sometimes required to report incidents to authorities that could lead to violence, the court ruled that prosecutors can't use testimony from therapists to help convict their patients.

Crisis Intervention Teams

The use of CIT – Crisis Intervention Teams based on the Memphis Police Department model – has been a great innovation in reducing officer use of force and injuries to officers and to persons with mental illnesses.

Many Florida communities have implemented CIT to address issues of officer safety, consumer safety, and jail diversion. Over 6% of adults in the general population have a serious mental illness. Many people with serious mental illnesses have limited access to treatment or do not remain in treatment. As a result, these people are at increased risk for crises. Law enforcement officers are often the first responders in crisis situations after calls from families or citizen call for help.

Many other jurisdictions around the country have modeled their programs after the “Memphis Model.” While little State or Federal funds have been provided to most communities, program costs are minimal and deployment of non-law

enforcement personnel is not required. Six benefits identified in CIT studies showed:

- Few injuries to law enforcement officers
- Reduction in arrest rates and use of force incidents
- Few repeat commitments to inpatient care
- Reduction in patient violence
- Less officer time involved per call
- Reduction in jail days for offenders with mental illnesses

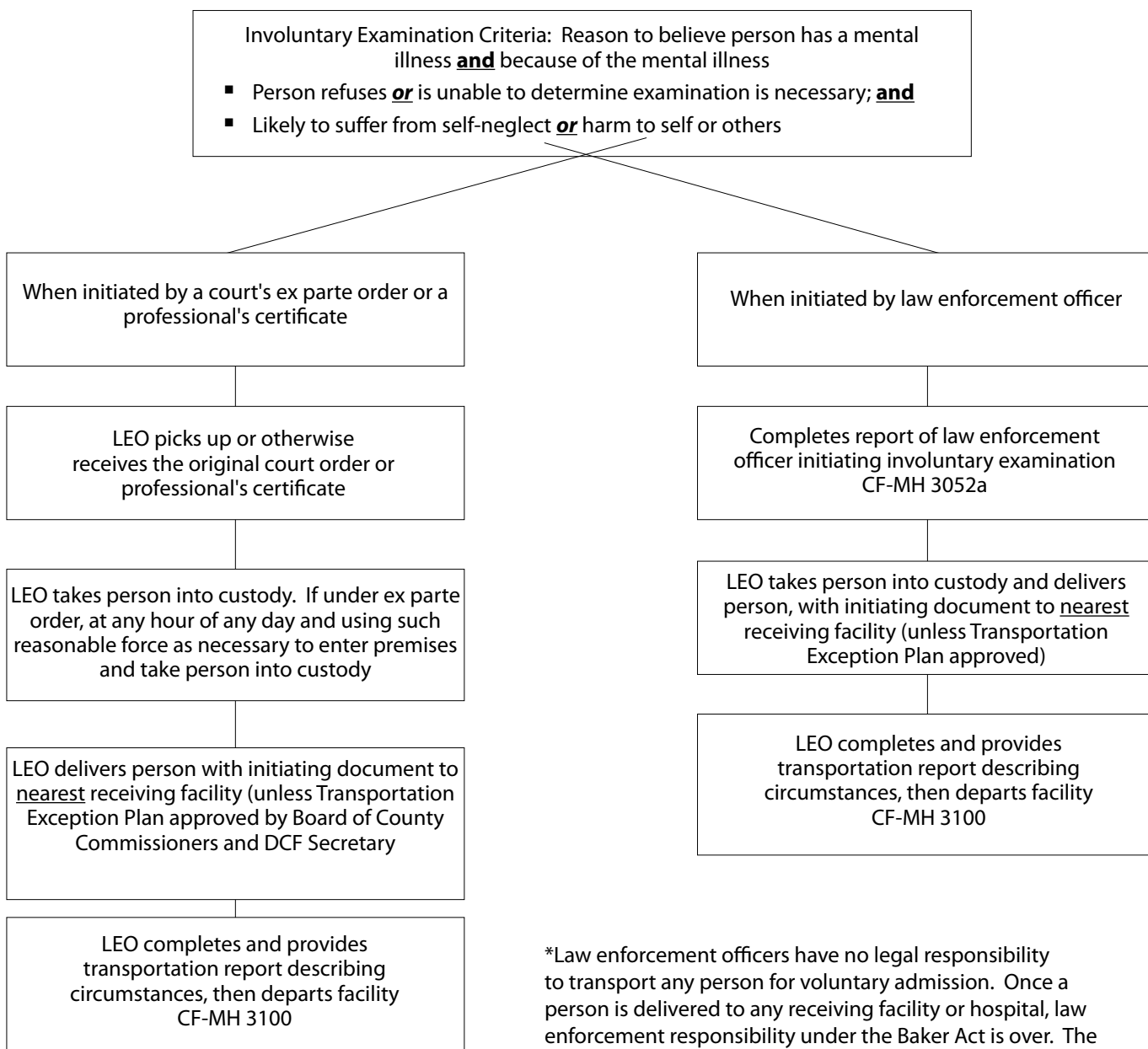
Conclusion

The role of law enforcement in dealing with persons having serious mental illnesses is a difficult one. The Department of Children and Families maintains extensive materials on its website regarding the Baker Act and the Marchman Act that can assist law enforcement personnel.

A specialized on-line Baker Act course for law enforcement officers can be found at
<http://www.bakeracttraining.org>.

For further assistance visit: <http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml> to view DCF’s most Frequently Asked Questions list.

Law Enforcement Officer (LEO)*



*Law enforcement officers have no legal responsibility to transport any person for voluntary admission. Once a person is delivered to any receiving facility or hospital, law enforcement responsibility under the Baker Act is over. The nearest receiving facility must accept persons brought by law enforcement for involuntary examination subject to the Baker Act. Hospitals, subject to federal EMTALA, must accept persons brought with emergency medical conditions (including psychiatric and substance abuse).

The Baker Act — A Quick Reference Guide for Law Enforcement Officers

SHOULD I OR SHOULDN'T I?

The **BAKER ACT** empowers law enforcement officers to initiate an involuntary evaluation of persons based on the following facts:

- They have a mental illness, and
- They are either a danger to themselves or to others, or
- Without treatment they are likely to suffer from neglect, which is potentially harmful.

Sometimes its hard to know whether or not you should “Baker Act” someone. You want to be a responsible officer and do the right thing to protect individuals and those nearby, but you’re not sure whether or not to take a person to jail or to initiate The Baker Act and take the person to a receiving facility.

There are three important key points for you to remember:

1. Your role is not to diagnose. However, if you have reason to believe that someone appears to have a mental illness, you can decide whether or not that person may be putting himself/herself or others in danger and meets the criteria for a complete evaluation.
2. You do not need to witness all of the behaviors personally. You can consider credible eyewitness accounts from others as you determine the need for further assessment.
3. Officers must complete two forms when initiating the Baker Act: Report of Law Enforcement Officer Initiating Involuntary Examination (CF-MH 3052a), and the Transportation to Receiving Facility (CF-MH 3100).

TRANSPORTATION

You must take persons to the **nearest** receiving facility unless they have a medical emergency or a Transportation Exception Plan has been approved by the Board of Commissioners and the DCF Secretary. It is very helpful if you call ahead to alert the facility that you are on the way. The following receiving facilities are available:

BEHAVIORS TO LOOK FOR

Individuals with mental illnesses who may need further evaluation typically exhibit a combination of the following behaviors, characteristics or indicators of their illness:

BEHAVIORS: rapid speech, flight of thought, no eye contact, quick movements, disconnected speech patterns, constantly moves or paces, can’t concentrate, mood changes quickly and frequently from the highs to the lows, disorganized thoughts, disoriented to time or place, acts of violence, cutting self, combative / aggressive behavior, inappropriate dress or nudity.

HALLUCINATIONS: sees people who aren’t there, hears voices telling them to hurt themselves or others, reports that the television is suggesting harm to others, turning the head as if listening to an unseen person.

SELF-CARE ISSUES: insomnia or increased sleep, has not eaten for days, not taking prescribed medications, home is in disarray, neglects household, property or personal hygiene—to the point of putting self/others at risk.

FEELINGS: low self esteem with feelings of hopelessness or helplessness, flat affect—not reacting with much feeling or interest.

SUICIDAL RISKS: has weapons or access to weapons, speaks about previous attempts, makes direct comments about dying or hurting self, evidence of previous attempts such as scars on the wrists.

ELDERLY ISSUES: wandering at night, leaving things on stove unattended, not eating or sleeping or caring for personal needs, unrealistic fears, uncontrollable anxiety, confusion, quantity and age of unused foods in home.

SUBSTANCE ABUSE: abuse of prescribed medications, use of alcohol or illegal substances while taking medications. (If substance abuse appears to be the only issue, the Marchman Act may be more appropriate.)

NOTE: If you have any doubts, don’t forget to contact your CIT (Crisis Intervention Team) officers or one of the receiving facilities.

Family Interaction with Law Enforcement

Calling 911

Having to call 911 is an extremely stressful situation. It is by definition an emergency. Not only do you have concern for the person about whom you are making the call, but also you want to make sure that you give law enforcement enough information so that they will be able to respond effectively and safely.

Try to control the volume of your voice. When you shout over the phone it is difficult for the 911 Operator to understand what you are saying. Certainly this is a very emotionally charged time, but if the Operator can only hear shouting, the information is not efficiently received. As calmly and clearly as possible, answer the Operator's questions, follow directions you are given, and tell the Operator the following:

1. Your name and address
2. Name of person with mental illness
3. Your relationship to the person
4. That the person has a mental illness
5. Person's diagnosis
6. Any medication being used
7. Has medication stopped? How long?
8. Describe what the person is doing now.
9. Do you feel threatened?
10. Is there a history of violent acting out?
11. Does the person hear voices?
12. Does the person have fears?
13. Location of person in house?
14. Are there weapons available? (Try to remove them)
15. Request a Crisis Intervention Trained (CIT) officer, if available

When Law Enforcement Arrives

Have all the lights in the house turned on, so that all occupants can be clearly visible to the arriving officers. Have nothing in your hands if you come out of the house to meet the officers. Do not run up to the officers. They have no idea who you are and anything you may carry can possibly be interpreted as a weapon. It is essential that the officers responding to your emergency call establish a comfort zone - knowing who the person is and that you, who possibly may be also agitated, are not a threat. As calmly as possible, identify yourself. Tell the officers:

1. Who you are
2. Who you have called about
3. Your relationship to the person with a mental illness
4. That the person has a mental illness
5. What kind of mental illness it is
6. What medication is being taken
7. Has medication stopped? How long?
8. Is the person violent or delusional (paranoid)?
9. History of suicide attempts?
10. The attending psychiatrist's or case manager's names, if any, and their phone #s

Officers responding to a 911 emergency call are very focused when they arrive on the scene. First, they will make the scene safe for you, the patient, and themselves. The more informed and at ease the officers are, the less likelihood that someone will get injured or that the situation will worsen. Spend all the time that is necessary answering all of the officers' questions. Answer directly and concisely. Offer any advice you deem helpful. Do not ramble. Officers tend to tune out persons who try to tell their entire life's story. After this is done, they will usually be able to deal with you and to answer any questions. Although it is difficult in times of crisis, being patient is essential.

** This information was provided courtesy of NAMI California.*

Baker Act and Emergency Medical Conditions

ss. 394.463(2)(g) and (h), F.S. Chapter 65E-5.280(4), F.A.C.

Introduction

Florida's Mental Health Act – the Baker Act – is designed to assure appropriate, responsive care for persons with acute mental illness within a system of protections for the individual.

Major violation of federal and state law by hospital staff and emergency physicians often revolve around the following issues:

- Misuse of the Baker Act
- Improper Initiation of Baker Act
- Documentation of Examination
- EMTALA Screening, Stabilization & transfers
- Elopements
- Rights of Persons

The Baker Act cannot be used to justify the examination and treatment of non-psychiatric medical conditions or to conduct diagnostic procedures or laboratory testing without the express and informed consent of the person or his/her legally authorized substitute decision-maker. The Baker Act provides no such authority to provide medical examination or treatment, other than the required physical examination ***within 24 hours following admission*** to a receiving facility. Neither can the Baker Act be used to hold a person against his or her will at a hospital for medical examination or treatment; it can only be used for initiating psychiatric examination and psychiatric treatment.

Many persons with serious mental illness first come to the attention of law enforcement or emergency medical personnel due to unusual or frightening behavior. Through this mechanism, they eventually get to receiving facilities where they can be examined and treated for their psychiatric condition.

Conversely, many persons with serious medical problems display what may appear to be psychiatric symptoms. These “mock symptoms” often disappear when the non-psychiatric medical condition is appropriately diagnosed and treated. This interrelationship between general medical and psychiatric care systems is crucial to appropriate care.

A specialized on-line Baker Act course for personnel responsible for examining or treating medical conditions of persons held under the Baker Act can be found at: <http://www.bakeracttraining.org>

Voluntary Admission

s. 394.4625, F.S. Chapter 65E-5.270

Persons can be held on voluntary status only when they are willing to be admitted and are making well-reasoned, willful and knowing decisions about their medical and mental health care. Otherwise, they must be held under the elevated protections found in the involuntary provisions of the law.

Criteria for Involuntary Examination

Chapter 394.463(1), F.A.C.

A person may be taken to a receiving facility for involuntary examination if there is reason to believe that he or she has a mental illness, as defined in the Baker Act, and because of his or her mental illness:

- The person has ***refused*** voluntary examination ***or*** is ***unable to determine*** for himself or herself whether examination is necessary; ***and***
- Without care or treatment, the person is likely to suffer from ***neglect*** resulting in real and present threat of substantial harm that can't be avoided through the help of others; ***or***
- There is substantial likelihood that without care or treatment the person will cause serious ***bodily harm*** to himself or herself or others in the near future, as evidenced by recent behavior.

There are many clinical definitions of mental illness, but only one legal definition in the State of Florida. That definition is:

An impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

If a person's symptoms or behavior are due to any form of substance abuse, developmental disability, or antisocial behavior, they do not meet the definition of having a mental illness and cannot be held on involuntary examination under the Baker Act. However, some people may have a

serious thought or mood disorder and be intoxicated at the same time – having co-existing disorders is not uncommon. In such cases, if the thought or mood disorder is sufficient to warrant an involuntary examination, the substance abuse condition would not be a barrier.

Initiation of Involuntary Examination

s. 394.463(2), F.S. Chapter 65E-5.280, F.A.C.

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

- A court **may** enter an ex parte order, based upon sworn testimony, directing a law enforcement officer to take the person to the nearest receiving facility.
- A law enforcement officer **shall** take a person who appears to meet the above criteria into custody and deliver the person to the nearest receiving facility. The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made part of the person's clinical record.
- A mental health professional (physician, clinical psychologist, psychiatric nurse, clinical social worker, mental health counselor, or marriage and family therapist – each as defined below) **may** execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating their observations upon which that conclusion is based.

Only those professionals specifically authorized in the Baker Act may initiate involuntary examinations. Further, the definitions of each professional in the Baker Act may differ from that in the licensure laws. When there is conflict between the general licensure laws and the specific Baker Act law, the Baker Act prevails. These professionals and definitions are as follows:

- **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.
- **Mental Health Counselor.** Means a mental health counselor licensed under chapter 491, F.S.
- **Marriage and Family Therapist.** Means a marriage and family therapist licensed under chapter 491, F.S.

In May 2008 the Florida Attorney General issued an opinion that Physician Assistants could under some circumstances initiate an involuntary examination. The opinion did not authorize any other rights limited to a physician.

Certificate of a Professional

The certificate must:

- Be signed within 48 hours of personally examining the patient leading to the professional's conclusion that he/she met the criteria for involuntary examination.
- Be initiated by a professional specifically authorized in the Baker Act.
- Cite the professional's observations on which his/her conclusion is based. Those observations must relate to the definition of mental illness and the specific criteria for involuntary examination.

A Certificate of a Professional Initiating an Involuntary Examination (CF-MH 3052b) is the mandatory form for a professional authorized under the Baker Act to use. This form must be complete and legible.

- Section I must include a diagnosis consistent with the definition of mental illness found in the Baker Act.
- Section II must include the professional's own observations about the behaviors seen or statements heard supporting the criteria for involuntary examination. Otherwise, the exam cannot be initiated.
- Section III permits the professional to consider other information relied upon in reaching the conclusion that may have been provided by credible third parties such as

staff, family, or others. This is only supplemental to the professional's own observations found in Section II.

- Section IV is only used when having a person taken into custody for failing to comply with the order of a court for involuntary outpatient placement.
- Section V is only used when the person has left the premises and law enforcement has been asked to search for the person and return him/her to a hospital or receiving facility.
- Section VI must be fully completed, identifying the professional completing the form.

Baker Act Involuntary Examination

ss. 394.463(2)(g) and (h), F.S. Chapter 65E-5.2801, F.A.C

A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition must be examined at a receiving facility within 72 hours. The only exception is when a physician or clinical psychologist affiliated with the hospital conducts the involuntary examination.

A Mandatory Initial Involuntary Examination must be completed and documented in the patient's chart. This exam must include:

- A thorough review of any observations of the person's recent behavior;
- Review of the "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.

A person held under involuntary examination status must have the Mandatory Initial Involuntary Examination conducted by a physician or clinical psychologist by one of the following methods:

1. A physician or psychologist employed at the emergency department can conduct the examination and if found not to meet the criteria for involuntary inpatient/outpatient placement, the person may be released or accept voluntary placement. (Form CF-MH 3101), or

2. The hospital must notify within two hours of medical stabilization a designated Baker Act receiving facility to perform the involuntary examination of the person (form CF-MH 3102). The law does not specify the nearest facility.

If the person hasn't already been released from the ED by a physician or psychologist, one of the following must occur **within 12 hours** of the determination of medical stability:

- The person must be examined by a designated receiving facility and released; or
- The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available.

In any case, any transfer from a hospital emergency department of a person with a psychiatric or substance abuse emergency must comply with all requirements of the federal EMTALA law.

Emergency Medical Conditions (EMC)

ss. 394.463(2)(g) and (h), F.S. Chapter 65E-5.280(4), F.A.C.

If a law enforcement officer transporting a person for involuntary examination initiated by a court, by an authorized mental health professional, or by law enforcement believes that the person has an emergency medical condition, the person may first be transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated Baker Act receiving facility.

An emergency medical condition is defined in the law as 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 or part

The emergency medical condition should be addressed in accordance with existing hospital policy without regard to the initiation of the involuntary examination. The Baker Act should never be used to authorize medical examination/treatment or to detain a person wishing to leave a hospital unless the person is held for psychiatric examination/psychiatric treatment and also meets the criteria under the Baker Act.

If a person on involuntary examination status has been taken to a hospital for the evaluation or treatment of an emergency medical condition, the 72-hour examination period begins

when the person arrives at the hospital and is suspended when the attending physician documents that the person has an emergency medical condition. The 72-hour clock resumes again upon the determination by a physician that the person's medical condition has stabilized or that an emergency medical condition does not exist.

Duties of all Hospitals

Persons held under the Baker Act, whether at a designated receiving facility or at a hospital where they may be undergoing evaluation or treatment of an emergency medical condition, must have their rights upheld.

Florida's hospital licensure law places certain responsibilities on all hospitals, not just those designated as Baker Act receiving facilities. Some of these responsibilities are as follows:

- 395.003(5)(a) Adherence to patient rights, standards of care, and examination and placement procedures provided under Baker Act shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment.
- 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 the Baker Act and the involuntary examination procedures, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility and regardless of whether the person is admitted to the hospital.
- 395.1055(5) AHCA shall enforce Baker Act law and rules, with respect to the rights, standards of care, and examination-placement procedures voluntarily or involuntarily admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment.
- 395.1065(4) In seeking to impose penalties against a facility for a violation of Baker Act, AHCA is authorized to rely on the investigation/findings by the Department of Health in lieu of conducting its own investigation.
- 395.3025 Patient and personnel records; copies; examination. 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. This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.

EMTALA and the Baker Act Emergency Medical Treatment and Active Labor Act

42 CFR 489.24

All public, for profit, or non-profit hospitals that offer services for medical, psychiatric or substance abuse emergency conditions are obligated to comply with all of EMTALA requirements. This includes freestanding psychiatric hospitals that serve persons with emergency psychiatric conditions.

All licensed hospitals are required to comply with the Florida law governing hospital licensure [s. 395.1041, F.S.]. Conversely, a facility that is not licensed as a hospital, such as a Crisis Stabilization Unit (CSU), nursing home, assisted living facility, outpatient clinic, or physician office is not required to comply with EMTALA or the hospital licensing law.

EMTALA applies to all transfers of persons from and to hospitals of persons with emergency medical conditions; which by federal definition includes psychiatric and substance abuse emergencies. An involuntary examination under Baker Act or protective custody under the Marchman Act would constitute such emergencies.

EMTALA discourages lateral transfers between hospitals, much less downward substitution of care for persons with emergency medical conditions. However, it defers to state and local plans to do so in some cases such as when CSU and detox facilities are established and funded by the state solely for persons unable to pay for care.

Once the person's emergency medical condition has been stabilized (defined as unlikely to experience a deterioration in condition during or as a result of the transfer) and other required conditions for an appropriate transfer have been met, the person can be transferred to a facility that has the capability and capacity to manage the person's condition and has agreed to accept the person, based on the prior review of medical records. If the transferring hospital has licensed psychiatric capability, it must have the consent of the patient or legal representative; if it doesn't have psychiatric capacity or capability, a physician can certify the benefits of the transfer outweigh the risks. No delay or denial of emergency care due to inability to pay can take place by either the transferring facility or the facility to which a request for transfer is made.

When the federal EMTALA law is in conflict with the state's Baker Act law, EMTALA takes precedence. When no conflict exists, hospitals must follow both.

Medical & Psychiatric Screening

Generally, any hospital's medical screening is a triage process that places highest priority upon identifying and responding to acute or volatile life-threatening situations such as overdoses or metabolic toxicity.

A medical screening may be conducted by qualified medical personnel authorized by the hospital's policies and procedures and in accordance with EMTALA. A Baker Act receiving facility cannot require an emergency department to conduct certain laboratory or diagnostic tests on a person under the Baker Act prior to accepting the person. However, if a receiving facility believes that a person's emergency medical condition has not been stabilized or the emergency medical condition continues to exist, it can refuse the requested transfer. A free-standing psychiatric facility is prohibited by law from admitting any person if it doesn't have appropriate medical treatment available. This may require CSU staff to determine in advance if the person requires services beyond its medical capability. Recurring transfer problems should be documented and reported to DCF circuits which contract for Baker Act services.

All medically required tests should be requested at one time (not sequentially) so that the transfer for psychiatric examination is not delayed.

An emergency department of a non-receiving facility is not required by the Baker Act to provide a psychiatric consult prior to the transfer of a person to a receiving facility. The Baker Act law and rule do not require that the ED provide a psychiatrist to evaluate the person's condition — that occurs upon arrival at the receiving facility. Requiring a psychiatric examination in an emergency department prior to transferring a person to a receiving facility is generally a waste of resources, duplicative, and creates unnecessarily delays.

The ED physician is permitted to perform the exam and, if the person doesn't meet the criteria for involuntary inpatient or outpatient placement, can directly release the person or convert a competent person to voluntary status. This assumes that the hospital doesn't have a higher standard that requires evaluation by a psychiatrist.

Further, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the federal Center for Medicare & Medicaid Services (CMS) Conditions of Participation govern chemical restraints and mechanical restraints for medical and behavioral purposes. If those requirements are more stringent than those in the Baker Act, they must be followed instead.

Where life threatening medical conditions may be present and a person cannot provide informed consent, there is a presumption of consent, absent a Do Not Resuscitate Order (DNR). In those circumstances, emergency staff should always attempt to obtain consent from another legally authorized decision-maker whenever possible. These may include:

- Substitute decision-makers such as guardians appointed by the court or health care surrogates/proxies when a physician determines the person lacks capacity to provide consent.
- Contact DCF to report suspected self-neglect (Chapter 415, F.S.)
- Petition the court for Expedited Judicial Intervention Concerning Medical Treatment Procedures (Rule 5.900)

For those individuals whose emergency medical conditions, including those of a psychiatric and substance abuse nature, have been resolved the physician has several options:

1. Discharge home with follow-up instructions. An individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions. The EMC that caused the individual to present to the ED must be resolved, but the underlying medical condition may persist. Hospitals are expected within reason to assist/provide discharged individuals the necessary information to secure the necessary follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital; or
2. Inpatient admission for continued care; or
3. Transfer, if all requirements of federal and state law are met.

Medical Clearance

A Baker Act receiving facility cannot require medical clearance as a condition for acceptance when brought by a law enforcement officer. The Baker Act is clear that "The nearest receiving facility must accept any person brought by law enforcement officers for involuntary examination." There is no exception to this — not even medical emergencies. Once the officer arrives at a receiving facility, the staff can call 911 to get an ambulance if they believe the person has an acute medical condition requiring emergency examination or treatment. The person should never be put back in a cruiser for the officer to

further transport in such a circumstance. The person should instead be referred by the CSU to the nearest ER via medically equipped and trained personnel, regardless of whether the hospital has psychiatric capability.

It is not appropriate for a receiving facility or a CSU to routinely utilize emergency departments to require “medical clearance” or to refer all intoxicated persons for blood levels unless an emergency medical condition is suspected.

A nursing assessment is required at a CSU and, if conditions are noted which suggest the need for acute medical treatment; the CSU would be required to refer the person to a hospital. These might include cases where there is reason to believe the person has ingested a toxic substance, is experiencing severe pain, has suffered a severe injury, or is in an acute medical crisis. The CSU would call 911 requesting emergency medical services and begin any interventions appropriate until EMS arrived.

However, once the person has been taken to a hospital that is not designated as a receiving facility for evaluation or treatment of an emergency medical condition, the person must be transferred to a designated receiving facility at which appropriate medical treatment is available within 12 hours of a physician determining the person’s medical condition has stabilized or that an emergency medical condition does not exist.

The federal EMTALA law (but not the state’s Baker Act) may require a second medical clearance closer to the time of transfer. Stabilization for transfer is determined at the time of transfer – not at some earlier period.

If a CSU routinely requires an emergency department to “medical clear” persons before acceptance, such practice should be documented and reported to DCF for investigation.

Baker Act Exam/Release

Many emergency department personnel use a phrase such as “rescinding,” “lifting,” “abrogating,” or “overturning” the Baker Act. This is incorrect in that once a Baker Act involuntary examination is initiated by any one of the three authorized methods, all components of the initial mandatory involuntary examination must be conducted by a physician or clinical psychologist.

Upon a determination by any physician or clinical psychologist that any one of the criteria for involuntary inpatient and outpatient placement doesn’t exist, the person may be released, or if competent to provide express and informed consent, become voluntary.

Some ED physicians are willing to initiate an involuntary examination but refuse to conduct the exam and to authorize release of persons from the Baker Act, resulting in hospitals having to admit persons pending transfer. These physicians often believe that only a psychiatrist can release a person from involuntary status. The law is explicit that a non-psychiatric physician is authorized at a non-receiving facility to perform the examination and to authorize the direct release of the person after documenting the person doesn’t meet the criteria for involuntary placement. A psychiatrist is not required to perform the examination or to approve the release from emergency departments.

If the hospital is designated as a receiving facility, the person’s release from involuntary status must have the documented approval of a psychiatrist, a clinical psychologist or, an attending emergency department physician.

Transfers

All hospitals, even those licensed as free-standing psychiatric hospitals are subject to EMTALA. EMTALA is based on the belief that transfers of people with emergency medical conditions are inherently dangerous and discourages them unless certain criteria are met. These include:

- Conducting the medical screening within the capability and capacity of the hospital to perform,
- Stabilization,
- Agreement of the person or his/her legal representative to the transfer,
- Sharing of all relevant medical records with the destination hospital,
- Approval of transfer by the destination hospital, and
- Arranging safe/appropriate means of transportation.

Only then can the payment source (or lack of payment) be considered. Transfer of a person who refuses consent can only be performed when the sending hospital doesn’t have the capability or capacity to meet the person’s needs.

EMTALA requires any hospital that goes over licensed or staffing capacity for any person must do so for indigent persons as well. It cannot make such accommodations just for paying persons. However, if the hospital never goes over census for any person, it is not required to go over census for an indigent person.

The capacity to render care is not reflected simply by the number of persons occupying a specialized unit, the number of staff on duty, or the amount of equipment on the hospital’s premises. Capacity includes whatever

a hospital customarily does to accommodate patients in excess of its occupancy limits. If a hospital has customarily accommodated patients in excess of its occupancy limits by whatever means (e.g., moving patients to other units, calling in additional staff, borrowing equipment from other facilities) it has, in fact, demonstrated the ability to provide services to patients in excess of its occupancy limits.

There is some possible risk of an EMTALA violation by selectively picking an indigent person for the transfer over a paying person, but EMTALA does recognize state/local plans for serving such persons. The only reason for the State of Florida to have established and funded CSU's is to serve persons who don't have the ability to pay for private care. Uninsured persons served by a facility may be informed, after the facility has met its EMTALA obligations, that they will receive a bill for the full cost of care they receive at the hospital. Most persons will agree to a transfer if it means they will not get a bill or that the bill will be based on their ability to pay.

Transfers from any licensed hospitals must first meet all requirements of the federal EMTALA law. Once those federal requirements are met, the requirements of the state's Baker Act apply when the transfer is between designated receiving facilities. The Baker Act [s.394.4685, F.S.] provides conditions for:

- » Transfers Between Public Facilities
- » Transfers From Public To Private Facilities
- » Transfers From Private To Public Facilities
- » Transfers Between Private Facilities

If an emergency physician doesn't conduct the exam and release the person, it is the responsibility of the ED to contact a designated receiving facility within 2 hours after the person's emergency medical condition has been stabilized or determined not to exist. It is the receiving facility's responsibility to either accept transfer of the person when it has capacity and appropriate medical treatment available or to have its physician or clinical psychologist conduct the initial mandatory examination and release the person or transfer to voluntary status, if competent.

The federal EMTALA regulations and the Baker Act require the sending hospital to arrange safe and appropriate transportation of the person to the receiving facility, unless other appropriate transportation arrangements can be made.

If one receiving facility refuses to accept the transfer, another receiving facility should be contacted or the person should be retained at the hospital in which the emergency department is located until resolution is reached.

There is no requirement that the person be transferred to the nearest receiving facility. Obviously, if the nearest receiving facility can meet the person's clinical needs and it has the capacity to accept the person, this is the ideal situation. However, if the nearest facility doesn't have either the capacity (space), or capability (psychiatric unit), the person should be transferred to the next closest receiving facility that does have the capability and capacity.

Transfer difficulties are most frequently reported over weekends. This is often attributed to on-call physicians at receiving facilities providing coverage for attending psychiatrists over the weekend, but who may be unwilling to discharge another doctor's patient. Lack of discharge planners on weekends in some receiving facilities also contributes to this problem.

The Baker Act doesn't provide a remedy to the problem of what happens when no Baker Act receiving facility can be located for a person on involuntary status within the 12 hour time frame permitted for transfer. The hospital should start referring immediately upon the person's medical clearance and document each contact with the date, time, location, person talked to, and his/her response. If it appears the person won't be transferred within the permitted 12 hour period, from a non-designated hospital, DCF/Mental Health Program staff should be contacted at the first possible time to report it. What cannot be done is to re-initiate another involuntary initiation (Certificate of a Professional) on top of the first one. Neither should a person be released who still meets the criteria for involuntary placement. However, an emergency department physician may conduct the exam and if the person doesn't meet the involuntary placement criteria, the examination and findings can be documented in the chart and the person can be either released or, if competent, converted to voluntary status. (See form 3101.)

If a hospital subject to EMTALA routinely refuses to accept transfers, a report to the Agency for Health Care Administration may be appropriate if the refusal was based on the financial status of the person. If the receiving facility is licensed under Chapter 394, F.S. (CSU), a complaint may be directed to the circuit office of DCF (funding source).

A hospital's delay or denial of a request for a transfer based on inability to pay may result in an EMTALA violation for "reverse dumping." Even the Florida law governing "Access to Emergency Services and Care" [395.1041(3) (e) & (h), FS] governs where a transfer can be made and prohibits conditioning such acceptance on an individual's ability to pay as follows:

- (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.

- (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.

CSU's

Crisis stabilization units exist to serve indigent persons. The benefits derived by CSU's from their tax exempt status and the state/county appropriated funds place a responsibility on them to coordinate care for persons with acute psychiatric conditions. In exchange for receipt of public funding, the Florida Administrative Code [chapter 65E-5.351(5) F.A.C.] requires that a public receiving facility that is affiliated with a publicly funded community mental health center ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness. A public receiving facility should take the leadership in solving local transfer problems.

Statutorily, CSU's serving adults are limited in size to a maximum of 30 beds; those serving minors are limited to 20 beds. The law prevents CSU's from exceeding their licensed capacity by more than ten percent, nor may they exceed their licensed capacity for more than three consecutive working days or for more than seven days in a month. Exceeding these limits would subject persons to a potentially dangerous environment and the CSU to loss of license.

DCF contracts, to the extent of its appropriations, with CSUs for indigent persons (up to 20% of the persons served by a CSU's may be financially ineligible under federal poverty guidelines). Due to limited funds, a CSU may still have beds available for purchase from other funders, including managed

care organizations. However, if a persistent problem occurs in accessing care for indigent persons, a report should be made to the DCF region office or the managing entity.

DCF and AHCA can check on the actual census of each publicly funded CSU in the circuit to determine how many persons were admitted, what percentage were financially eligible, and the average length of stay. If the ALOS exceeds the statewide ALOS, it reduces the number of persons who can be stabilized in the funded/licensed beds. DCF can also check on the CSU policies for accepting transfers, specifically whether they accept up to the licensed or funded capacity and what priority is placed on whether the transfer is initiated from designated or non-designated facilities.

Law Enforcement

A law enforcement officer's duty is over once he/she has presented the person and the required paperwork to responsible staff at the ED where the person has been taken for evaluation or treatment of an emergency medical condition.

Law enforcement officers should provide a copy of the involuntary examination initiation form (court order, law enforcement officer's report or mental health professional's certificate) and the required transportation form (3100 form) at the time of arrival.

Law enforcement should not be expected to stay with the person while awaiting medical screening or transfer unless the person has criminal charges. The safety of the person while at the hospital is the responsibility of hospital personnel.

Law enforcement agencies are under no obligation to further transport the person after medical clearance. That is the duty of the hospital under EMTALA.

It is not acceptable for a hospital to return the person to law enforcement personnel for transfer to a designated receiving facility. The transferring hospital is responsible for arranging a safe and appropriate method to transport a person to a receiving facility, as required by EMTALA, regardless of whether the receiving facility is nearby or in a remote location.

Safety/Stabilization

While persons on Baker Act involuntary examination status are in the emergency department awaiting medical screening or transfer, it is the hospital's responsibility to ensure their safety.

Safety can be arranged in many ways. Some hospitals use one-on-one sitters or a single sitter in the doorway of a room that has multiple persons awaiting transfer to receiving facilities. It is important that sitters be trained as to their

responsibilities should the person try to leave the room. Other hospitals place these persons in a room at the back of the ED, farthest away from any exit doors. Some hospitals provide gowns and paper slippers instead of street clothing. Some facilities use video monitoring to reduce elopements. In any case, the ideal is to expedite the person's transfer and, if the volume is sufficient, a specialty psychiatric ED in part of the existing ED may be appropriate. This would provide secure space and specially trained staff.

However, if a person does elope from a hospital, staff may want to consider the following:

- Voluntary not meeting criteria for involuntary placement, law enforcement not notified by the facility.
- Voluntary but meets criteria for involuntary placement, 3052b initiated and law enforcement requested to take person into custody and deliver to nearest receiving facility. Transfer of person, if appropriate, will be arranged from facility-to-facility.
- Involuntary examination status, within 72 hours of arrival at facility, meets criteria for involuntary placement, but prior to Petition for Involuntary Placement being filed with court. Law enforcement given 3052 (a or b) or order and requested to take person into custody and deliver to nearest receiving facility. Transfer of person, if appropriate, then arranged from facility-to-facility.
- Petition for Involuntary Placement filed with court, law enforcement provided copy of petition (3032) and requested to return person to the facility from which the petition was filed.
- Under court's Order for Involuntary Placement (3008) and leaves facility without authorization, administrator authorizes search and the return of person. Administrator of facility may request law enforcement to search for and return person and provide copy of order (3008).
- If the elopement is from an emergency department, the person should be returned to the emergency department by law enforcement for appropriate transfer required by EMTALA.

If a person is locked up for behavioral reasons in a room of the ED, this would be considered seclusion under the federal Conditions of Participation. However, if the person has been identified as meeting the criteria for involuntary examination under the Baker Act and documentation exists that the person is at imminent risk of danger from assault, suicide, elopement, etc., seclusion or restraint can generally be justified if no less restrictive alternative is appropriate and effective.

There is no requirement that a CSU that refers a person to a hospital remain with a referred person, once a responsible hand-off of the person is performed. Once the person is presented, federal EMTALA requirements that apply to a hospital must be followed. This places responsibility on the hospital staff to be sure the person is stabilized, which may include safely retaining him/her at the ED until an appropriate transfer back to the CSU or other receiving facility can be arranged, along with the other EMTALA requirements for an appropriate transfer.

Persons with psychiatric diagnoses are considered stable when they are protected and prevented from injuring or harming him/herself or others.

Informed Consent for Transfer

A hospital ED can transfer a person under involuntary provisions of the Baker Act to a receiving facility without the person's consent only if the sending hospital doesn't have the capability or capacity to meet the person's needs. This means that if the hospital is part of a designated receiving facility, it generally cannot transfer a person without the person's consent (or that of his/her representative). If the hospital is not licensed for psychiatric services, a physician can generally certify that the benefits of the transfer outweigh the risks.

Florida's hospital licensing law [s.395.1041, F.S.] and the federal EMTALA law permit transfers of persons who have come to a hospital as a result of an emergency medical condition, only when one of the following has occurred:

- (a) When the person, or a person who is legally responsible for the person and acting on the person's behalf, after being informed of the hospital's obligation pursuant to section 395.1041, F.S. and the risk of transfer, requests that the transfer be effected; or
- (b) If a physician or other qualified medical personnel, certifies that the benefits to the condition of the person outweigh the risks associated with the transfer.

It is not appropriate to simply note that a transfer is being done because the person was "Baker Acted." Initiation of an involuntary examination doesn't deprive people of any right assured under federal or state law – the person actually has enhanced rights under the law.

Funding

The Florida Agency for Health Care Administration has determined that when a transfer from an emergency department to a designated receiving facility must take place and all other EMTALA requirements have been met, the

transfer destination may be decided based on the person's paying status. Given that the person must be transferred anyway from the non-designated hospital to a designated receiving facility, as long as an appropriate transfer is initiated pursuant to state (s.395.1041, F.S.) and federal EMTALA law, then the person may be transferred to the nearest private receiving facility that takes the person's insurance.

Once a person's emergency medical condition has been stabilized, hospital personnel can inquire about the person's insurance even if the hospital has not psychiatrically screened or examined the person's psychiatric condition. Hospital personnel can inquire as to a person's ability to pay as long as the inquiry does not in any way delay the provision of emergency services and care being provided to the person.

After the determination of the person's insurance status has been made, it is appropriate to transfer the paying persons to the nearest private receiving facility (even if it bypasses a closer public receiving facility) and indigent persons to the nearest public receiving facility (even if other private receiving facilities are closer) for psychiatric screening, examination and placement.

Just as an emergency department can't refuse or delay acceptance of a person based on inability to pay, a destination hospital can't refuse or delay a requested transfer of an indigent person if it has the capability and capacity to manage the person's care and the sending hospital does not. Refusal of a transfer under such circumstances would constitute "reverse dumping" under EMTALA.

A sending hospital, after meeting all other EMTALA transfer requirements, can consider the payment status of the person in determining which facility the person will be sent – hopefully avoiding yet another transfer for the person. The sending

hospital can consider state/local plans for how certain special populations are served – thus allowing a lateral or even a downward substitution of care if in accord with the plan. However, EMTALA would not allow a destination hospital to refuse to accept a transfer for financial reasons or require pre-certification of insurance or sending of a face sheet with insurance information as a condition of acceptance.

However, if a non-designated hospital makes an error in determining whether or not a person has insurance, a hospital-based receiving facility can't refuse the person due to the person's insurance status. Once contact is made with a designated receiving facility, whether public or private, by an initiating facility, if that hospital has the capability and capacity to care for the person, the receiving hospital is required to accept the person under state (s.395.1041, F.S.) and federal EMTALA regulations. A private receiving facility may transfer a person (pursuant to the transfer requirements contained in s. 394.4685, F.S., s.395.1041, F.S. and the EMTALA regulations) to a public receiving facility for further treatment after the person has been screened and stabilized.

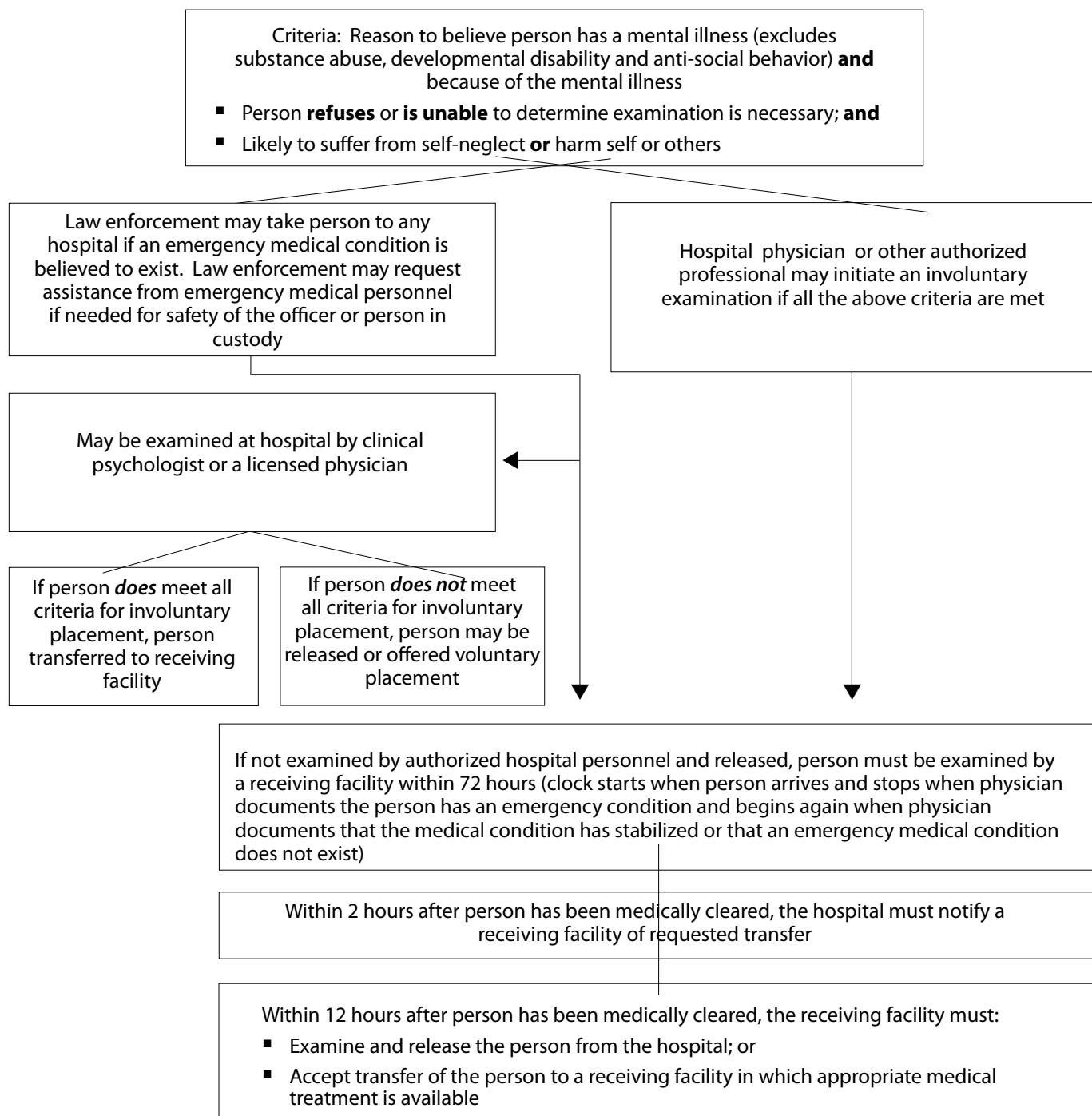
Summary

Hospital emergency departments will always play a vital role in the continuity of care for persons with acute mental illnesses. Because of the overlap between the federal EMTALA law and the state Baker Act law, it is critical that hospitals meet their obligations. However, it is just as critical that persons under Baker Act involuntary examination status be transferred as quickly as possible to designated receiving facilities to get the psychiatric examination and treatment they need.

A specialized on-line Baker Act course can be found at
<http://www.bakeracttraining.org>.

For further assistance visit: <http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml> to view
DCF's most Frequently Asked Questions list.

Emergency Medical Treatment of Persons for Whom Involuntary Examination has been or will be Initiated



*Transportation from a hospital to a receiving facility or between receiving facilities is the responsibility of the referring facility unless other methods of transportation have been arranged

Orders for Emergency Treatment Including Restraints and Seclusion

s. 394.459(4), F.S. Chapter 65E-5.1703, F.A.C.

42 U.S.C. 1301 and 1395hh, Subpart B Administration Sec. 482.13 (e)

Cautionary Note:

Many statutes, federal/state regulations, accreditation standards, and even an organization's own policies/procedures govern how restraints and seclusion can be used. Facility staff must use the most stringent of these requirements that apply to persons served in their facility, whether it be Hospital Conditions of Participation (as per Federal Code – 42 C.F.R. 482.1-482.66), The Joint Commission, or the Commission on Accreditation of Rehabilitation Facilities (CARF). Administrative Code 65E-5.100 was revised in April 2013 to delete definitions that were redundant with the *Florida Statutes*.

In 2007 the the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) was renamed The Joint Commission.

Introduction

394.453 and 394.457(5), F.S.]

The Florida Legislative expression of its intent for the Baker Act includes the following provision:

It is the policy of this state that the use of restraint and seclusion on clients is justified only as an emergency safety measure to be used in response to imminent danger to the client or others. It is, therefore, the intent of the Legislature to achieve an ongoing reduction in the use of restraint and seclusion in programs and facilities serving persons with mental illness.

The Legislature requires the Department of Children and Families to develop rules implementing all aspects of the Baker Act, including provisions governing restraint and seclusion, as follows:

1. Rules establishing forms and procedures relating to the rights and privileges of patients seeking mental health treatment from facilities.
2. A program subject to the Baker Act shall not be permitted to operate unless rules designed to ensure the protection of the health, safety, and welfare of the patients treated through such program have been adopted. Rules adopted must include provisions governing the use of restraint and seclusion which are consistent with recognized best practices and professional judgment; prohibit inherently dangerous

restraint or seclusion procedures; establish limitations on the use and duration of restraint and seclusion; establish measures to ensure the safety of program participants and staff during an incident of restraint or seclusion; establish procedures for staff to follow before, during, and after incidents of restraint or seclusion; establish professional qualifications of and training for staff who may order or be engaged in the use of restraint or seclusion; and establish mandatory reporting, data collection, and data dissemination procedures and requirements. Rules adopted under this subsection must require that each instance of the use of restraint or seclusion be documented in the record of the patient.

In addition to state requirements, the federal Center for Medicare and Medicaid Services (CMS) issued Conditions of Participation for hospitals participating in Medicare and Medicaid programs due to the danger posed to health and safety by violations of basic rights of persons, such as freedom from inappropriate use of restraints and seclusion. These requirements are found in 42 CFR Part 482.13(e). CMS has issued interpretive guidelines implementing the regulations. *The material included in this Handbook is accurate as of its printing date.* The reader needs to consider the federal standards as the basis for determining how its own policies and procedures will meet new emerging community standards of care for the use of restraints and seclusion, as a supplement to the requirements of Florida Statutes and Administrative Code.

General Management of the Treatment Environment

[65E-5.1601, F.A.C.]

The Florida Administrative Code establishes minimum standards for general management of the services in which individuals admitted to or served in facilities under the Baker Act must meet. These included:

- Management and personnel of the facility's treatment environment must use positive incentives in assisting persons to acquire and maintain socially positive behaviors as determined by the person's age and developmental level.
- Interventions such as the loss of personal freedoms, loss of earned privileges or denial of activities otherwise available to other persons must be minimized and utilized only after the documented failure of the unit's positive incentives for the individuals involved.
- Facilities must ensure that any verbal or written information provided to persons must be accessible in the language and terminology the person understands.

Individual Behavior Management Programs

[65E-5.1602, F.A.C.]

When an individualized treatment plan requires interventions beyond the existing unit rules of conduct, the person shall be included, and the person's treatment plan shall reflect:

- (1) Documentation, signed by the physician that the person's medical condition does not exclude the proposed interventions;
- (2) Consent for the treatment to be provided;
- (3) A general description of the behaviors requiring the intervention, which may include previous emergency interventions;
- (4) Antecedents of that behavior;
- (5) The events immediately following the behavior;
- (6) Objective definition of the target behaviors, such as specific acts, level of aggression, encroachment on others' space, self-injurious behavior or excessive withdrawal;
- (7) Arrangements for the consistent collection and recording of data;
- (8) Analysis of data;
- (9) Based on data analysis, development of intervention strategies, if necessary;

- (10) Development of a written intervention strategy that includes criteria for starting and stopping specific staff interventions and the process by which they are to occur;
- (11) Continued data collection, if interventions are implemented; and
- (12) Periodic review and revision of the plan based upon data collected and analyzed.

Emergency Treatment Orders

The Baker Act specifies under Quality of Treatment that each individual must receive services, which are suited to his or her needs, and which shall be administered skillfully, safely, and humanely with full respect for the patient's dignity and personal integrity. This requires that facilities develop and maintain, in a form accessible to and readily understandable by individuals and consistent with rules adopted by the department, the following:

- Criteria, procedures, and required staff training for any use of close or elevated levels of supervision, of restraint, seclusion, or isolation, or of emergency treatment orders, and for the use of bodily control and physical management techniques.
- Procedures for documenting, monitoring, and requiring clinical review of all uses of the procedures above and for documenting and requiring review of any incidents resulting in injury to patients.
- A facility can't use seclusion or restraint for punishment, to compensate for inadequate staffing, or for the convenience of staff. Facilities shall ensure that all staff are made aware of these restrictions on the use of seclusion and restraint and shall make and maintain records which demonstrate that this information has been conveyed to individual staff members.

Chapter 65E-5.100, F.A.C.) specifically defines certain terms, as follows:

Emergency treatment order (ETO) means a written emergency order for psychotropic medications, as described in Rule 65E-5.1703, F.A.C.; or a written emergency order for seclusion or restraint, as described in subsection (7) of Rule 65E-5.180, F.A.C.

The Florida Administrative Code governing the Baker Act prohibits the use of PRN or standing orders for the purpose of ordering any type of emergency treatment. This means that an order initiating restraints or seclusion can only be initiated or terminated upon the specific order of an authorized professional – not “as needed.”

Pro re nata (PRN) means an individualized order for the care of an individual person which is written after the person has been seen by the practitioner, which order sets parameters for attending staff to implement according to the circumstances set out in the order [65E-5.100(11), F.A.C.]. A PRN order shall not be used as an emergency treatment order.

Standing order means a broad protocol or delegation of medical authority that is generally applicable to a group of persons, hence not individualized. As limited by this chapter, it prohibits improper delegations of authority to staff that are not authorized by the facility, or not permitted by practice licensing laws, to independently make such medical decisions; such as decisions involving determination of need, medication, routes, dosages for psychotropic medication, or use of restraints or seclusion upon a person [65E-5.100(16), F.A.C.].

In many situations, the use of restraint, seclusion and emergency medications can be minimized by the use of **Personal Safety Plans** (CF-MH 3124) that identify what types of events cause an individual to become upset and what interventions will calm the individual. A Personal Safety Plan should guide individualized intervention techniques [65E-5.180(7)(C), F.A.C.].

Among the requirements governed by the Florida Administrative Code concerning Right to Quality Treatment [65E-5.180(5), F.A.C.] includes that mental health services provided must comply with standards including a clinical safety assessment 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. A Personal Safety Plan can help accomplish this goal and reduce the need for restraint, seclusion and emergency medications.

Restraint and Seclusion

s. 394.455, FS and 65E-180, F.A.C.

All facilities serving persons under the Baker Act are required to adhere to the standards and requirements for behavior management programs and must comply with the standards required by the state's Baker Act law and rule, as well as with national standards that may apply to their facilities (federal Conditions of Participation, The Joint Commission, CARF, etc.). In addition, each facility must comply with its own organization's policies and procedures. Whichever of these standards applicable to the organization is most stringent on a given issue is the one the organization must follow:

Restraint means

- A physical device, method, or drug used to control behavior. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the individual's body so that he or she cannot easily remove the restraint and which restricts freedom of movement or normal access to one's body.
- A drug used as a restraint is a medication used to control the person's behavior or to restrict his or her freedom of movement and is not part of the standard treatment regimen of a person with a diagnosed mental illness who is a client of the department. Physically holding a person during a procedure to forcibly administer psychotropic medication is a physical restraint.
- Restraint does not include physical devices, such as orthopedically prescribed appliances, surgical dressings and bandages, supportive body bands, or other physical holding when necessary for routine physical examinations and tests; or for purposes of orthopedic, surgical, or other similar medical treatment; when used to provide support for the achievement of functional body position or proper balance; or when used to protect a person from falling out of bed.

The Florida Administrative Code implementing the Baker Act further states that **Protective medical devices** mean a specific category of medical restraint that includes devices, or combinations of devices, to restrict movement for purposes of protection from falls or complications of physical care, such as geri-chairs, posey vests, mittens, belted wheelchairs, sheeting, and bed rails. The requirements for the use and documentation of use of these devices are for specific medical purposes rather than for behavioral control. [65E-5.100(12), F.A.C.].

When ordering safety or protective devices such as posey vests, geri-chairs, mittens, and bed rails which also restrain, facility staff shall consider alternative means of providing such safety so that the person's need for regular exercise is accommodated to the greatest extent possible. Where frequent or prolonged use of safety or protective devices is required, the person's treatment plan must address debilitating effects due to decreased exercise levels such as circulation, skin, and muscle tone and the person's need for maintaining or restoring bowel and bladder continence. The treatment plan must include scheduled activities to lessen deterioration due to the usage of such protective medical devices.

Seclusion means the physical segregation of a person in any fashion or involuntary isolation of a person in a room or area from which the person is prevented from leaving. The prevention may be by physical barrier or by a staff member who is acting in a manner, or who is physically

situated, so as to prevent the person from leaving the room or area. For purposes of this chapter, the term does not mean isolation due to a person's medical condition or symptoms. [394.455(29), FS]

Elevated Levels of Supervision. Receiving and treatment facilities must ensure that where one-on-one supervision is ordered by a physician, it must be continuous and not be interrupted as a result of shift changes or due to conflicting staff assignments. Such supervision must be continuous until documented as no longer medically necessary by a physician [65E-5.180(9)].

The Baker Act standards mandate that the health and safety of the individual must be the primary concern at all times. Seclusion or restraint can only be employed in emergency situations when necessary to prevent a person from seriously injuring self or others, and less restrictive techniques have been tried and failed, or if it has been clinically determined that the danger is of such immediacy that less restrictive techniques cannot be safely applied.

There is a high prevalence of past traumatic experience among persons who receive mental health services. The response to trauma can include intense fear and helplessness, a reduced ability to cope, and an increased risk to exacerbate or develop a range of mental health and other medical conditions. The experience of being placed in seclusion or being restrained is potentially traumatizing. Seclusion and restraint practices shall be guided by the following principles of trauma-informed care: assessment of traumatic histories and symptoms; recognition of culture and practices that are re-traumatizing; processing the impact of a seclusion or restraint with the person; and addressing staff training needs to improve knowledge and sensitivity.

Staff Training

Staff must be trained as part of orientation and subsequently on at least an annual basis. Staff responsible for the following actions must demonstrate relevant competency in the following areas before participating in a seclusion or restraint event or related assessment, or before monitoring or providing care during an event:

- Strategies designed to reduce confrontation and to calm and comfort people, including the development and use of a personal safety plan,
- Use of nonphysical intervention skills as well as bodily control and physical management techniques, based on a team approach, to ensure safety,
- Observing for and responding to signs of physical and psychological distress during the seclusion or restraint event,

- Safe application of restraint devices,
- Monitoring the physical and psychological well-being of the person who is restrained or secluded, including but not limited to: respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by facility policy associated with the one hour face-to-face evaluation,
- Clinical identification of specific behavioral changes that indicate restraint or seclusion is no longer necessary,
- The use of first aid techniques, and
- Certification in the use of cardiopulmonary resuscitation, including required periodic recertification. The frequency of training for cardiopulmonary resuscitation will be in accordance with certification requirements.

Prior to the Implementation of Seclusion or Restraint

Prior intervention must include individualized therapeutic actions such as those identified in a personal safety plan that address individual triggers leading to psychiatric crisis. Recommended form CF-MH 3124, Feb. 05, "Personal Safety Plan," may be used for the purpose of guiding individualized techniques. Prior interventions may also include verbal de-escalation and calming strategies. Non-physical interventions must be the first choice unless safety issues require the use of physical intervention.

A personal safety plan must be completed or updated as soon as possible after admission and filed in the person's medical record. This form must be reviewed by the recovery team, and updated if necessary, after each incident of seclusion or restraint. Specific intervention techniques from the personal safety plan that are offered or used prior to a seclusion or restraint event must be documented in the person's medical record after each use of seclusion or restraint. All staff must be aware of and have ready access to each person's Personal Safety Plan.

Implementation of Seclusion or Restraint

Use of restraint or seclusion can be very high risk for individuals with severe mental illnesses. To protect the safety of these individuals for whom restraint or seclusion has been determined to be unavoidable, the following represent some of the minimum requirements for safety and dignity:

- A person who is restrained cannot be located in areas, whenever possible, subject to view by persons other than involved staff or where exposed to potential injury by other persons.

- Seclusion or restraint use cannot be based on the person's seclusion or restraint use history or solely on a history of dangerous behavior. Dangerous behaviors include those behaviors that jeopardize the physical safety of oneself or others.
- Persons can't be restrained in a prone position unless required by the immediate situation to prevent imminent serious harm to the person or others.
- To reduce the risk of positional asphyxiation, the person must be repositioned as quickly as possible. Objects that impair respiration cannot be placed over a person's face. In situations where precautions need to be taken to protect staff, staff may wear protective gear.
- Unless necessary to prevent serious injury, a person's hands shall not be secured behind the back during containment or restraint.
- In order to protect the safety of each person served by a facility, each person must be searched for contraband before or immediately after being placed into seclusion or restraints.
- The person must be clothed appropriately for temperature and at no time may a person be placed in seclusion or restraint in a nude or semi-nude state.
- Seclusion and restraint may not be used simultaneously for children less than 18 years of age.

The use of walking restraints is prohibited except for purposes of off-unit transportation and may only be used under direct observation of trained staff. In this instance, direct observation means that staff maintains continual visual contact of the person and is within close physical proximity to the person at all times.

Additional standards governing initiation of restraint or seclusion include:

1. A registered nurse or highest level staff member, as specified by written facility policy, who is immediately available and who is trained in seclusion and restraint procedures may initiate seclusion or restraint in an emergency when danger to oneself or others is imminent. An order for seclusion or restraint must be obtained from the physician, Advanced Registered Nurse Practitioner (ARNP), or Physician's Assistant (PA), if permitted by the facility to order seclusion and restraint and stated within their professional protocol. The treating physician must be consulted as soon as possible if the seclusion or restraint was not ordered by the person's treating physician.
2. An examination of the person will be conducted within one hour by the physician or may be delegated to an Advanced Registered Nurse Practitioner, Physician's Assistant, or Registered Nurse (RN), if authorized by the facility and trained in seclusion and restraint procedures. This examination must include a face-to-face assessment of the person's medical and behavioral condition, a review of the clinical record for any pre-existing medical diagnosis or physical condition which may contraindicate the use of seclusion or restraint, a review of the person's medication orders including an assessment of the need to modify such orders during the period of seclusion or restraint, and an assessment of the need or lack of need to elevate the person's head and torso during restraint. The comprehensive examination must determine that the risks associated with the use of seclusion or restraint are significantly less than not using seclusion or restraint and whether to continue or terminate the intervention. A licensed psychologist may conduct only the behavioral assessment portion of the comprehensive assessment if authorized by the facility and trained in seclusion and restraint procedures. Documentation of the comprehensive examination, including the time and date completed, must be included in the person's medical record. If the face-to-face evaluation is conducted by a trained Registered Nurse, the attending physician who is responsible for the care of the person must be consulted as soon as possible after the evaluation is completed.
3. Each written order for seclusion or restraint is limited to
 - four hours for adults, age 18 and over;
 - two hours for children and adolescents age nine through 17; or
 - one hour for children under age nine.

A seclusion or restraint order may be renewed in accordance with these limits for up to a total of 24 hours, after consultation and review by a physician, ARNP, or PA in person, or by telephone with a Registered Nurse who has physically observed and evaluated the person. When the order has expired after 24 hours, a physician, ARNP, or PA must see and assess the person before seclusion or restraint can be re-ordered. The results of this assessment must be documented. Seclusion or restraint use exceeding 24 hours requires the notification of the Facility Administrator or designee.

4. All seclusion and restraint orders must be signed within 24 hours of the initiation of and cannot be issued as a standing order or on an as-needed basis.
5. The order must include the specific behavior prompting the use of seclusion or restraint, the time limit for seclusion or restraint, and the behavior necessary for the person's release. Additionally, for restraint, the order must contain the type of restraint ordered and the positioning of the person, including possibly elevating the person's head for respiratory and other medical safety considerations. Consideration must be given to age, physical fragility, and physical disability when ordering restraint type.
6. Every secluded or restrained person must be immediately informed of the behavior that resulted in the seclusion or restraint and the behavior and the criteria reflecting absence of imminent danger that are necessary for release.
7. For each use of seclusion or restraint, the following information must be documented in the person's medical record: the emergency situation resulting in the seclusion or restraint event; alternatives or other less restrictive interventions attempted, as applicable, or the clinical determination that less restrictive techniques could not be safely applied; the name and title of the staff member initiating the seclusion or restraint; the date/time of initiation and release; the person's response to seclusion or restraint, including the rationale for continued use of the intervention; and that the person was informed of the behavior that resulted in the seclusion or restraint and the criteria necessary for release.
8. For persons under the age of 18, the facility must notify the parent(s) or legal guardian(s) of the person who has been restrained or placed in seclusion as soon as possible, but no later than 24 hours, after the initiation of each seclusion or restraint event. This notification must be documented in the person's medical record, including the date and time of notification and the name of the staff person providing the notification.
9. For each use of seclusion or restraint, the following information must be documented in the person's medical record:
 - The emergency situation resulting in the seclusion or restraint event;
 - Alternatives or other less restrictive interventions attempted, as applicable, or the clinical determination that less restrictive techniques could not be safely applied;
 - The name and title of the staff member initiating the seclusion or restraint;
 - The date/time of initiation and release;

- The person's response to seclusion or restraint, including the rationale for continued use of the intervention; and
- That the person was informed of the behavior that resulted in the seclusion or restraint and the criteria necessary for release.

During Seclusion or Restraint

Monitoring the physical and psychological well-being of the person who is secluded or restrained must include but is not limited to: respiratory and circulatory status; signs of injury; vital signs; skin integrity; and any special requirements specified by facility policies. This monitoring must be conducted by trained staff as required in rule.

When restraint is initiated, nursing staff must see and assess the person as soon as possible but no later than 15 minutes after initiation and at least every hour thereafter. The assessment must include checking the person's circulation and respiration, including necessary vital signs (pulse and respiratory rate at a minimum). Documentation of the observations and the staff person's name must be recorded at the time the observation takes place.

A person over age 12 who is secluded must be observed by trained staff every 15 minutes. At least one observation an hour will be conducted by a 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 the first hour and then at least every 15 minutes thereafter.

During each period of seclusion or restraint, the person must be offered reasonable opportunities to drink and toilet as requested. In addition, the person who is restrained must be offered opportunities to have range of motion at least every two hours to promote comfort. Each facility must have written policies and procedures specifying the frequency of providing drink, toileting, and check of bodily positioning to avoid traumatizing a person and retaining the person's maximum degree of dignity and comfort during the use of bodily control and physical management techniques.

Responders must pay close attention to respiratory function of the person during containment and restraint. All staff involved must observe the person's respiration, coloring, and other possible signs of distress and immediately respond if the person appears to be in distress. Responding to the person's distress may include repositioning the person, discontinuing the seclusion or restraint, or summoning medical attention, as necessary.

When a person demonstrates a need for immediate medical attention in the course of an episode of seclusion or restraint, the seclusion or restraint must be discontinued, and immediate medical attention must be obtained.

Release from Seclusion or Restraint and Post-Release Activities

A person must be released from seclusion or restraint as soon as he or she is no longer an imminent danger to self or others. Upon release from seclusion or restraint, the person's physical condition must be observed, evaluated, and documented by trained staff. Documentation must also include the name and title of the staff releasing the person and the date and time of release.

After a seclusion or restraint event, a debriefing process must take place to decrease the likelihood of a future seclusion or restraint event for the person and to provide support.

Each facility must develop policies to address:

- A review of the incident with the person who was secluded or restrained. The person must be given the opportunity to process the seclusion or restraint event as soon as possible but no longer than within 24 hours of release. This debriefing discussion must take place between the person and either the recovery team or another preferred staff member. This review must seek to understand the incident within the framework of the person's life history and mental health issues. It should assess the impact of the event on the person and help the person identify and expand coping mechanisms to avoid the use of seclusion or restraint in the future. The discussion must include constructive coping techniques for the future. A summary of this review should be documented in the person's medical record.
- A review of the incident with all staff involved in the event and supervisors or administrators. This review must be conducted as soon as possible after the event and must address: the circumstances leading to the event, the nature of de-escalation efforts and alternatives to seclusion and restraint attempted, staff response to the incident, and ways to effectively support the person's constructive coping in the future and avoid the need for future seclusion or restraint. The outcomes of this review should be documented by the facility for purposes of continuous performance improvement and monitoring. The review findings must be forwarded to the Seclusion and Restraint Oversight Committee, and
- Support for other persons served and staff, as needed, to return the unit to a therapeutic milieu.

Within two working days after any use of seclusion or restraint, the recovery team must meet and review the circumstances preceding its initiation and review the person's recovery plan and personal safety plan to determine whether any changes are needed in order to prevent the further use of seclusion or restraint. The recovery team must also assess the impact the event had on the person and provide any counseling, services, or treatment that may be necessary as a result. The recovery team must analyze the person's clinical record for trends or patterns relating to conditions, events, or the presence of other persons immediately before or upon the onset of the behavior warranting the seclusion or restraint, and upon the person's release from seclusion. The recovery team must review the effectiveness of the emergency intervention and develop more appropriate therapeutic interventions. Documentation of this review must be placed in the person's clinical record.

Oversight

Every facility permitting use of restraint or seclusion is required to have a **Seclusion and Restraint Oversight Committee**. This is a group of people at an agency or facility that monitors the use of seclusion and restraint at the facility. This committee is intended to assist in the reduction of seclusion and restraint use at the agency or facility. Membership includes, but is not limited to, the facility administrator/designee, medical staff, quality assurance staff, and a peer specialist or advocate, if employed by the facility or otherwise available. If no such person is employed by the facility, an external peer specialist or advocate may be appointed. [65E-5.100(15), F.A.C.]

The Seclusion and Restraint Oversight Committee must conduct timely reviews of each use of seclusion and restraints and monitor patterns of use, for the purpose of assuring least restrictive approaches are utilized to prevent or reduce the frequency and duration of use.

Reporting

All facilities are required to report each seclusion and restraint event to the Department of Children and Families. This reporting must be done electronically using the Department's web-based application either directly via the data input screens or indirectly via the File Transfer Protocol batch process. The required reporting elements are:

- Provider tax identification number;
- Person's social security number and identification number;

- Date and time the seclusion or restraint event was initiated;
- Discipline of the person ordering the seclusion or restraint;
- Discipline of the person implementing the seclusion or restraint;
- Reason seclusion or restraint was initiated;
- Type of restraint used;
- Whether significant injuries were sustained by the person; and
- Date and time seclusion or restraint was terminated.

Facilities must report seclusion and restraint events on a monthly basis. Events that result in death or significant injury either to a staff member or person must be reported to the department's web based system in accordance with department operating procedures.

All facilities that are subject to CMS Conditions of Participation for Hospitals, 42 Code of Federal Regulations, part 482, must report to CMS any death that occurs in the following circumstances:

- While a person is restrained or secluded;
- Within 24 hours after release from seclusion or restraint; or
- Within one week after seclusion or restraint, where it is reasonable to assume that use of the seclusion or restraint contributed directly or indirectly to the person's death.

Each death associated with restraint or seclusion must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the persons' death. A report must simultaneously be submitted to the Substance Abuse and Mental Health Director/Designee in the Mental Health Program Office headquarters in Tallahassee, FL. The address is: 1317 Winewood Blvd., Tallahassee, FL, 32399-0700. The Department is required to collect and review the data on a monthly basis. The Director of Mental Health must be informed of any deaths or significant injuries related to seclusion or restraint and significant trends regarding seclusion and restraint use.

When **Individual Behavioral Management** is required, it can only be implemented in compliance with chapter 65E-5.1602, F.A.C.. When an individualized treatment plan requires interventions beyond the existing unit rules of conduct, the person must be included, and the person's treatment plan must reflect:

- Documentation, signed by the physician that the person's medical condition does not exclude the proposed interventions;
- Consent for the treatment to be provided;
- A general description of the behaviors requiring the intervention, which may include previous emergency interventions;
- Antecedents of that behavior;
- The events immediately following the behavior;
- Objective definition of the target behaviors, such as specific acts, level of aggression, encroachment on others' space, self-injurious behavior or excessive withdrawal;
- Arrangements for the consistent collection and recording of data;
- Analysis of data;
- Based on data analysis, development of intervention strategies, if necessary;
- Development of a written intervention strategy that includes criteria for starting and stopping specific staff interventions and the process by which they are to occur;
- Continued data collection, if interventions are implemented; and
- Periodic review and revision of the plan based upon data collected.

Emergency Orders for Psychiatric Medications

The Baker Act statute and rules prohibit the administration of psychiatric medication unless a competent adult has provided express and informed consent to those medications, or if not competent to provide this consent, it be provided by the person's, guardian, guardian advocate, or a health care surrogate/proxy as specified by law. The only exception is due to imminent danger in which a physician can order an Emergency Treatment Order (ETO) for such medications.

Among the requirements governed in the Florida Administrative Code concerning Right to Quality Treatment [s65E-5.180(5), F.A.C.] includes that mental health services provided must comply with the following standards: The development and implementation of protocols or procedures for conducting and documenting the following must be accomplished by each facility:

- Determination of a person's competency to consent to treatment within 24 hours after admission;
- Identification of a duly authorized decision-maker for the person upon any person being determined not to be competent to consent to treatment;
- Obtaining express and informed consent for treatment and medications before administration, except in an emergency; and
- Required involvement of the person and guardian, guardian advocate, or health care surrogate or proxy, in treatment and discharge planning.

The Baker Act specifically defines "Express and informed consent" and "incompetent to consent to treatment" as follows:

- **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. [394.455(9), FS]
- **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. [394.455(15), FS]

An individual, if competent has the right to refuse psychiatric treatment, even if held for involuntary examination or court ordered for involuntary placement. Only if a court has appointed a guardian or guardian advocate or a physician has determined the individual lacks the competence to prove express and informed consent and a health care surrogate/proxy has provided substitute decision-making, can psychiatric treatment be administered, short of an emergency treatment order.

Initiation of an Emergency Treatment Order For Psychiatric Medications

[65E-5.1703(1), F.A.C.]

An emergency treatment order for psychotropic medication supersedes the person's right to refuse psychotropic medication if based upon the physician's assessment that the individual is not capable of exercising voluntary control over his or her own symptomatic behavior and that these uncontrolled symptoms and behavior are an imminent danger to the person or to others in the facility. When emergency treatment with psychotropic

medication is ordered for a minor or an incapacitated or incompetent adult, facility staff must document attempts to promptly contact the guardian, guardian advocate, or health care surrogate or proxy to obtain express and informed consent for the treatment in advance of administration where possible and if not possible, as soon thereafter as practical.

An emergency treatment order must be consistent with the least restrictive treatment interventions, including the emergency administration of psychotropic medications or the emergency use of restraints or seclusion.

To assure the safety and rights of the person, and since emergency treatment orders by a physician absent express and informed consent are permitted only in an emergency, any use of psychotropic medications other than rapid response psychotropic medications requires a detailed and complete justification for the use of such medication. Both the nature and extent of the imminent emergency and any orders for the continuation of that medication must be clearly documented daily as required above.

The need for each emergency treatment order must be documented in the person's clinical record in the progress notes and in the section used for physician's orders and must describe the specific behavior which constitutes a danger to the person or to others in the facility, and the nature and extent of the danger posed.

The issuance of an emergency treatment order requires a physician's review of the person's condition for causal medical factors, such as insufficiency of psychotropic medication blood levels, as determined by drawing a blood sample; medication interactions with psychotropic or other medications; side effects or adverse reactions to medications; organic, disease or medication based metabolic imbalances or toxicity; or other biologically based or influenced symptoms.

All emergency treatment orders for medications may only be written by a physician as defined in the Baker Act. The physician must review, integrate and address such metabolic imbalances in the issuance of an emergency treatment order.

The physician's initial order for emergency treatment may be by telephone but such a verbal order must be reduced to writing upon receipt and signed by a physician within 24 hours. Each emergency treatment order is only valid and is only the authority for emergency treatment for a period not to exceed 24 hours.

Upon the initiation of an emergency treatment order the facility must, within two court working days, petition the court for the appointment of a guardian advocate to provide

express and informed consent, unless the person voluntarily withdraws a revocation of consent or requires only a single emergency treatment order for emergency treatment. If a second emergency treatment order is issued for the same person within any 7 day period, the petition for the appointment of a guardian advocate to provide express and informed consent must be filed with the court within 1 court working day.

While awaiting court action, treatment may be continued without the consent of the person, but only upon the daily written emergency treatment order of a physician who has determined that the person's behavior each day during the wait for court action continues to present an immediate danger to the safety of the person or others and who documents the nature and extent of the emergency each day of the specific danger posed. Such orders may not be written in advance of the demonstrated need for same.

Health Care Surrogate and Proxy

65E-5.2301, F.A.C.

When an adult has been determined by a physician to be incompetent to consent to his or her own treatment, it is critical for facility staff to determine if a health care advance directive had been prepared by the individual at a previous time when competent to do so. Such an advance directive is likely to have named a person to make health care decisions on behalf of the individual and to include preferences for care. Some definitions for this substitute decision making include:

- **Advance directive** means a witnessed written document described in Section 765.101, F.S.
- **Health care surrogate** means any competent adult expressly designated by a principal's advance directive to make health care decisions on behalf of the principal upon the principal's incapacity.
- **Health care proxy** means a competent adult who has not been expressly designated by an advance directive to make health care decisions for a particular incapacitated individual, but is authorized pursuant to Section 765.401, F.S., to make health care decisions for such individual.

When a person hasn't completed a health care advance directive or hasn't named a surrogate or a named surrogate is no longer able or willing to serve, a proxy can be named by the facility from a list in the order of listing, as follows [s.765.401(1), FS]:

1. Judicially appointed guardian of the patient

2. Spouse;
3. Adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation;
4. Parent of the patient;
5. Adult sibling of the patient or, if the patient has more than one sibling, a majority of the adult siblings who are reasonably available for consultation;
6. Adult relative of the patient who has exhibited special care and concern for the patient and who has maintained regular contact with the patient and who is familiar with the patient's activities, health, and religious or moral beliefs; or
7. Close friend of the patient.
8. LCSW selected by the provider's bioethics committee and must not be employed by the provider. If the provider doesn't have a bioethics committee, then such a proxy may be chosen through an arrangement with the bioethics committee of another provider. Documentation of efforts to locate proxies from prior classes must be recorded in the patient record.

Any health care decision made must be based on the surrogate or proxy's informed consent and on the decision the proxy reasonably believes the patient would have made under the circumstances. If there is no indication of what the individual would have chosen, the proxy may consider the individual's best interest in deciding that proposed treatments are to be withheld or that treatments currently in effect are to be withdrawn.

When a Health Care Surrogate or Proxy has been designated to make medical and psychiatric decisions for an adult who has been determined by a physician to be incompetent to make his or her own decisions, the following requirements govern this process

1. During the interim period between the time a person is determined to be incompetent to consent to treatment by one or more physicians and the time a guardian advocate is appointed by a court to provide express and informed consent to the person's treatment, a health care surrogate designated by the person may provide such consent to treatment.
2. In the absence of an advance directive or when the health care surrogate named in the advance directive is no longer able or willing to serve, a health care proxy, may also provide interim consent to treatment.
3. Upon the documented determination that a patient is incompetent to make health care decisions for himself or

herself by one or more physicians, the facility must notify the surrogate or proxy in writing that the conditions under which he or she can exercise his or her authority under the law have occurred. Recommended form CF-MH 3122, Feb. 05, “Certification of Person’s Incompetence to Consent to Treatment and Notification of Health Care Surrogate/Proxy,” may be used for this purpose.

4. If the surrogate selected by the person is not available or is unable to serve or if no advance directive had been prepared by the person, a proxy may be designated as provided by law. Recommended form CF-MH 3123, Feb. 05, “Affidavit of Proxy,” may be used for this purpose.
5. A petition for adjudication of incompetence to consent to treatment and appointment of a guardian advocate must be filed with the court within 2 court working days of the determination of the patient’s incompetence to consent to treatment by one or more physicians, Recommended form CF-MH 3106, “Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate,” may be used for this purpose.
6. The facility must immediately provide to the health care surrogate or proxy the same information required by statute to be provided to the guardian advocate. In order to protect the safety of the person, the facility must make available to the health care surrogate or proxy the training required of guardian advocates and ensure that the surrogate or proxy communicate with the person and person’s physician prior to giving express and informed consent to treatment.
7. Each designated receiving and treatment facility must adopt policies and procedures specifying how its direct care and assessment staff will be trained on how to honor each person’s treatment preferences as detailed in his or her advance directives. The person being served must be provided information about advance directives and offered assistance in completing an advance directive, if willing and able to do so.

Specialized on-line Baker Act courses can be found at
<http://www.bakeracttraining.org>.

For further assistance visit: <http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml> to view
 DCF’s most Frequently Asked Questions list.

Quick Reference Guide to Restraint and Seclusion

(This guide does not substitute for use of state and federal statutes and regulations. The most restrictive provision applies. Organizations accredited by The Joint Commission must also comply with Commission standards)

State Baker Act Statute and Rules	Federal Centers for Medicare and Medicaid (CMS)
Legal Citation	
s. 394.455 and 394.459 (4), F.S. Chapter 65E-5.180, F.A.C.	Social Security Act (42 U.S.C. 1301 and 1395hh, Subpart B Administration Sec. 482.13 (e))
Application	
All designated receiving and treatment facilities as well as other hospitals holding persons under the authority of the Baker Act.	Hospitals participating in federal Medicare and Medicaid programs
Principles	
<p>A facility can't use seclusion/restraint for punishment, to compensate for inadequate staffing, or for the convenience of staff.</p> <p>Facilities shall ensure that all staff are made aware of these restrictions on the use of seclusion/restraint and shall make/maintain records demonstrating this information has been conveyed to individual staff.</p> <p>DCF must adopt rules establishing forms/procedures relating to rights/privileges of persons seeking mental health treatment from Baker Act facilities;</p>	<p>Persons have a right to be free from seclusion and restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.</p> <p>Seclusion or a restraint can only be used in emergency conditions if needed to ensure the patient's physical safety and less restrictive interventions have been determined to be ineffective.</p>
Definitions	
<p>Restraint means</p> <p>(a) Physical device, method, or drug used to control behavior. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the individual's body so that he or she cannot easily remove the restraint and which restricts freedom of movement or normal access to one's body.</p> <p>(b) A drug used as a restraint is a medication used to control the person's behavior or to restrict his or her freedom of movement and is not part of the standard treatment regimen of a person with a diagnosed mental illness who is a client of the department. Physically holding a person during a procedure to forcibly administer psychotropic medication is a physical restraint.</p> <p>(c) Restraint does not include physical devices, such as orthopedically prescribed appliances, surgical dressings and bandages, supportive body bands, or other physical holding when necessary for routine physical examinations and tests; or for purposes of orthopedic, surgical, or other similar medical treatment; when used to provide support for the achievement of functional body position or proper balance; or when used to protect a person from falling out of bed.</p> <p>Seclusion means the physical segregation of a person in any fashion or involuntary isolation of a person in a room or area from which the person is prevented from leaving. The prevention may be by physical barrier or by a staff member who is acting in a manner, or who is physically situated, so as to prevent the person from leaving the room or area. For purposes of this chapter, the term does not mean isolation due to a person's medical condition or symptoms.</p> <p>Protective medical devices mean a specific category of medical restraint that includes devices, or combinations of devices, to restrict movement for purposes of protection from falls or complications of physical care, such as geri-chairs, posey vests, mittens, belted wheelchairs, sheeting, and bed rails. The requirements for the use and documentation of use of these devices are for specific medical purposes rather than for behavioral control.</p> <p>Use of these devices are different from the general requirements for the use of restraint in this rule.</p> <p>Emergency treatment order (ETO) means a written emergency order for psychotropic medications, as described in Rule 65E-5.1703, F.A.C.; or a written emergency order for seclusion or restraint, as described in subsection (7) of Rule 65E-5.180, F.A.C., of this rule chapter.</p>	<p>Restraint includes either a physical restraint or a drug that is being used as a restraint.</p> <p>Physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.</p> <p>Drug used as a restraint is a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.</p> <p>Seclusion is the involuntary confinement of a person in a room or an area where the person is physically prevented from leaving.</p> <p>Emergency is a situation where a person's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the person, or other patients, staff, or others.</p>

State Baker Act Statute and Rules	Federal Centers for Medicare and Medicaid (CMS)
Required of Facilities Facilities must develop: <ul style="list-style-type: none"> Criteria, procedures, and required staff training for any use of close or elevated levels of supervision, of restraint, seclusion, or isolation, or of emergency treatment orders, and for the use of bodily control and physical management techniques. Procedures for documenting, monitoring, and requiring clinical review of all uses of the procedures above and for documenting and requiring review of any incidents resulting in injury. 	N/A
Training Required Staff must be trained as part of orientation and subsequently on at least an annual basis. Staff responsible for following actions must demonstrate relevant competency in following areas before participating in a seclusion/restraint event or related assessment, or before monitoring/providing care during an event: <ul style="list-style-type: none"> Strategies designed to reduce confrontation and to calm/comfort people, including the development/use of a personal safety plan, Use of nonphysical intervention skills as well as bodily control/physical management techniques, based on a team approach, to ensure safety, Observing for/responding to signs of physical/psychological distress during seclusion/restraint event, Safe application of restraint devices, Monitoring the physical/psychological well-being of person who is restrained/secluded, including but not limited to: respiratory/circulatory status, skin integrity, vital signs, and any special requirements specified by facility policy associated with the one hour face-to-face evaluation, Clinical identification of specific behavioral changes that indicate restraint/seclusion is no longer necessary, The use of first aid techniques, and Certification in the use of cardiopulmonary resuscitation, including required periodic recertification. The frequency of training for cardiopulmonary resuscitation will be in accordance with certification requirements 	All staff who have direct patient contact must have ongoing education and training in the proper and safe use of seclusion and restraint application and techniques and alternative methods for handling behavior, symptoms, and situations that traditionally have been treated through the use of restraints and seclusion.
Use of Restraints and Seclusion Seclusion/restraint use cannot be based on the person's seclusion/restraint use history or solely on a history of dangerous behavior. Dangerous behaviors include those behaviors that jeopardize the physical safety of oneself or others. Each person shall be searched for contraband before or immediately after being placed into seclusion or restraints. <ol style="list-style-type: none"> A registered nurse or highest level staff member immediately available and who is trained in seclusion/restraint procedures may initiate seclusion/restraint in an emergency when danger to self/others is imminent. An order must be obtained from a physician, ARNP, or PA, if permitted by the facility to order seclusion/restraint and stated within their professional protocol. The treating physician must be consulted as soon as possible if not ordered by the physician. An examination of the person conducted within 1 hour by the physician or may be delegated to an ARNP or PA, or RN, if authorized by the facility and trained in seclusion/restraint procedures. Must include a face-to-face assessment of person's medical/behavioral condition, a review of clinical record for any pre-existing medical diagnosis/physical condition which may contraindicate the use of seclusion/restraint, a review of medication orders including an assessment of the need to modify such orders, and assessment of need to elevate the person's head and torso during restraint. A psychologist may conduct only the behavioral assessment portion of the assessment if authorized by the facility and trained in seclusion/restraint procedures. Documentation of the comprehensive examination, including time/date completed, shall be included in medical record. If the face-to-face evaluation is conducted by a trained RN, the physician responsible for the care of the person must be consulted as soon as possible after the evaluation is completed. All orders signed within 24 hours of initiation - no standing order or as-needed basis. <p style="text-align: center;">—Continued—</p>	The use of restraints or seclusion to manage behavior is an emergency measure that should be reserved for those occasions when an unanticipated, severely aggressive or destructive behavior places the patient or others in imminent danger. Restraints and seclusion should only be used: <ul style="list-style-type: none"> When less restrictive measures have been found to be ineffective to protect the patient or others from harm; Upon order of a physician In accordance with a written modification to the patient's plan of care; When employing safe appropriate restraining techniques; When the treating physician has been consulted ASAP if not ordered by the treating physician; and

State Baker Act Statute and Rules	Federal Centers for Medicare and Medicaid (CMS)
Use of Restraints and Seclusion (Continued)	
<p>4. Order must include the specific behavior prompting the use of seclusion/restraint, time limit, and behavior necessary for release. For restraint, order must contain type of restraint ordered and positioning of person and other medical safety considerations. Consideration must be given to age, physical fragility, and physical disability.</p> <p>5. Every person must be immediately informed of the behavior that resulted in seclusion/restraint and the behavior/criteria reflecting absence of imminent danger necessary for release.</p> <p>6. Medical record must document: the emergency situation resulting in the seclusion/restraint event; alternatives/less restrictive interventions attempted, as applicable; name and title of staff initiating seclusion/restraint; date/time of initiation/release; person's response to</p> <p>7. Facility must notify the parent(s) or legal guardian(s) of a minor who has been restrained/ secluded ASAP, but no later than 24 hours, after the initiation of each event. Notification must be documented in medical record, including the date/ time of notification and name of staff providing notification.</p>	When a physician sees and evaluates the need for restraint or seclusion within 1 hour after initiation.
Length of Restraint or Seclusion	
<p>Each written order for seclusion or restraint is limited to</p> <ul style="list-style-type: none"> ▪ Four hours for adults, age 18 and over; ▪ Two hours for children and adolescents age nine through 17; or ▪ One hour for children under age nine. 	<p>Same as Florida</p> <p>Ended at the earliest possible time, regardless of the length of the order.</p>
Renewal of Order	
A seclusion/restraint order may be renewed with these limits for up to a total of 24 hours, after consultation and review by a physician, ARNP, or PA in person, or by telephone with a RN who has physically observed and evaluated the person. When order has expired after 24 hours, a physician, ARNP, or PA must see and assess the person before seclusion/restraint can be re-ordered. The results of this assessment must be documented. Seclusion/restraint use exceeding 24 hours requires notification of Facility Administrator/designee.	<p>The original order may only be renewed in accordance with these limits for up to a total of 24 hours.</p> <p>If discontinued prior to expiration of original order, new order required prior to reapplication.</p> <p>Face-to-face by physician not required to renew within 24 hours, but must return to renew if restraint or seclusion exceed 24 hour total.</p>
Monitoring	
<p>Monitoring physical/psychological well-being of person who is secluded/restrained must include but is not limited to: respiratory and circulatory status; signs of injury; vital signs; skin integrity; and any special requirements specified by facility policies and be conducted by trained staff</p> <p>When restraint is initiated, nursing staff must see/assess the person ASAP but no later than 15 minutes after initiation and at least every hour thereafter. The assessment must include checking circulation and respiration, necessary vital signs (pulse and respiratory rate at a minimum). Documentation of observations and staff name must be recorded at the time the observation takes place.</p> <p>A person over age 12 who is secluded must be observed by trained staff every 15 minutes. At least one observation an hour must be conducted by a 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 the first hour and then at least every 15 minutes thereafter.</p> <p>During each period of seclusion/restraint, person must be offered reasonable opportunities to drink and toilet as requested and be offered opportunities to have range of motion at least every two hours to promote comfort. Each facility must have written policies and procedures on these issues to avoid traumatizing person and retaining person's maximum degree of dignity/comfort during the use of bodily control/physical management techniques.</p> <p>Responders must pay close attention to respiratory function during containment/ restraint. All staff involved must observe person's respiration, coloring, and other possible signs of distress and immediately respond if person appears to be in distress. Responding to the person's distress may include repositioning, discontinuing seclusion/restraint, or summoning medical attention. When person demonstrates need for immediate medical attention, the seclusion/restraint must be discontinued, and immediate medical attention must be obtained.</p>	<p>The condition of the patient who is in a restraint or in seclusion must continually be assessed, monitored, and reevaluated.</p> <p>Continuous assessment and reevaluation of the patient's condition.</p>

State Baker Act Statute and Rules	Federal Centers for Medicare and Medicaid (CMS)
Clinical Oversight <p>Every facility using restraint/seclusion must have a Seclusion and Restraint Oversight Committee, to monitors the use of seclusion/ restraint at the facility and to assist in the reduction of seclusion/restraint use. The Committee must conduct timely reviews of each use of seclusion/restraints and monitor patterns of use to assure least restrictive approaches are used and to prevent or reduce the frequency and duration of use.</p>	NA
Specific Prohibition <p>PRN and Standing Orders may not be used to authorize restraints or seclusion or other specified actions, as follows:</p> <ul style="list-style-type: none"> ■ Pro re nata (PRN) means an individualized order for the care of an individual person which is written after the person has been seen by the practitioner, which order sets parameters for attending staff to implement according to the circumstances set out in the order. A PRN order shall not be used as an emergency treatment order. ■ Standing order means a broad protocol or delegation of medical authority that is generally applicable to a group of persons, hence not individualized. As limited by this chapter, it prohibits improper delegations of authority to staff that are not authorized by the facility, or not permitted by practice licensing laws, to independently make such medical decisions; such as decisions involving determination of need, medication, routes, dosages for psychotropic medication, or use of restraints or seclusion upon a person. <p>Other prohibitions include:</p> <ul style="list-style-type: none"> ■ Cannot be located in areas in view by persons other than involved staff or where exposed to potential injury by other persons. ■ Cannot be based on the person's seclusion or restraint use history or solely on a history of dangerous behavior. Dangerous behaviors include those behaviors that jeopardize the physical safety of oneself or others. ■ Prone position can't be used unless required by the immediate situation to prevent imminent serious harm to the person or others and repositioned as quickly as possible. Objects that impair respiration cannot be placed over a person's face. In situations where precautions need to be taken to protect staff, staff may wear protective gear. ■ Person's hands shall not be secured behind the back during containment or restraint. ■ Person clothed appropriately for temperature and at no time shall a person be placed in seclusion or restraint in a nude or semi-nude state. ■ May not be used simultaneously for children less than 18 years of age. <p>The use of walking restraints is prohibited except for purposes of off-unit transportation and may only be used under direct observation of trained staff where staff maintains continual visual contact of the person and is within close physical proximity to the person at all times.</p>	<p>Restraint and seclusion may not be used simultaneously unless the patient is:</p> <ul style="list-style-type: none"> ■ Continually monitored face-to-face by an assigned staff member; or ■ Continually monitored by staff using both video and audio equipment. <p>This monitoring must be in close proximity to the patient.</p> <p>PRN and standing orders should never be used with or as a part of seclusion and restraints.</p>
Release from Restraints and Seclusion <p>A person must be released from seclusion or restraint as soon as he or she is no longer an imminent danger to self or others. Release from seclusion/restraint must occur as soon as the person no longer appears to present imminent danger to self/others. Upon release from seclusion/ restraint, the person's physical condition must be observed, evaluated, and documented by trained staff. Documentation must also include: the name and title of the staff releasing the person; and date/time of release.</p> <p>After a seclusion or restraint event, a debriefing process must take place to decrease the likelihood of a future seclusion/restraint event for the person and to provide support. Each facility must develop policies to address:</p> <ul style="list-style-type: none"> ■ A review of the incident with the person who was secluded/restrained. Person must be given opportunity to process the seclusion/restraint event ASAP as soon as possible but no longer than 24 hours after release. This debriefing discussion must take place between person and either the recovery team or another preferred staff member to understand the incident within the framework of the person's life history and MH issues. It should assess the impact of the event on the person and help the person identify and expand coping mechanisms to avoid the use of seclusion/restraint in future. A review summary should be documented in person's medical record. <p style="text-align: center;">—Continued—</p>	<p>Restraints and seclusion should be discontinued at the earliest possible time; as soon as the patient can commit to safety and no longer pose a threat to themselves or others.</p>

State Baker Act Statute and Rules	Federal Centers for Medicare and Medicaid (CMS)
Release from Restraints and Seclusion CONTINUED	
<ul style="list-style-type: none"> ▪ A review of the incident with all staff involved in the event and supervisors or administrators. This review must be conducted ASAP after the event and must address: the circumstances leading to the event, the nature of de-escalation efforts and alternatives to seclusion/restraint attempted, staff response to the incident, and ways to effectively support the person's constructive coping in the future and avoid the need for future seclusion/restraint. The outcomes of this review should be documented for continuous performance improvement and monitoring. The review findings must be forwarded to the Seclusion and Restraint Oversight Committee, and ▪ Support for other persons served and staff, as needed, to return the unit to a therapeutic milieu. <p>Within two working days after any use of seclusion or restraint, the recovery team must meet and review the circumstances preceding its initiation and review the person's recovery plan and personal safety plan to determine whether any changes are needed in order to prevent the further use of seclusion/restraint. The recovery team must also assess the impact the event had on the person and provide any counseling, services, or treatment that may be necessary as a result. The recovery team must analyze the person's clinical record for trends or patterns relating to conditions, events, or the presence of other persons immediately before or upon the onset of the behavior warranting the seclusion/restraint, and upon the person's release from seclusion. The recovery team must review the effectiveness of the emergency intervention and develop more appropriate therapeutic interventions. Documentation of this review must be placed in the person's clinical record.</p>	
Reporting Required	
<p>All facilities are required to report each seclusion and restraint event to the Department of Children and Families. This reporting must be done electronically using the Department's web-based application either directly via the data input screens or indirectly via the File Transfer Protocol batch process. The required reporting elements are:</p> <ul style="list-style-type: none"> ▪ Provider tax identification number; ▪ Person's social security number and identification number; ▪ Date and time the seclusion or restraint event was initiated; ▪ Discipline of the person ordering the seclusion or restraint; ▪ Discipline of the person implementing the seclusion or restraint; ▪ Reason seclusion or restraint was initiated; ▪ Type of restraint used; ▪ Whether significant injuries were sustained by the person; and ▪ Date and time seclusion or restraint was terminated. <p>Facilities must report seclusion and restraint events on a monthly basis. Events that result in death or significant injury either to a staff member or person must be reported to the department's web based system in accordance with department operating procedures.</p>	<p>All facilities that are subject to CMS Conditions of Participation for Hospitals, 42 Code of Federal Regulations, part 482, must report to CMS any death that occurs in the following circumstances:</p> <ul style="list-style-type: none"> ▪ While a person is restrained or secluded; ▪ Within 24 hours after release from seclusion or restraint; or ▪ Within one week after seclusion or restraint, where it is reasonable to assume that use of the seclusion or restraint contributed directly or indirectly to the person's death.
Required of Facilities	
<p>Facilities must develop:</p> <ul style="list-style-type: none"> ▪ Criteria, procedures, and required staff training for any use of close or elevated levels of supervision, of restraint, seclusion, or isolation, or of emergency treatment orders, and for the use of bodily control and physical management techniques. ▪ Procedures for documenting, monitoring, and requiring clinical review of all uses of the procedures above and for documenting and requiring review of any incidents resulting in injury. 	N/A

Federal CMS regulations defines physical restraints as “any manual method or physical or mechanical device that restricts freedom of movement or normal access to one’s body, material, or equipment, attached or adjacent to the patient’s body that he or she cannot easily remove. Holding a patient in a manner that restricts his/her movement constitutes restraint for that patient.”

According to federal regulations, an object may be a restraint by functional definition; that is, when an object restricts a patient’s movement or access to his or her body, it is a restraint. Under this definition, all sorts of more commonly used hospital devices and practices could meet the federal definition of a restraint, such as side rails or tucking a sheet in tightly. Medical restraints may be used to limit mobility, temporarily immobilizing a person related to a medical, post-surgical or dental procedure. In such cases, it would not be considered a restraint. However, if the same intervention is used because of an unanticipated outburst of severe aggression or destructive behavior that poses an imminent danger to the person or others, it is a restraint. The federal behavior management standard doesn’t apply to situations where the hospital wishes to restrain a person to address the risk of a fall or to control wandering. The use of restraint for a non-violent or non-aggressive, otherwise cooperative

person may be governed by the medical/surgical care restraint standards.

In 2009, The Joint Commission adopted requirements based on the CMS requirements for only for hospitals that use Joint Commission accreditation for deemed status purposes. For example,

- Hospitals that use The Joint Commission accreditation for deemed status purposes must comply with standards PC.03.05.01-PC .03.05.19; these hospitals do not have to follow standards PC.03.02.01-PC03.03.031 and RC.02.01.05 in the Record of Care chapter.
- Hospitals that do not use The Joint Commission accreditation for deemed status purposes must continue to comply with the current The Joint Commission standards PC.03.02.01-PC.03.03.031 and RC.02.01.05.

While these standards are quite similar to those found in the state Baker Act rules and by the federal Centers for Medicare and Medicaid (CMS), they are not identical. Facilities accredited by The Joint Commission must be in compliance with The Joint Commission standards, unless the standards required by the Baker Act or CMS are more stringent on a given subject.

Involuntary Inpatient Placement

s. 394.467, F.S. Chapter 65E-5.290, F.A.C.

The Baker Act encourages people to seek and receive voluntary psychiatric care, but only when they are able to understand the decision and its consequences and are able to fully exercise their rights for themselves.

When individuals cannot understand and cannot fully exercise their rights due to the severity of their condition, the law requires that they be extended the due process rights assured under the involuntary provisions of the Baker Act.

Involuntary inpatient placement (commitment) only occurs after an examination and court hearing.

Criteria

s. 394.467(1), F.S.

A person may be involuntarily placed for inpatient treatment upon a finding of the court by clear and convincing evidence that he or she has a mental illness **and** because of his/her mental illness:

1. He/she has **refused** voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; **or** he/she **is unable to determine** for himself or herself whether placement is necessary; **and**
2. He/she 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 himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; **or**
3. There is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; **and**
4. All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

Each allegation must be supported by evidence sufficient to reach the high level of evidence required in the involuntary inpatient placement hearing. Appellate courts have found that expert opinions and conclusions are not sufficient, without evidence to prove the allegations. The Florida Supreme Court defined clear and convincing evidence to mean:

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.

Initiation of Involuntary Inpatient Placement

s. 394.467(2), F.S.

After an examination, a person meeting involuntary inpatient placement criteria must be held pending a court hearing. The hearing is initiated based upon the recommendation of the administrator of a receiving facility where the person has been examined.

The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the individual within the preceding 72 hours, that the criteria for involuntary inpatient placement are met. The second opinion may be conducted by electronic means in which all parties maintain visual as well as audio communication. However, in counties of less than 50,000 population, if the administrator certifies that no psychiatrist or clinical psychologist is available to provide the second opinion, such second opinion may be provided by a licensed physician with postgraduate training and experience in diagnosis and treatment of mental and nervous disorders or by a psychiatric nurse.

The recommendation must be entered on an involuntary inpatient placement certificate (CF-MH 3032) or other form approved by the court, which authorizes the receiving facility to retain the person pending transfer to a treatment facility or completion of a hearing.

Petition for Involuntary Inpatient Placement

s. 394.467(3), F.S.

The administrator of the facility must file a petition for involuntary inpatient placement (CF-MH 3032) or other form approved by the court in the county where the person is located.

Upon filing, the clerk of the court must provide copies to the department, the person, the person's guardian or representative, and the state attorney and public defender of the judicial circuit in which the person is located. No fee can be charged for the filing of a petition for involuntary inpatient placement.

Appointment of Counsel

s. 394.467(4), F.S.

Within one court working day after the filing of a petition for involuntary inpatient placement, the court must appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court must immediately notify the public defender of such appointment.

Any attorney representing the person shall have access to the person, witnesses, and records relevant to the presentation of the person's case and shall represent the interests of the person, regardless of the source of payment to the attorney.

The state attorney for the circuit in which the person is located must represent the state, rather than the petitioning facility administrator, as the real party in interest in the proceeding.

Continuance of Hearing

s. 394.467(5), F.S.

The person is entitled, with the concurrence of the person's counsel, to at least one continuance of the hearing. The continuance shall be for a period of up to four weeks. This continuance may be obtained by counsel for the person by filing a Notice to Court – Request for Continuance of Involuntary Placement Hearing (CF-MH 3113) or other form approved by counsel or the court. Only the person has standing to make such a request; not the facility administrator or other parties.

Multiple continuances should not be sought to avoid placement unless legally sufficient express and informed consent has been obtained for the person's treatment. Otherwise, facilities lack authority to routinely treat many persons being held pending hearing.

Independent Expert Examination

s. 394.467(6)(a)2, F.S.

The person and the person's guardian or representative must be informed by the court of the right to an independent expert examination. Recommended form "Application for Appointment of Independent Expert Examiner" (CF-MH 3022) may be used. If the person cannot afford this examination, the court will provide for one. In August of 2005, the Chair of the Florida Trial Court Budget Commission advised the Chief Judges and Court Administrators of all circuits that while the court must appoint such an independent expert, the expert is a defense witness and not a court expense. The independent expert's

report is confidential and not discoverable, unless the expert is to be called as a witness for the person at the hearing.

Hearing on Involuntary Inpatient Placement

s. 394.467(6), F.S.

The court will hold the hearing on involuntary inpatient placement within five court working days after the petition is filed, unless a continuance is granted. The 5th DCA held that the computation of time for involuntary placement hearings exclude Saturdays, Sundays, and legal holidays when the time period is seven days or less. The hearing is not required to be held within five calendar days [DMH v. Pietilla, 33So. 3d 800 (Fla 5th DCA 2010)].

The hearing must be held in the county where the person is located and must be as convenient to the person as may be consistent with orderly procedure and must be conducted in physical settings not likely to be injurious to the person's condition.

- The court may appoint a magistrate to preside at the hearing.
- One of the two professionals who executed the involuntary placement certificate must be a witness. This role cannot be delegated to others.
- The testimony in the hearing must be given under oath, and the proceedings must be recorded. The person may refuse to testify at the hearing.
- If the court finds that the person's attendance at the hearing is not consistent with the best interests of the person, and the person's counsel does not object, the court may waive the presence of the person from all or any portion of the hearing. Several appellate courts have ruled that if the patient waives his/her right to be personally present and be constructively present through counsel, the trial court must certify through proper inquiry that a respondent's waiver is knowing, intelligent, and voluntary.

At the hearing on involuntary inpatient placement, the court must consider testimony and evidence regarding the person's competence to consent to treatment. If the court finds that the person is incompetent to consent to treatment, it must appoint a guardian advocate (CF-MH 3107 or other form approved by the court) as provided in s. 394.4598, F.S.

If the placement sought for the person is a state treatment facility, the court must receive and consider the information documented in the statutorily required Transfer Evaluation (CF-MH 3089). The person who conducted the transfer evaluation, or in the absence of the evaluator, another

knowledgeable staff employed by the community mental health center or clinic, must be present at the hearing to provide testimony as desired by the court.

If at any time prior to the conclusion of the hearing on involuntary inpatient placement it appears to the court that the person does not meet the criteria for involuntary inpatient placement but instead meets the criteria for substance abuse involuntary assessment, protective custody, or involuntary admission pursuant to s. 397.675, F.S., then the court may order (Order Requiring Involuntary Assessment and Stabilization for Substance Abuse and for Baker Act Discharge of Patient CF-MH 3114 or other form approved by the court) the person to be admitted for involuntary assessment for a period of five days pursuant to s. 397.6811, F.S. Thereafter, all proceedings must be governed by Chapter 397, F.S. (Marchman Act).

If the court concludes that the person meets the criteria for involuntary inpatient placement, it must enter an Order for Involuntary Inpatient Placement (CF-MH 3008 or other form approved by the court) for a period of up to six months that:

- the person be transferred to a treatment facility, *or*
- if the person is at a treatment facility, that the person be retained there, *or*
- be treated *at* any other appropriate receiving or treatment facility, or
- the person receive services *from* a receiving or treatment facility on an involuntary basis.

Admission to a Treatment Facility

s. 394.467(6)(e), F.S.

The administrator of the receiving facility must provide a copy of the court order and adequate documentation of a person's mental illness to the administrator of a treatment facility whenever a person is ordered for involuntary inpatient placement, whether by civil or criminal court. Such documentation shall include:

1. Any advance directives made by the person,
2. A psychiatric evaluation of the person,
3. Any evaluations of the person performed by a clinical psychologist or a clinical social worker,
4. State Mental Health Facilities Admission Form (CF-MH 7000) with attachments, and
5. Physician to Physician Transfer (CF-MH 7002).

The administrator of a treatment facility may refuse admission to any person directed to its facilities on an

involuntary basis, whether by civil or criminal court order, who is not accompanied at the same time by adequate orders and documentation.

Release of Persons

s. 394.469, F.S. Chapter 65E-5.320, F.A.C.

The facility must discharge a person any time the person no longer meets any one of the criteria for involuntary inpatient placement, unless the person has transferred to voluntary status. If the release or transfer to voluntary status occurs prior to the hearing on involuntary inpatient placement, the facility must immediately notify the court by telephone and by filing a Notification to Court of Withdrawal of Petition for Hearing on Involuntary Inpatient or Involuntary Placement (CF-MH 3033).

The administrator must:

1. Discharge the person, unless the person is under a criminal charge, in which case the person must be transferred to the custody of the appropriate law enforcement officer;
2. Transfer the person to voluntary status on his or her own authority or at the person's request, unless the person is under criminal charge or adjudicated incapacitated. Such a transfer from involuntary to voluntary status must be conditioned on the certification by a physician that the person has the capacity to make well-reasoned, willful, and knowing decisions about mental health and medical issues; or
3. Place an improved person, except a person under a criminal charge, on convalescent status in the care of a community facility.

Return of Persons

s. 394.467(8), F.S.

When a person at a treatment facility leaves the facility without authorization, the administrator may authorize a search for the person and the return of the person to the facility. The administrator may request the assistance of a law enforcement agency in the search for and return of the person.

Procedure for Continued Involuntary Inpatient Placement

s. 394.467(7), F.S. Chapter 65E-5.300, F.A.C.

Continued involuntary inpatient placement hearings are conducted by Administrative Law Judges employed by the State Division of Administrative Hearings, rather than circuit court judges.

Hearings on petitions for continued involuntary inpatient placement are administrative hearings and are conducted in accordance with the provisions of ss. 120.569 and 120.57(1), F.S. except that any order entered by the Administrative Law Judge is final and subject to judicial review in accordance with s. 120.68, F.S.

The 5th DCA held that while continued involuntary inpatient placement hearings are administrative, that the circuit court retains concurrent jurisdiction during the first six months after the order is entered. After six months, only the Division of Administrative Hearings (DOAH) has jurisdiction [W.M. v. State of Florida. No. 5D07-3762. October 10, 2008].

If the person continues to meet the criteria for involuntary inpatient placement, the administrator must, prior to the expiration of the period during which the treatment facility is authorized to retain the person, file a petition requesting authorization for continued involuntary inpatient placement (CF-MH 3035).

If continued involuntary inpatient placement is necessary for a person admitted while serving a criminal sentence, but whose sentence is about to expire, or for a person involuntarily placed while a minor but who is about to reach the age of 18, the administrator must petition the administrative law judge for an order authorizing continued involuntary inpatient placement.

The Petition Requesting Authorization for Continued Involuntary Inpatient Placement (CF-MH 3035) must be filed with:

State of Florida Division of Administrative Hearings
The Desoto Building
1230 Apalachee Parkway
Tallahassee, FL 32399-3060
Phone (850) 488-9675
Suncom 278-9675
Fax Filing (850) 921-6847

And accompanied by:

1. A statement from the person's physician or clinical psychologist justifying the request;

2. A brief description of the person's treatment during the time he or she was involuntarily placed; and
3. An individualized plan of continued treatment.

Notice of the hearing shall be provided as set forth in s. 394.4599, F.S.

Unless the person is otherwise represented, he or she must be represented at the hearing on the petition for continued involuntary inpatient placement by the public defender of the circuit in which the facility is located.

If at the hearing, the administrative law judge finds that attendance at the hearing is not consistent with the best interests of the person, the administrative law judge may waive the presence of the person from all or any portion of the hearing, unless the person, through counsel, objects to the waiver of presence.

The testimony in the hearing must be under oath, and the proceedings must be recorded.

If the person has been previously found incompetent to consent to treatment, the administrative law judge shall consider testimony and evidence regarding the person's competence. If the administrative law judge finds evidence that the person is now competent to consent to treatment, the administrative law judge may enter a recommended order to the court that found the person incompetent to consent to treatment that the person's competence be restored and that any guardian advocate previously appointed be discharged. (Findings and Recommended Order Restoring Person's Competence to Consent to Treatment and Discharging the Guardian Advocate CF-MH 3116).

If at a hearing it is shown that the person continues to meet the criteria for involuntary inpatient placement, the administrative law judge must sign the Order for Continued Involuntary Inpatient Placement (CF-MH 3031) for a period not to exceed six months. The same procedure must be repeated prior to the expiration of each additional period the person is retained.

*See attached flowcharts for Involuntary Inpatient Placement and Continued Involuntary Inpatient Placement. Also attached is a Quick Reference Guide for Receiving and Treatment Facilities regarding Involuntary Inpatient Placement.

For further assistance visit: <http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml> to view DCF's most Frequently Asked Questions list.

Quick Reference Guide for Receiving and Treatment Facilities

Involuntary Inpatient Placement

If it is determined that the person who has undergone involuntary examination has a mental illness and either refuses voluntary placement or is unable to determine that such placement is needed and otherwise meets the criteria for involuntary inpatient placement, the facility shall:

- _____ Complete the "Petition for Involuntary Inpatient Placement" (CF-MH 3032), within 72 hours after the person's arrival at a receiving facility, signed by:
 - ☐ Psychiatrist who has examined the person within preceding 72 hours; and
 - ☐ Second psychiatrist or clinical psychologist, who has examined person within the preceding 72 hours (2nd opinion may be conducted by electronic means in which all parties maintain visual and audio communication)
- _____ File the petition within the 72 hours or, if the 72-hour period ends on a weekend or holiday, no later than the next working day.
- _____ Provide the person and his/her guardian or representative with copies of the petition and notices, if agreement has been reached between the clerk of the court and the receiving facility that this function shall be performed by the facility.
- _____ Explain the above forms to the person.

At the time of admission, the facility must open a clinical record for the person containing the following information and may include the following completed recommended forms.

If a competent and willing person seeks voluntary admission (after notification of involuntary inpatient placement proceedings):

- _____ Person must sign "Request for Voluntary Admission (CF-MH 3040, 3097, or 3098)
- _____ Physician has certified the person's competence to provide express and informed consent (CF-MH 3104)
- _____ Facility must provide court with "Notification to Court of Withdrawal of Petition for Hearing on Involuntary Inpatient or Involuntary Outpatient Placement" (CF-MH 3033), with copies to person's guardian or representative
- _____ If physician determines person is of imminent danger, packet of forms prohibiting firearm purchase to clerk of court

If involuntary inpatient placement in a state mental health treatment facility is sought for the person, the following shall be completed:

- _____ Transfer Evaluation (CF-MH 3089)
- _____ State Mental Health Facilities Admission Form (CF-MH 7000 with attachments)
- _____ Physician to Physician Transfer Form (CF-MH 7002)

If the court orders involuntary inpatient placement in a receiving or treatment facility, the following forms must be present in the person's clinical record:

- _____ Order for Involuntary Inpatient Placement (CF-MH 3008) or other form approved by the court
- _____ General Authorization for Treatment Except Psychotropic Medications (CF-MH 3042a) for those persons appearing to be competent to consent to treatment or by their guardian or health care surrogate/proxy.
- _____ Completion of a Specific Authorization for Psychotropic Medications (CF-MH 3042b), **prior** to the administration of any psychotropic medications, after a complete disclosure to the person, the guardian, guardian advocate, health care surrogate/proxy, and to the guardian of a minor as to:

<ul style="list-style-type: none"> _____ Reason for admission or treatment _____ Proposed treatment, including proposed psychotropic medications _____ Purpose of treatment to be provided _____ Alternative treatments _____ Specific dosage range of medications _____ Frequency and method of administration _____ Common risks, benefits and common short-term and long-term side effects _____ Any contraindications which may exist 	<ul style="list-style-type: none"> _____ 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 _____ 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 on behalf of the person
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_____ Certification of Person's Competence to Provide Express and Informed Consent (CF-MH 3104) if the person was permitted to sign a General Authorization for Treatment Except for Psychotropic Medications or a Specific Authorization for Psychotropic Medications (CF-MH 3042b).

_____ Inventory of Personal Effects (CF-MH 3043) documenting property brought by the person to the facility signed by the person, if able, and witnessed by two staff members.

_____ Authorization for Release of Information (CF-MH 3044) completed and signed only when such release is to take place. No blank forms should be signed by the person or substitute decision-maker.

_____ Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances (CF-MH 3036)

_____ Signed copy of "Rights of Persons in Mental Health Facilities and Programs" (CF-MH 3103), after explanation given to person.

_____ Documentation of a physical examination by a licensed health practitioner within 24 hours of arrival

_____ Personal Safety Plan (CF-MH 3124)

_____ An individualized treatment plan completed within five days of the person's admission in which the person has had the opportunity to assist in preparing, including space for the person's comments and a copy of which has been provided to the person, guardian, guardian advocate, and a minor's guardian.

The following forms shall be included only if applicable:

_____ Authorization for Electroconvulsive Treatment (CF-MH 3057)

_____ Refusal or Revocation of Consent to Treatment (CF-MH 3105)

_____ Restriction of Communication or Visitors (CF-MH 3049)

_____ Restriction of Person's Access to Own Record (CF-MH 3110)

_____ Petition for Writ of Habeas Corpus or for Redress of Grievances (CF-MH 3090)

_____ Application for and Notice of Transfer to Another Facility (CF-MH 3046)

_____ Notification to Court of Withdrawal of Petition for Hearing on Involuntary Inpatient or Involuntary Outpatient Placement (CF-MH 3033)

_____ Notice of Release or Discharge (CF-MH 3038)

_____ Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate (CF-MH 3106)

_____ Order Appointing Guardian Advocate (CF-MH 3107)

_____ Certification of Guardian Advocate Training Completion (CF-MH 3120)

_____ Petition Requesting Court Approval for Guardian Advocate to Consent to Extraordinary Treatment (CF-MH 3108)

_____ Order Authorizing Guardian Advocate to Consent to Extraordinary Treatment (CF-MH 3109)

At least 20 days prior to the expiration date of a person's authorized period of involuntary inpatient placement:

_____ Petition Requesting Authorization for Continued Involuntary Inpatient Placement (CF-MH 3035) shall be filed with the Division of Administrative Hearings.

_____ Notice of Petition for Continued Involuntary Inpatient Placement (CF-MH 3024)

_____ Order for Continued Involuntary Inpatient Placement or Release (CF-MH 3031)

Recommended forms are those which are not required by the department, but which have been determined to satisfy the specific requirements for which the form has been developed. Alteration of recommended forms may jeopardize this status. Mandatory forms may not be altered. No blank forms should be signed by staff, the person, or substitute decision-maker.

Involuntary Inpatient Placement

s. 394.467, F.S.

Chapter 65E-5.290, F.A.C.

Criteria: Finding by court by clear and convincing evidence that the person has a mental illness and because of the mental illness

- Person refused **or** unable to determine whether voluntary placement is necessary; and
- Likely to suffer from self-neglect **or** harm self or others; **and**
- All available less restrictive treatment alternatives judged to be inappropriate

Psychiatrist determines person does not meet one or more of the criteria and person is discharged **or** if person meets criteria for voluntary admission, may be transferred to voluntary status and required notices given

Psychiatrist determines person **does meet all** criteria for involuntary inpatient placement

Second psychiatrist or a psychologist performs examination. Second opinion can be done by electronic means if all parties maintain visual and audio communication. If second professional

Two opinions entered on petition for involuntary inpatient placement, signed by administrator, and filed with court within the 72 hour exam period

Court appoints a PD in 1 working day unless person otherwise represented by counsel and notifies person of right to an independent expert examination (BA3022)

Clerk immediately notifies PD of appointment and SAO which represents the state as real party in interest

Clerk provides copy of petition (BA3032) and notice of Hearing (BA-3024) to DCF, person, guardian or representative, state attorney, and public defender

Hearing held within 5 working days by judge or magistrate. Person's competence to consent to treatment is considered and if found to be incompetent, Guardian Advocate appointed (BA3107)

Does not meet one or more criteria for involuntary inpatient placement

Person discharged

Meets all criteria for involuntary inpatient placement

Court ordered (BA3008) to treatment facility or receiving facility for period of up to 6 months. Clerk submits firearm Prohibition to FDLE.

Competent to consent to treatment

May consent or refuse to consent to own treatment

Incompetent to consent to treatment

Guardian advocate appointed

Person meets criteria for involuntary assessment, protective custody, or involuntary admission pursuant to Marchman Act

Court ordered for 5 day substance abuse impairment involuntary assessment. Clerk submits Firearm Prohibition to FDLE.

Continued Involuntary Inpatient Placement

s. 394.467(7), F.S. Chapter 65E-5.300, F.A.C.

Criteria: Finding by administrative law judge, by clear and convincing evidence, that person has a mental illness and because of the mental illness

- Person refused or unable to determine whether voluntary placement is necessary; and
- Likely to suffer from self-neglect or harm to self or others; and
- All available less restrictive treatment alternatives judged to be inappropriate

Prior to end of period facility is authorized to retain person, or for person placed while a minor but about to reach age of 18, or person admitted while serving a criminal sentence but whose sentence is about to expire; a petition for continued involuntary inpatient placement may be filed with the state Division of Administrative Hearings (DOAH) for persons continuing to meet criteria, as follows:

Person does not meet one or more placement criteria

Facility shall discharge a person any time the person no longer meets all criteria for involuntary inpatient placement unless the person has been transferred to voluntary status

Person continues to meet all placement criteria

Petition (BA3035) filed by facility administrator with State Division of Administrative Hearings

Notice of hearing (BA3024) provided to person, attorney, representative

Appointment of PD

Testimony under oath and proceedings recorded

If previously found incompetent to consent to treatment, shall consider testimony about person's competence

Administrative law judge signs order (BA3031) for continued involuntary inpatient placement for up to 6 months

Continues to be incompetent to consent to treatment

Appears to be competent to consent to own treatment

Administrative law judge sends recommended order (BA3116) to court for restoration of competency to consent and discharge of guardian advocate

Does not meet all criteria

Person discharged or transferred to voluntary status

Involuntary Outpatient Placement

s.394.4655, F.S. s. 65E-5.285, F.A.C

Introduction

The 2004 Florida Legislature enacted a major revision to the Florida Mental Health Act by adding an involuntary outpatient placement provision to the involuntary examination and involuntary inpatient placement provisions. This revision was made effective on January 1, 2005.

The Legislature permits the administrator of a Baker Act receiving facility or treatment facility to file a petition for involuntary placement in the circuit court when **outpatient** or **inpatient** treatment is deemed necessary. The Legislature also stated that any person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition can be released by a physician or clinical psychologist if found not to meet the criteria for involuntary **inpatient or outpatient** placement.

Rights of Persons

Rights of persons incorporated in the Florida Mental Health Act apply to all persons whose services are governed by the Baker Act – voluntary or involuntary and inpatient or outpatient.

Each person must receive services, including those under an involuntary outpatient placement court order which are suited to his or her needs, and which must be administered skillfully, safely, and humanely with full respect for the person's dignity and personal integrity.

Criteria

A person may be ordered to involuntary **outpatient** placement upon a finding of the court by clear and convincing evidence that each criterion below has been met. Each allegation must be supported by evidence sufficient to reach the high level of evidence required in the involuntary outpatient placement hearing. Appellate courts have found that expert opinions and conclusions are not sufficient, without evidence to prove the allegations. The Florida Supreme Court defined clear and convincing evidence to mean:

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.

The criteria are as follows:

1. Person is 18 years of age or older. Evidence of age must be substantiated, whenever there is any question as to whether the person may be age 18 or older.
2. Person has a mental illness. A diagnosis of mental illness shall be substantiated by two professionals as provided in Section 394.4655(2)(a), F.S. who have recently examined the person and whose observations of the person's condition are consistent with the statutory definition of mental illness, pursuant to Section 394.455(18), F.S., and the clinical description of that diagnosis as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, American Psychiatric Association, which may be obtained from the American Psychiatric Association, 1000 Wilson Boulevard, Arlington, VA 22209-3901.
3. Person is unlikely to survive safely in the community without supervision, based on a clinical determination. The clinical determination that a person is unlikely to survive safely in the community without supervision must be substantiated by evidence of current or past behaviors.
4. Person has a history of non-compliance with treatment. The person's history of lack of compliance with treatment for mental illness must be substantiated by evidence showing specific previous incidents in which the person was non-compliant with treatment, including time periods in which the person was non-compliant with treatment.
5. Person has either:
 - a. At least twice within last 36 months been involuntarily admitted to receiving or treatment facility or received mental health services in a forensic or correctional facility **or**
 - b. 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.

In either of the above circumstances, official clinical or legal documents must document that the person was in fact admitted to and treated at such facilities in the required time period. The person's involuntarily admission to a receiving or treatment facility or the mental health services in a forensic or correctional facility at least twice in the preceding 36 months, or the person's acts of serious violent behavior toward self or others or attempted serious bodily harm to self or others at least once during the preceding 36 months, shall be substantiated by evidence.

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 the unlikelihood of the person to voluntarily participate in the recommended treatment plan, and either his or her refusal of voluntary placement or inability to determine whether placement is necessary must be substantiated by behaviors, events, and statements by the person supporting this finding.
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 the person's treatment history and current behavior must be presented, including time periods of such treatment to substantiate the conclusion that the person needs involuntary 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 or her well-being.
8. It is likely the person will benefit from involuntary outpatient placement. Evidence must be presented to substantiate the likelihood of how the person will benefit from involuntary outpatient placement.
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 must be presented to substantiate each less restrictive alternative that was examined that would have offered an opportunity for the improvement of the person's condition.

The person must meet **all** the above criteria.

Petition

If a person is not released or transferred to voluntary status within 72 hours after arrival at a receiving facility, a petition for involuntary placement must be filed with the circuit court by the facility administrator within the 72-hour examination period, or if the 72 hours ends on a weekend or legal holiday, the petition must be filed no later than the next court working day thereafter. If involuntary outpatient placement is sought the form titled, "Petition for Involuntary Outpatient Placement," (CF-MH 3130) can be used. A copy of the completed petition must be retained in the person's clinical record.

A petition by a **Receiving** Facility administrator must be filed in the circuit court **where the facility is located**. This

authorizes the person's retention 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 while awaiting the hearing on involuntary outpatient placement. The petition must include a certificate recommending placement completed by psychiatrist and a psychologist or 2nd psychiatrist, both of who have examined the person within the preceding 72 hours, that each of the criteria for involuntary outpatient placement are met. A copy of a proposed treatment plan must be attached. No fee can be charged for filing of petition.

A Petition by a **Treatment** Facility administrator must be filed in the circuit court **where the person will be living**. A copy of the petition, state mental health discharge form, and a treatment plan prepared by the designated service provider must be given to the DCF representative in the circuit where person is to reside at the time it is filed with the circuit court.

Service Provider

Prior to filing the petition for involuntary outpatient placement, the receiving or treatment facility administrator or DCF must identify the service provider that will have primary responsibility for court ordered treatment. If the person is currently participating in outpatient treatment and is not in need of public financing for that treatment, the person, if eligible, may be ordered to involuntary treatment to the existing psychiatric treatment relationship. However, a proposed treatment plan must still be prepared, in accordance with the law and rules, for submission to the court with the petition.

A service provider, in the context of the Baker Act is defined as:

- A public or private receiving facility
- An entity under contract with DCF to provide mental health services
- A clinical psychologist
- A licensed clinical social worker
- A licensed mental health counselor
- A licensed marriage and family therapist
- A physician
- A psychiatric nurse (as defined in the Baker Act), or
- A community mental health center or clinic.

The department or receiving facility must designate which service provider will be responsible for developing a treatment plan for the person and for service provision. Recommended form titled "Designation of Service Provider for Involuntary Outpatient Placement" (CF-MH 3140) may be used.

No petition for involuntary outpatient placement may be filed with a court by a receiving or treatment facility administrator unless a treatment plan, complying with the requirements of the law and rule is attached to the petition, along with a certification from the service provider that:

- The proposed services are available,
- There is space for the person in the program,
- There is funding available,
- The services proposed are clinically appropriate as certified by an authorized mental health professional, and
- That the service provider agrees to provide the services.

Recommended form titled “Proposed Individualized Treatment Plan for Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement” (CF-MH 3145) may be used.

Treatment Plan

A service provider must prepare a written proposed treatment plan in consultation with person or guardian advocate for the court’s consideration in an involuntary outpatient treatment order. The treatment plan must specify:

- Nature and extent of the person’s mental illness
- Reduction of symptoms and include measurable treatment goals and objectives
- How the person will be assisted in living and functioning or prevent relapse or deterioration

Services proposed in the treatment plan must be deemed clinically appropriate by a physician, psychologist, clinical social worker, mental health counselor, marriage and family therapist, or psychiatric nurse.

The service provider selected by the receiving facility or DCF to develop/render a service plan may select and supervise others to implement aspects of the treatment plan. The service provider must certify to court that the services in plan are currently available and that the service provider agrees to provide them.

The confidentiality provisions of the Baker Act have been revised for purpose of determining whether a person meets the criteria for involuntary outpatient placement or for preparing the proposed treatment plan. While any release must be in accordance with state and federal law, the clinical record may be released for this purpose to the:

- State attorney,
- Public defender or the person’s private legal counsel

- Court, and
- Appropriate mental health professionals, including the service provider.

County of Filing

The petition initiated by a **receiving** facility administrator must be filed in the county where the facility is located.

The petition for involuntary outpatient placement initiated by a **treatment** facility administrator must be filed in the county where the person will be living after discharge from the facility. It must be filed prior to the expiration of the involuntary inpatient placement order. A copy of form titled “State Mental Health Facility Discharge Form” (CF-MH 7001) must be attached to the petition. The service provider designated by the department that will have primary responsibility for service provision must provide a certification to the court, attached to the petition, whether the services recommended in the discharge plan are available in the local community and whether the provider agrees to provide those services. Also attached to the petition must be an individualized treatment or service plan that addresses the needs identified in the discharge plan developed by the treatment facility. Recommended form titled “Proposed Individualized Treatment Plan for Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement” (CF-MH 3145) may be used. This plan must have been deemed to be clinically appropriate by a physician, clinical psychologist, clinical social worker, mental health counselor, marriage and family therapist, or psychiatric nurse, as defined in the Baker Act.

Notice of Petition

A copy of the petition for involuntary outpatient placement and proposed treatment plan must be provided within one working day after filing by the clerk of the court to the:

- Respondent,
- Department of Children & Families,
- Guardian or representative,
- State attorney, and
- Counsel for the respondent.

A notice of filing of the petition must also be provided by the clerk of court. Recommended form titled “Notice of Petition for Involuntary Placement” (CF-MH 3021) or other equivalent form adopted by the court may be used.

The person and his or her representative or guardian must be informed by the court of the right to an independent

expert examination and that if the person cannot afford such an examination, the court shall provide for one. In August of 2005, the Chair of the Florida Trial Court Budget Commission advised the Chief Judges and Court Administrators of all circuits that while the court must appoint such an independent expert, the expert is a defense witness and not a court expense. Recommended form titled “Application for Appointment of Independent Expert Examiner” (CF-MH 3022) may be used. The results of the examination by an independent expert are confidential and not discoverable unless the expert is called as a witness.

Hearing

A hearing on the petition for involuntary outpatient placement must be conducted within 5 working days after the filing of the petition in the county in which the petition is filed.

The person is entitled, with the concurrence of counsel, to at least one continuance of the hearing, for a period of up to 4 weeks. Recommended form titled “Notice to Court – Request for Continuance of Involuntary Placement Hearing” (CF-MH 3113) may be used.

The Public Defender must be appointed by the court within 1 court working day after the petition is filed, unless the person is otherwise represented by private counsel. Counsel for the person shall serve until the petition is dismissed, the court order expires, or the person is discharged from placement. The State attorney represents the state as the real party in interest in the proceedings.

The hearing must be conducted in a setting as convenient to the person as consistent with orderly procedure and not likely to be harmful to person. A judge or magistrate may preside.

If the facility administrator seeks to withdraw the petition for involuntary outpatient placement prior to the hearing, recommended form 3033 titled “Notification to Court of Withdrawal of Petition on Involuntary Inpatient or Outpatient Placement” may be used. The facility must retain a copy in the person’s clinical record. When a facility withdraws a petition for involuntary placement, it must notify by telephone the court, state attorney, attorney for the person, and guardian or representative within one business day of its decision to withdraw the petition unless the decision is made within 24 hours prior to the hearing. In such cases, the notification must be made immediately.

The Court must hear testimony and evidence regarding the person’s competence to consent to treatment. If the person is found incompetent, the Court must appoint a guardian advocate. The guardian advocate appointed by the court for a

person who has been found to be incompetent to consent to treatment must be discharged when:

- The person is discharged from an order for ***involuntary outpatient placement***, or involuntary inpatient placement, or
- The person is transferred from involuntary to voluntary status.

If the court determines the person instead meets the criteria for involuntary inpatient placement, use of recommended form titled “Ex Parte Order for Involuntary Inpatient Examination” (CF-MH 3001) may be used.

If the court determines the person meets the criteria for involuntary assessment, protective custody, or involuntary admission, and issues an order, recommended form titled “Order Requiring Involuntary Assessment and Stabilization for Substance Abuse and for Baker Act Discharge of Person” (CF-MH 3114) may be used.

If at any time prior to conclusion of the hearing on involuntary inpatient placement, it appears to the court that the person does not meet criteria for involuntary inpatient placement but instead meets criteria for involuntary outpatient placement, the court may order the person evaluated for involuntary outpatient placement.

Testimony

All testimony must be given under oath and must be recorded.

- The court may waive the presence of the person from all or any part of the hearing if consistent with the best interests of the person and the person’s counsel does not object. Several appellate courts have ruled that if the patient waives his/her right to be personally present and be constructively present through counsel, the trial court must certify through proper inquiry that a respondent’s waiver is knowing, intelligent, and voluntary. The person may refuse to testify at the hearing.
- One of the two professionals who executed involuntary outpatient placement certificate must be a witness at the hearing.
- In addition to one of the two professionals who executed the petition, other staff from the receiving or treatment facility who have direct knowledge of how the person meets the criteria for involuntary outpatient placement and are expected to testify in support of the petition must be identified on the petition and be present to testify at the hearing, as desired by the court.
- The court shall also allow testimony from individuals, including family members, deemed by the court to

be relevant, regarding the person's prior history and how that prior history relates to the person's current condition. Such testimony must be factual as to events and dates, rather than only opinions and conclusions.

- A representative of the designated service provider must be present to provide testimony about the proposed treatment or service plan as desired by the court

Court Order

If the court finds that the person meets all criteria for involuntary outpatient placement, it shall issue an order for a period of up to 6 months. Recommended form titled "Order for Involuntary Outpatient Placement or Continued Involuntary Outpatient Placement" (CF-MH 3155) may be used.

The court can't order services that are not available in the person's local community, if no space is available, if funding isn't available, if the treatment plan hasn't been certified as clinically appropriate by an authorized mental health professional, and if an eligible service provider hasn't agreed to provide the recommended services.

This signed order must be given to the person, guardian, guardian advocate or representative, counsel for the person, state attorney, and administrator of the receiving or treatment facility, with a copy of the order retained in the person's clinical record.

A copy of the court order must also be sent by the service provider to AHCA within one working day after received from the court accompanied by mandatory form titled "Cover Sheet to Agency for Health Care Administration" (CF-MH 3118) to: BA Reporting Center, FMHI-MHC 2637, 13301 Bruce B. Downs Boulevard, Tampa, Florida 33612-3807.

The court order and treatment plan must be part of person's clinical record.

Continued Involuntary Outpatient Placement

Criteria

If the person continues to meet the criteria for involuntary outpatient placement, the service provider must, prior to end of the court order, file in the circuit court a petition for continued involuntary outpatient placement. The existing order remains in effect until the continued involuntary outpatient placement petition is disposed of.

Criteria for continued involuntary outpatient placement are identical to the criteria for the original order, except that

the 36-month time period for having been at least twice involuntarily admitted to a receiving/treatment facility or received mental health 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 is not applicable in determining the appropriateness of additional periods of involuntary outpatient placement.

Petition

In order to request continued involuntary outpatient placement, the service provider administrator shall, prior to the expiration of the period for which the treatment was ordered, file a petition for continued involuntary outpatient placement with the circuit court. Recommended form titled "Petition Requesting Authorization for Continued Involuntary Outpatient Placement" (CF-MH 3180) may be used. The petition must be filed with the circuit court in the county where the person who is the subject of the petition resides.

The petition must include:

- A statement from person's physician or clinical psychologist justifying the request,
- A brief description of person's treatment during the order,
- An individualized plan of continued treatment developed by the service provider, in consultation with person or the guardian advocate, if appointed.

Notice of Petition for Continued Involuntary Outpatient Placement

The clerk of court must provide copies of the petition and attachments to the person, DCF, guardian advocate, state attorney, and the person's public defender or private counsel.

The clerk of court must provide notice of the hearing. Recommended form titled "Notice of Petition for Involuntary Placement" (CF-MH 3021) may be used. Copies must be provided to the person, his or her attorney, the state attorney, and guardian, guardian advocate or representative, with a copy of the notice filed in the person's clinical record.

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

- Petition filed with the circuit court in county where person is hospitalized (receiving facility) or will be living (treatment facility).
- Office of public defender appointed to represent person if not otherwise represented by counsel.

- Date, time, place of hearing, name of each examining expert and every other person expected to testify in support of continued involuntary outpatient placement.
- The person, guardian, representative or administrator may apply for change of venue for convenience of parties or witnesses or because of person's condition.
- The person is entitled to independent expert examination and, if person cannot afford an examination, the court will provide for one.

The **public defender** must be appointed and notified within 1 court working day, who will represent the person until:

- The petition is dismissed,
- The order expires, or
- The person discharged from placement.

The attorney for the person has access to the person, witnesses and records, and represents interests of the person, regardless of source of payment to the attorney. The State Attorney is appointed to represent the state as the real party in interest, rather than for the petitioner.

Hearing on Continued Involuntary Outpatient Placement

The court may appoint a magistrate to preside over continued involuntary placement hearings.

The person and his or her attorney may agree to a period of continued outpatient placement without a court hearing. Should such a hearing be waived recommended form titled "Notice to Court of Waiver of Continued Involuntary Outpatient Placement Hearing and Request for Order" (CF-MH 3185) may be used.

If the person was previously found incompetent to consent to treatment, the court must consider testimony and evidence regarding the person's competence. The guardian advocate must be dismissed if the person is found competent to make decisions about his or her own treatment.

If the administrator of the service provider withdraws the petition for continued involuntary outpatient placement prior to the hearing, recommended form titled "Notification to Court of Withdrawal of Petition on Involuntary Inpatient or Outpatient Placement" (CF-MH 3033) may be used. The facility will retain a copy of the notice in the person's clinical record. When a facility withdraws a petition for involuntary placement, it must notify the court, state attorney, public defender or other attorney for the person, and guardian or representative by telephone within one business day of its decision to withdraw the petition, unless such decision is

made within 24 hours prior to the hearing. In such cases, the notification must be made immediately. The same procedure must be repeated before expiration of each additional period the person is placed in treatment.

Order for Continued Involuntary Outpatient Placement

Based on the findings of the hearing, the court may extend the period of involuntary outpatient commitment pending the next statutorily required periodic hearing, release the person from involuntary outpatient placement, or find the person eligible for voluntary status. Recommended form titled "Order for Continued Involuntary Inpatient Placement or for Release" (CF-MH 3031) may be used. A copy of the completed order must be filed in the person's clinical record and a copy provided to the person, attorney, facility administrator, and guardian, guardian advocate or representative.

A copy of the order must be sent to the Agency for Health Care Administration by the designated service provider, accompanied by mandatory form titled "Cover Sheet to Agency for Health Care Administration" (CF-MH 3118) to: BA Reporting Center, FMHI-MHC 2637, 13301 Bruce B. Downs Boulevard, Tampa, Florida 33612-3807.

Modification to Court Order for Involuntary Outpatient Placement

After an order for involuntary outpatient placement or continued involuntary outpatient placement is entered, the provider and the person (or his or her substitute decision-maker, if appointed) may modify provisions of the treatment plan. Any **material modifications** where parties **agree** require the provider to **notice** the court. If material modifications are **contested**, the court must approve or disapprove the modifications.

At any time material modifications are proposed to the court ordered treatment plan for which the person and his or her substitute decision maker, if any, agree, or if the person or his substitute decision-maker object to the modifications proposed by the service provider or wish to propose modifications not proposed by the service provider, recommended petition titled "Notice to Court of Modification to Treatment Plan for Involuntary Outpatient Commitment and/or Petition Requesting Approval of Material Modifications to Plan" (CF-MH 3160) may be used.

Change of Service Provider

If the person who is subject to an order for involuntary outpatient placement (or his or her substitute decision-maker, if appointed) objects to the service provider that is court ordered to provide his or her treatment or services, recommended form titled “Notice to Court of Modification to Treatment Plan for Involuntary Outpatient Commitment and/or Petition Requesting Approval of Material Modifications to Plan” (CF-MH 3160) may be used.

Non-Compliance with Court Order

If a physician has determined that the person who is subject to a court order for involuntary outpatient placement or continued involuntary outpatient placement has failed or has refused to comply with the treatment ordered by the court, and in his or her clinical judgment, efforts were made to solicit compliance and the person meets the criteria for involuntary examination, the person may be brought to a receiving facility pursuant to the involuntary examination requirements of the Baker Act. Mandatory form titled “Certificate of a Professional Initiating Involuntary Examination” (CF-MH 3052b) may be used.

If the person doesn’t meet criteria for involuntary inpatient placement, the person must be discharged from the receiving facility.

The service provider must determine whether modifications should be made to the existing treatment plan and must attempt to continue to engage the person in treatment.

Discharge from Involuntary Outpatient Placement

A service provider has a duty to discharge a person at any time the order for involuntary outpatient placement or continued involuntary outpatient placement expires or at any time the person no longer meets the criteria for involuntary outpatient placement or to transfer the person to voluntary status, if the person is able and willing to provide express and informed consent.

Upon the person’s discharge, the service provider must send a notice of discharge to the court. Recommended form titled “Notice of Release or Discharge” (CF-MH 3038) may be used. The administrator of the service provider will provide notification to the person, guardian, guardian advocate, representative, attorney for the person, and the court that ordered such treatment, and a copy of the notice must be placed in the person’s clinical record.

At any time the person who is subject to an order for involuntary outpatient placement or continued involuntary outpatient placement, or another person on his or her behalf, believes any one of the criteria for involuntary outpatient placement is no longer met, a petition for termination of the order may be filed with the circuit court having jurisdiction. Recommended form titled “Petition for Termination of Involuntary Outpatient Placement Order (CF-MH 3170) may be used. If the court determines a hearing on the petition is to be conducted, a notice of the hearing, as required by law, shall be provided by the clerk of court.

For further assistance visit: <http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml> to view DCF’s most Frequently Asked Questions list.

Involuntary Outpatient Placement

s.394.4655, F.S. s. 65E-5.285, F.A.C

Criteria: Finding by court by clear and convincing evidence that an adult has a mental illness and

- Is unlikely to survive safely in the community without supervision
- Has a history of non-compliance with treatment
- 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;
- Is unlikely to voluntarily participate in the recommended treatment plan and has either refused voluntary placement or is unable to determine whether placement is necessary
- 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.
- It is likely the person will benefit from involuntary outpatient placement; and
- 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.



Psychiatrist determines person doesn't meet one or more criteria and person is discharged or is transferred to voluntary status, if eligible

Psychiatrist determines person meets all criteria for involuntary outpatient placement. Psychologist or second psychiatrist concurs. Both opinions entered on petition, signed by administrator.



If some or all services needed by person are unavailable or unfunded, submit "Notification to DCF of Non-filing of Petition or Diminished Treatment Plan"



Service Provider selected by DCF or receiving facility to develop treatment plan



Service provider completes treatment plan in consult with person or guardian/guardian advocate ensuring all proposed services are available and funded and committing service provider to deliver services



Proposed service plan submitted to physician, psychologist, LCSW, or psychiatric nurse employed by, consulting with or contracted by service provider for certification of clinical appropriateness



Petition with treatment plan submitted to Clerk of Court. Copy of petition and treatment plan sent by Clerk of Court to person, DCF, PD, and ASA



PD and ASA appointed and hearing scheduled within 5 working days



If person found incompetent to consent to own treatment, guardian advocate appointed by court



If all criteria proven by clear and convincing evidence, court order issued for up to 6 months and remains in affect until service provider determines person no longer meets criteria or order expires



If person instead meets criteria for involuntary inpatient placement, court may order involuntary exam under 394.463

If person instead meets involuntary admission criteria for Marchman Act, may be ordered for 5 day assessment

Copy of court order sent within 1 working day to BA reporting center

Person discharged from facility



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Continued Involuntary Outpatient Placement

s.394.4655, F.S. s. 65E-5.285, F.A.C

Criteria: Finding by court by clear and convincing evidence that adult has a mental illness and

- Is unlikely to survive safely in community without supervision
- Has a history of non-compliance with treatment
- Is unlikely to voluntarily participate in the recommended treatment plan and has either refused voluntary placement or is unable to determine whether placement is necessary
- 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 or her well-being.
- It is likely the person will benefit from involuntary outpatient placement; and
- 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.

If physician or clinical psychologist determines person doesn't meet one or more criteria, person is discharged or is transferred to voluntary status, if eligible

Physician or clinical psychologist determines person meets all above criteria for involuntary outpatient placement, entered on petition, signed by administrator. Brief description of person's treatment during placement; and an individualized plan of continued treatment, developed in consult with person or guardian / guardian advocate, if appointed, must be attached to petition



Petition, description of past treatment, and proposed treatment plan submitted by service provider to Clerk of Court who will provide copies to person, DCF, guardian/guardian advocate, PD and state attorney



Hearing scheduled within 5 working days unless person and his or her attorney have agreed to waive hearing.



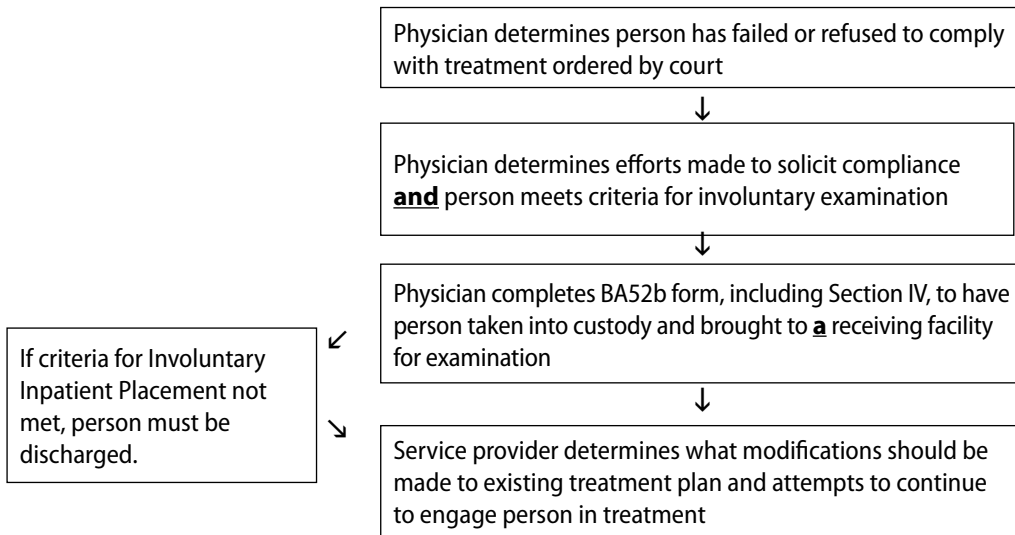
All procedures for initial hearing also apply to continued - same procedure followed before expiration of each additional period person placed in treatment.



Court order for up to 6 months of treatment.

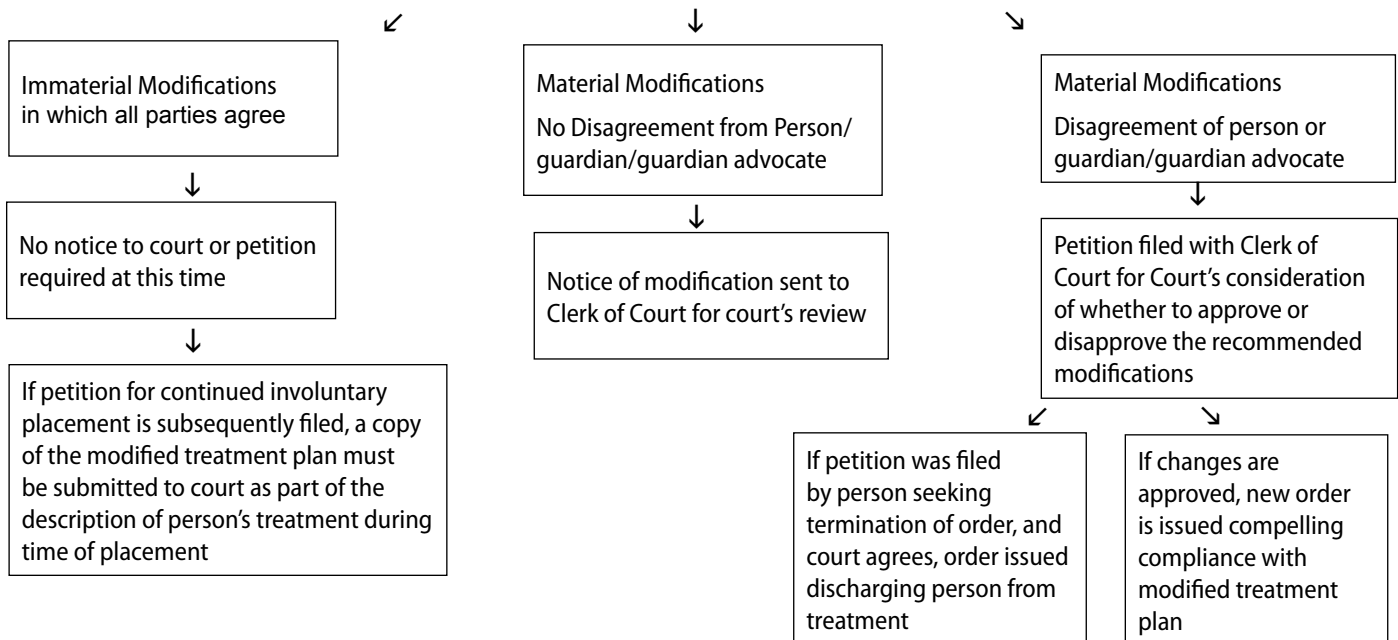
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Non-Compliance with Treatment Order



Modification to Treatment Plans

Proposed Modification To Court Ordered Treatment Plan



* Material modification defined as "Important, more or less necessary, having influence or effect, going to the merits, having to do with matter rather than form."

** Material modification to treatment plan can be initiated by person, guardian, guardian/advocate or service provider

Qualifications of Professionals & Others to Perform Baker Act Related Functions

Cautionary Note:

The professionals identified as having some role in the examination or treatment of persons under the Baker Act law are specifically defined in the Baker Act [Ch. 394, Part 1, *Florida Statutes*].

- Some of these definitions differ from those in the professional licensing laws. Where difference between the Baker Act and the licensing laws occur, the Baker Act, as the more specific statute, prevails.
- The Baker Act and related rules may limit what some professionals are authorized to do more narrowly than under the scope of practice specified in their license laws. Where there are differences between the Baker Act and the professional scope of practice occur, the Baker Act as the more specific statute prevails.
- If the Baker Act and related rules do not specify a particular definition or limitation as to which professional is authorized to perform a particular function, the scope of practice identified in the professional's license law prevails.

The Department of Children and Families has proposed modification to the Baker Act definitions of certain professionals to bring these definitions more closely in line with those in the professional licensing statutes. DCF has also proposed several changes in which professionals can conduct specific roles. However, until the Florida Legislature enacts these proposed changes, the information in this appendix must be followed.

Definitions

The Baker Act defines various professionals and other categories of persons involved in providing services to and protecting the rights of persons on voluntary and involuntary status undergoing examination and treatment provisions of the law as follows:

- **“Administrator”** means the chief administrative officer of a receiving or treatment facility or his or her designee. [394.455(1), F.S.]
- **“Clinical psychologist”** means 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 under this part. [394.455(2), F.S.]
- **“Clinical social worker”** means a person licensed as a clinical social worker under chapter 491. [394.455(4), F.S.]
- **“Guardian”** means the natural guardian of a minor, or a person appointed by a court to act on behalf of a ward's person if the ward is a minor or has been adjudicated incapacitated. [394.455(11), F.S.]
- **“Guardian advocate”** or **“GA”** means a person appointed by a court to make decisions regarding mental health treatment on behalf of a patient who has been found incompetent to consent to treatment pursuant to this part. The guardian advocate may be granted specific additional powers by written order of the court, as provided in this part. [394.455(12), F.S.]
- **“Physician”** means a medical practitioner licensed under chapter 458 or chapter 459 who has experience in the diagnosis and treatment of mental and nervous disorders or a physician employed by a facility operated by the United States Department of Veterans Affairs which qualifies as a receiving or treatment facility under this part. [394.455(21), F.S.]
- **“Psychiatric nurse”** means a registered nurse licensed under part I of 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. [394.455(23), F.S.]
- **“Psychiatrist”** means a medical practitioner licensed under chapter 458 or chapter 459 who has primarily diagnosed and treated mental and nervous disorders for a period of not less than 3 years, inclusive of psychiatric residency. [394.455(24), F.S.]
- **“Marriage and family therapist”** means a person licensed as a marriage and family therapist under chapter 491. [394.455(36), F.S.]

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- “**Mental health counselor**” means a person licensed as a mental health counselor under chapter 491. [394.455(37), F.S.]
 - “**Health care proxy**” means a competent adult who has not been expressly designated by an advance directive to make health care decisions for a particular incapacitated individual, but is authorized pursuant to Section 765.401, F.S., to make health care decisions for such individual. [65E-5.100 (8), FAC]
 - “**Health care surrogate**” means any competent adult expressly designated by a principal’s advance directive to make health care decisions on behalf of the principal upon the principal’s incapacity. [65E-5.100 (9), FAC]

Credentials

The professionals and other categories of persons authorized by the Baker Act to perform specific functions on the following Quick Reference Guide are the minimum permitted by law. However, if the hospital or receiving facility has policies that require increased level of credentials to perform a specific function or if standards adopted in the federal Conditions of Participation or by JCAHO or CARF apply to the facility and are more stringent than the Baker Act, those more stringent standards would apply.

A specialized on-line Baker Act course can be found at
<http://www.bakeracttraining.org>.

For further assistance visit: <http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml> to view
DCF’s most Frequently Asked Questions list.

Quick Reference Guide to Decision-Making by Mental Health Professionals and Others

Function	Psychiatrist	Non- psychiatric Physician	Physician Assistant*	Clinical Psychologist	Psych Nurse	LCSW LMHC LMFT	Administrator	Competent Adult, Guardian, GA, Health Care Surrogate/Proxy
Voluntary								
Certification of Competence to Consent	X	X						
Transfer from Voluntary to Involuntary (BA32)	X							
Discharge							X	
Involuntary Examination								
Initiate Examination	X	X	X	X	X	X		
Conduct involuntary Examination	X	X		X				
Transfer to Voluntary	X	X		X				
Authorize Release from Receiving Facility	X	X-ER physician only		X				
Authorize Release from non-receiving Facility	X	X		X				
Involuntary Placement								
1st Opinion on Petition	X							
2nd Opinion on Petition	X			X				
Petition for Continued Involuntary Placement	X	X		X				
Discharge							X	
Treatment								
Physical Examination	X	X	X		X if ARNP			
Psychiatric Examination	X							
Psychological Examination				X				
Non-emergency treatment orders	X	X	X		X			
Emergency medical treatment	X	X						
Emergency Psychiatric Treatment	X	X						
Determine Competence to consent to Treatment	X	X						
Restraint or Seclusion	X	X	X		X			
Consent, Refuse or Revoke Consent to treatment								X
ECT	X	X						
Restriction of Rights								
Communication							X	
Personal Effects							X	
Access one's own records	X	X						
Transfers (hospitals must comply w/EMTALA)								
Public to Public							X DCF	X
Public to Private								X
Private to Public							X	X
Private to Private								X

* Physician Assistants are not explicitly authorized in the Baker Act to initiate involuntary examinations. However, the Florida Attorney General on May 28, 2008 interpreted the law to provide such authorization. This AGO didn't authorize Physician Assistants to perform any other responsibilities under the Baker Act assigned to psychiatrists or other physicians.

Baker Act Notices

s. 394.4597 and s. 394.4599, F.S.

Voluntary Admission

At the time a person is voluntarily admitted to a receiving or treatment facility, the identity and contact information of a person to be notified in case of an emergency must be entered in the person's clinical record. Notice of a person's voluntary admission shall only be given at the request of the person, except that in an emergency, notice shall be given as determined by the facility.

Involuntary Examination

At the time a person is admitted to a facility for involuntary examination or placement, or when a petition for involuntary placement is filed, the names, addresses, and telephone numbers of the person's guardian or guardian advocate or representative if the person has no guardian, and the person's attorney must be entered in the clinical record.

If the person has no guardian, the person must be asked to designate a representative. If unable or unwilling to designate a representative the facility will select one with the consultation of the person from the list below, in the order of listing. The person has the authority to request that any representative be replaced.

First preference must be given to a health care surrogate selected by the person and named in an advance directive. If the person hasn't previously selected a health care surrogate, the selection, except for good cause documented in the clinical record must be made from the following list in the order of listing:

1. Spouse
2. Adult child
3. Parent
4. Adult next of kin
5. Adult friend

A **receiving** facility must give prompt notice of the whereabouts of a person who is being involuntarily held for examination, by telephone or in person within 24 hours after the person's arrival at the facility to the person's representative, **unless the person requests that no notification be made.** Notice of admission to a person's guardian cannot be waived. Contact attempts must be documented in the person's clinical record and must begin as soon as reasonably possible after the person's arrival. While the Baker Act permits a person on involuntary status to request no notice of **admission** be

provided to his/her representative, other notices must be provided – **no waiver is permitted.**

A **treatment** facility must provide notice of a person's involuntary admission on the next regular working day after the person's arrival at the facility. When a person is to be transferred from one facility to another, notice must be given by the facility where the person is located prior to the transfer.

Whenever notice is required to be given, such notice must be given to the person and the person's guardian, guardian advocate, attorney, and representative.

1. Notice must be given both orally and in writing, in the language and terminology that the person can understand, and, if needed, the facility must provide an interpreter for the person.
2. Notice must be given by U.S. mail and by registered or certified mail with the receipts attached to the person's clinical record. Hand delivery by a facility employee may be used as an alternative, with delivery documented in the clinical record. If notice is given by a state attorney or an attorney for the department, a certificate of service is sufficient to document service.

The role of a Designated Representative includes:

- 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
- 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

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- 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

The written notice of the filing of the petition for involuntary inpatient or outpatient placement must contain the following:

1. Notice that the petition has been filed with the circuit court in which the person is hospitalized, and the address of such court.
2. Notice that the office of the public defender has been appointed to represent the person in the proceeding, if the person is not otherwise represented by counsel.
3. The date, time, and place of the hearing, and the name of each examining expert and every other person expected to testify in support of continued detention.
4. Notice that the person, the person's guardian or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the person.
5. Notice that the person is entitled to an independent expert examination and, if the person cannot afford such an examination, that the court will provide for one.

See attached Quick Reference Guide for Provision of Baker Act Notices.

Notices/Copies Quick Reference Guide

Facilities

	Person	Guard	GA	Rep	Atty	AHCA/ Reporting Center	Initiator	Court	DCF	PD	SAO
Rights of Persons (3103)	X	X	X	X							
Communication Restriction (3049)	X	X	X	X	X						
Inventory of Personal Effects (3043)	X	X	X	X							
Restriction of Record Access (3110)	X	X	X	X	X						
Right to Discharge Voluntary Persons (3051a and b)	X										
Notice of Right to Habeas Corpus (3036)	X	X	X	X							
Petition for Habeas Corpus (3090)	X	X	X	X							
Involuntary Initiation Forms (3001 & 3052a and b)						X					
Notice of Involuntary Admission (3045)		X		X							
Refusal or Revocation of Consent to Treatment (3105)		X	X								
Petition for Adjudication of Incompetence and Appt of Guardian Advocate (3106)	X		X	X	X						
Petition Requesting GA to Consent to Extraordinary Tx (3108)	X		X	X							
Release from Involuntary Status (3038)	X	X	X	X			X	X			
Transfer Notice (3046)	X	X	X	X	X						
Notice to Court of Withdrawal of Petition for Involuntary Placement (3033)	X	X		X	X						
Petition Requesting Continued Involuntary Inpatient Placement (3035)	X	X	X	X	X				X	X	X
Order for Involuntary Outpatient Placement	X	X	X	X	X	X					

COURTS

Petition for Involuntary Placement (3032 & 3130)	X	X		X							
Notice of Petition (3021) including: (1) filed with court; (2) PD appointed; (3) date/time/place; (4) change of venue; (5) Independent expert	X	X	X	X	X						
Right to Independent Expert (3022)	X	X		X							
Order Appointing Guardian Advocate (3107)	X		X	X							
Order Authorizing GA to Consent to Extraordinary Treatment (3109)	X		X								

LEGEND

Guard: Guardian
GA: Guardian Advocate
Rep: Representative
Atty: Attorney

AHCA: Agency for Health Care
Administration
(Baker Act Reporting Center)
Initiator: Initiator

DCF: Department of Children & Families
PD: Public Defender
SAO: State Attorney's Office

Marchman Act History and Overview

Chapter 397, FS Chapter 65-D, FAC

History

The Florida Legislature enacted Chapter 397 governing the Treatment and Rehabilitation of Drug Dependents in 1970. The following year, it enacted Chapter 396 titled the Myers Act as the state's "Comprehensive Alcoholism Prevention, Control, and Treatment Act," modeled after the federal Hughes Act. These two laws, each governing different aspects of addiction had a different Florida Administrative Code (or rules) promulgated by the state to fully implement the respective pieces of legislation.

Since persons with substance abuse issues often do not contain their misuse to one substance or another, having two separate laws dealing with the prevention and treatment of addiction was cumbersome and did not address the problems faced by Florida's citizens.

In 1993 Representative Steven Wise of Jacksonville introduced legislation to combine chapters 396 and 397 of Florida Statutes into a single law that clearly spelled out legislative intent, licensure of service providers, client rights, voluntary and involuntary admissions, offender and inmate programs, service coordination, and children's substance abuse services.

The statute was named the Hal S. Marchman Alcohol and Other Drug Services Act of 1993 -- generally referred to as the Marchman Act. The Act was named after Rev. Hal. S. Marchman, a tireless advocate for persons who suffer from alcoholism and drug abuse, who was recognized by the Legislature for his contributions addressing the delivery of substance abuse services.

To implement the new chapter 397, Florida Administrative Code was developed to provide the standards that service providers must uphold in order to be licensed to serve persons with addictions. It also provided detailed policies governing the entire licensing process as well as other provisions. These rules are identified as Chapter 65D-30 of the Florida Administrative Code. These rules have specific legislative authority. Since the rules cannot restate language from the statute, it is critical that individuals are aware of the provision from the law AND the rules in order to carry out the law, protect their agencies from liability, and protect their clients from harm.

Related Legislation

The Marchman Act is the Florida Substance Abuse Impairment Act and it does not serve any other purpose. For many persons, the use of other statutes may be more appropriate. Alternative statutes may include:

The Florida Mental Health Act—The Baker Act. Chapter 394, F.S. governs all issues related to mental illness. The definition of mental illness specifically excludes intoxication and substance abuse impairment.

Emergency Examination and Treatment of Incapacitated Persons Act s. 401.445, F.S. governs EMS examination and treatment without consent where an emergency medical condition is a life-threatening one and the individual is unable to provide informed consent.

EMTALA, 42 USC 1395dd. A federal statute prohibiting hospitals to delay or deny emergency medical services, including psychiatric and substance abuse emergencies. The law requires that each patient must have a medical screening conducted within the full capability and capacity of the hospital and must be stabilized before a transfer or discharge takes place.

Access to Emergency Services and Care. 395.1041, F.S. is a state statute, equivalent of the federal EMTALA law, prohibiting the denial of emergency services and care by hospitals and physicians and enforcing the ability of persons to get all necessary and appropriate emergency care within the capability and capacity of each hospital. This statute also requires hospitals to adhere to rights and involuntary examination procedures provided by the Baker Act, regardless of whether the hospital is designated as a receiving or treatment facility.

Adult Abuse, Neglect, and Exploitations. 415.1051, F.S. is a state statute that may be appropriate when a vulnerable adult (elderly or disabled) is alleged to be a victim of abuse, neglect, or exploitation and lacks the capacity to consent. This means a mental impairment that causes a person to lack sufficient understanding or capacity to make or communicate responsible decisions concerning his person or property, including whether or not to accept protective services from DCF.

Advance Directive. Chapter 765, F.S. provides that if a person has previously executed an advance directive designating a health care surrogate and a physician has found the person to be incompetent or incapacitated to consent to his/her own

treatment, the surrogate may instead be asked to provide such consent. In the absence of an advance directive, a health care proxy may be notified, if a person meeting the degree of relationship is available to serve.

Guardianship. Chapter 744, F.S. governs guardianship procedures. Some persons, due to their incapacity, require either a limited or a plenary guardian appointed by the court to make many life decisions. An incapacitated person is one who has been judicially determined to lack the capacity to manage at least some of his/her property or to meet at least some of the essential health and safety requirements of such person.

Legislative Intent

The 1993 Florida Legislature studied issues surrounding the use and abuse of alcohol and other drugs. The legislators made the following findings:

1. Substance abuse is a major health problem and leads to such profoundly disturbing consequences as serious impairment, chronic addiction, criminal behavior, vehicular casualties, spiraling health care costs, AIDS, and business losses, and profoundly affects the learning ability of children within our schools and educational systems. Substance abuse impairment is a disease, which affects the whole family and the whole society and requires specialized prevention, intervention, and treatment services that support and strengthen the family unit.
2. Provide for a comprehensive continuum of accessible and quality substance abuse prevention, intervention, and treatment services in the least restrictive environment of optimum care that protects and respects the rights of clients, especially for involuntary admissions, primarily through community-based private not-for-profit providers working with local governmental programs involving a wide range of agencies from both the public and private sectors.
3. Ensure within available resources a full continuum of substance abuse services based on projected identified needs, delivered without discrimination and with adequate provision for specialized needs.
4. Discourage substance abuse by promoting healthy lifestyles and drug-free schools, workplaces, and communities.
5. Integrate program evaluation efforts, adequate administrative support services, and quality assurance strategies with direct service provision requirements and to ensure funds for these purposes.

6. Require the cooperation of departmental programs, services, and program offices in achieving the goals of this chapter and addressing the needs of clients.
7. Provide, for substance abuse impaired adult and juvenile offenders, an alternative to criminal imprisonment by encouraging the referral of such offenders to service providers not generally available within the correctional system instead of or in addition to criminal penalties.
8. Provide, within the limits of appropriations and safe management of the correctional system, substance abuse services to substance abuse impaired offenders who are incarcerated within the Department of Corrections, in order to better enable these inmates to adjust to the conditions of society presented to them when their terms of incarceration end.
9. Provide for assisting substance abuse impaired persons primarily through health and other rehabilitative services in order to relieve the police, courts, correctional institutions, and other criminal justice agencies of a burden that interferes with their ability to protect people, apprehend offenders, and maintain safe and orderly communities.
10. Establish a clear framework for the comprehensive provision of substance abuse services in the context of a coordinated and orderly system.
11. Freedom of religion of all citizens shall be inviolate. Nothing in this act shall give any governmental entity jurisdiction to regulate religious, spiritual, or ecclesiastical services.

Selected Definitions

397.311, F.S.

“Substance abuse” means the misuse or abuse of, or dependence on alcohol, illicit drugs, or prescription medications. As an individual progresses along this continuum of misuse, abuse, and dependence, there is an increased need for substance abuse intervention and treatment to help abate the problem. (36)

“Impaired” or “substance abuse impaired” means a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behavior. (14)

“Qualified professional” means a physician or a physician assistant licensed under chapter 458 or chapter 459; a professional licensed under chapter 490 or chapter 491; an advanced registered nurse practitioner having a specialty

in psychiatry licensed under part I of chapter 464; or a person who is certified through a department-recognized certification process for substance abuse treatment services and who holds, at a minimum, a bachelor's degree. A person who is certified in substance abuse treatment services by a state-recognized certification process in another state at the time of employment with a licensed substance abuse provider in this state may perform the functions of a qualified professional as defined in this chapter but must meet certification requirements contained in this subsection no later than 1 year after his or her date of employment. (26)

“Service provider” or “provider” means a public agency, a private for-profit or not-for-profit agency, a person who is a private practitioner, or a hospital licensed under this chapter or exempt from licensure under this chapter. (33)

“Licensed service provider” means a public agency under this chapter, a private for-profit or not-for-profit agency under this chapter, a physician or any other private practitioner licensed under this chapter, or a hospital that offers substance abuse services through one or more licensed service components. (17)

Client Rights

The Marchman Act provides an array of statutorily protected rights of persons seeking and or receiving substance abuse services as well as due process rights of those persons for whom involuntary interventions are sought. These include:

1. **INDIVIDUAL DIGNITY** must be respected at all times and upon all occasions, including any occasion when the client is admitted, retained, or transported. Substance abuse clients who are not accused of a crime or delinquent act may not be detained or incarcerated in jails, detention centers, or training schools of the state, except for purposes of protective custody in strict accordance with this chapter. A client may not be deprived of any constitutional right.
2. **NONDISCRIMINATORY SERVICES.** Service providers may not deny a client access to substance abuse services solely on the basis of race, gender, ethnicity, age, sexual preference, HIV status, prior service departures against medical advice, disability, or number of relapse episodes. Service providers may not deny a client who takes medication prescribed by a physician access to substance abuse services solely on that basis. Service providers who receive state funds to provide substance abuse services may not, provided space and sufficient state resources are available, deny a client access to services based solely on inability to pay.
3. **QUALITY SERVICES.** Each client must be delivered services suited to his or her needs, administered skillfully, safely, humanely, with full respect for his or her dignity and personal integrity, and in accordance with all statutory and regulatory requirements. Each client in treatment must be afforded the opportunity to participate in the formulation and periodic review of his or her individualized treatment or service plan to the extent of his or her ability to so participate. It is the policy of the state to use the least restrictive and most appropriate services available, based on the needs and the best interests of the client and consistent with optimum care of the client. Each client must be afforded the opportunity to participate in activities designed to enhance self-image.
4. **COMMUNICATION.** Each client has the right to communicate freely and privately with other persons within the limitations imposed by service provider policy. Because the delivery of services can only be effective in a substance abuse free environment, close supervision of each client's communications and correspondence is necessary, particularly in the initial stages of treatment, and the service provider must therefore set reasonable rules for telephone, mail, and visitation rights, giving primary consideration to the well-being and safety of clients, staff, and the community. It is the duty of the service provider to inform the client and his or her family if the family is involved at the time of admission about the provider's rules relating to communications and correspondence.
5. **CARE AND CUSTODY OF PERSONAL EFFECTS.** A client has the right to possess clothing and other personal effects. The service provider may take temporary custody of the client's personal effects only when required for medical or safety reasons, with the reason for taking custody and a list of the personal effects recorded in the client's clinical record.
6. **EDUCATION OF MINORS.** Each minor client in a residential service component is guaranteed education and training appropriate to his or her needs. The service provider shall coordinate with local education agencies to ensure that education and training is provided to each minor client in accordance with other applicable laws and regulations and that parental responsibilities related to such education and training are established within the provisions of such applicable laws and regulations. Nothing in this chapter may be construed to relieve any local education authority of its obligation under law to provide a free and appropriate education to every child.

7. CONFIDENTIALITY OF CLIENT RECORDS.

The records of service providers which pertain to the identity, diagnosis, and prognosis of and service provision to any individual client are confidential in accordance with this chapter and with applicable federal confidentiality regulations and are exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. Such records may not be disclosed without the written consent of the client to whom they pertain except that appropriate disclosure may be made without such consent. Federal regulations also provides extensive protections regarding confidentiality.

8. **COUNSEL.** Each client must be informed that he or she has the right to be represented by counsel in any involuntary proceeding for assessment, stabilization, or treatment and that he or she, or if the client is a minor his or her parent, legal guardian, or legal custodian, may apply immediately to the court to have an attorney appointed if he or she cannot afford one.

9. **HABEAS CORPUS.** At any time, and without notice, a client involuntarily retained by a provider, or the client's parent, guardian, custodian, or attorney on behalf of the client, may petition for a writ of habeas corpus to question the cause and legality of such retention and request that the court issue a writ for the client's release.

10. **LIABILITY AND IMMUNITY.** Service provider personnel who violate or abuse any right or privilege of a client under this chapter are liable for damages as determined by law. All persons acting in good faith, reasonably, and without negligence in connection with the preparation or execution of petitions, applications, certificates, or other documents or the apprehension, detention, discharge, examination, transportation, or treatment of a person under the provisions of this chapter shall be free from all liability, civil or criminal, by reason of such acts.

Voluntary Admission

A person, whether adult or minor, who wishes to enter treatment for substance abuse may apply to a service provider for voluntary admission. Within the financial and space capabilities of the service provider, a person of any age must be admitted to treatment when sufficient evidence exists that the person is impaired by substance abuse and the medical and behavioral conditions of the person are not beyond the safe management capabilities of the service provider.

Involuntary Admissions

The Marchman Act encourages persons to seek out treatment on a voluntary basis and to be actively involved in planning their own services with the assistance of qualified professionals. However, denial of addiction is a common symptom, raising a barrier to early intervention and treatment. As a result, treatment often comes as a result of a spouse, employer, doctor, judge or other person with influence over one's life to obtain needed substance abuse services.

The Marchman Act established a variety of methods under which substance abuse assessment, stabilization and treatment could be obtained on an involuntary basis. There are five involuntary admission procedures. Three of the procedures do not involve the court, while two require direct petitions to the circuit court. The three non-court procedures are:

- Protective Custody
- Emergency Admission
- Alternative Involuntary Assessment for Minors

However, the law also offers a court-related procedure titled "Involuntary Assessment and stabilization."

Based on findings of one of the four methods above, a petition for Involuntary Treatment can be filed with the circuit court seeking up to 60 days of treatment.

Regardless of the court-involved or non court-involved nature of the proceedings, the same criteria for involuntary admission apply.

Criteria

The criteria for all involuntary admissions includes:

There is good faith reason to believe the person is substance abuse impaired and, because of such impairment:

1. Has lost the power of self-control with respect to substance use; **and either**
 - a. Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; **or**
 - b. Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto; however, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services.

Each of the five methods of initiating an involuntary admission specified above has different requirements and procedures. See the quick reference guide at the end of this appendix for a summary of the provisions of each method of initiating involuntary admission.

Protective Custody

This procedure is used by law enforcement officers when a person is intoxicated in public *or* brought to the attention of the officer. The purpose is to take the person to a safe environment where the person can be assessed to determine the need for treatment. The officer may take the person home, to a hospital, a detoxification center, or addiction receiving facility, or in certain circumstances, to a jail, whichever the law enforcement officer believes is most appropriate. Minors cannot be taken to jail. A person can be held for assessment for up to 72 hours prior to release, unless converting to voluntary status or a petition for involuntary treatment filed with the court.

Emergency Admission

This procedure permits a person who appears to meet the criteria for involuntary admission to be admitted to a hospital, an addiction receiving facility or a detoxification facility for emergency assessment and stabilization. This procedure may be initiated by a physician, spouse, guardian, relative, or any responsible adult who has personal knowledge of the person. In the case of a minor, emergency admission can be initiated by a parent, legal guardian or legal custodian. In any case, the application for an emergency admission must be accompanied by the certificate of a physician.

A person can be held up to 72-hours under Emergency Admission status before being released, unless converting to voluntary status or a petition for involuntary treatment is filed with the court.

Alternative Involuntary Assessment for Minors

This procedure provides a way for a parent, legal guardian or legal custodian to have a minor admitted to an addiction receiving facility to assess the minor's need for treatment. The minor can be held for up to 72 hours, but this period can be extended to five total days upon a physician's assessment.

Involuntary Assessment & Stabilization

This procedure involves filing a petition with the Clerk of the Court. The petition may be filed by the person's spouse, guardian, any relative, a private practitioner, the director of a

licensed service provider, or any three adults with knowledge of the person. If the person is a minor, the petition may be filed by a parent, a legal guardian, a legal custodian, or a licensed service provider. The court can schedule a hearing to take place within 10 days or can issue an ex parte order immediately. The person can be admitted to a hospital, an addictions receiving facility or a detoxification facility for assessment and stabilization to determine the person's need for treatment.

A person can be held up to five days for court ordered assessment and stabilization, unless the person transfers to voluntary status or a petition for involuntary treatment is filed with the court. If additional time is required to complete the assessment, the court may grant an additional 7 days upon a timely written request.

Involuntary Treatment

This procedure involves filing a petition with the Clerk of the Court after the person has been involved in at least one of the four previously mentioned procedures. The petition may be filed by the same petitioners as involuntary assessment and stabilization. The person can be court ordered for involuntary treatment up to 60 days, but the term of treatment can be extended by the court upon a timely filing of a petition for an extension.

Provider Responsibilities

Service provider responsibilities regarding involuntary admissions are as follows:

- Ensure that a person who is admitted to a licensed service component meets the admission criteria specified in the law;
- Ascertain whether the medical and behavioral conditions of the person, as presented, are beyond the safe management capabilities of the service provider;
- Provide for the admission of the person to the service component that represents the least restrictive available setting that is responsive to the person's treatment needs;
- Verify that the admission of the person to the service component does not result in a census in excess of its licensed service capacity;
- Determine whether the cost of services is within the financial means of the person or those who are financially responsible for the person's care; and
- Take all necessary measures to ensure that each individual in treatment is provided with a safe

environment, and to ensure that each individual whose medical condition or behavioral problem becomes such that he or she cannot be safely managed by the service component is discharged and referred to a more appropriate setting for care.

When, in the judgment of the service provider, the person who is being presented for involuntary admission should not be admitted because of his or her failure to meet admission criteria, because his or her medical or behavioral conditions are beyond the safe management capabilities of the service provider, or because of a lack of available space, services, or financial resources to pay for his or her care, the service provider, in accordance with federal confidentiality regulations, must attempt to contact the referral source, which may be a law enforcement officer, physician, parent, legal guardian if applicable, court and petitioner, or other referring party, to discuss the circumstances and assist in arranging for alternative interventions.

When the service provider is unable to reach the referral source, the service provider must refuse admission and attempt to assist the person in gaining access to other appropriate services, if indicated.

Upon completing these efforts, the service provider must, within one workday, report in writing to the referral sources, in compliance with federal confidentiality regulations:

1. The basis for the refusal to admit the person, and
2. Documentation of the service provider's efforts to contact the referral source and assist the person, when indicated, in gaining access to more appropriate services.

When, in the judgment of the service provider, the medical conditions or behavioral problems of an involuntary individual become such that they cannot be safely managed by the service component, the service provider must discharge the individual and attempt to assist him or her

in securing more appropriate services in a setting more responsive to his or her needs. Upon completing these efforts, the service provider must, within 72 hours, report in writing to the referral source, in compliance with federal confidentiality regulations:

1. The basis for the individual's discharge; and
2. Documentation of the service provider's efforts to assist the person in gaining access to appropriate services.

Upon giving his or her written informed consent, an involuntarily admitted individual may be referred to a service provider for voluntary admission when the service provider determines that the individual no longer meets involuntary criteria.

An individual involuntarily admitted to a licensed service provider may be released without further order of the court only by a qualified professional in a hospital, a detoxification facility, an addictions receiving facility, or any less restrictive treatment component. Notice of the release must be provided to the applicant in the case of an emergency admission or an alternative involuntary assessment for a minor, or to the petitioner and the court if the involuntary assessment or treatment was court ordered. In the case of a minor, the release must be:

1. To the individual's parent, legal guardian, or legal custodian or the authorized designee;
2. To the Department of Children and Family Services; or
3. To the Department of Juvenile Justice.

Oversight

The Department of Children and Family Services is designated the "Substance Abuse Authority" of Florida. It is required to adopt rules establishing standards relating to the rights and privileges of persons seeking substance abuse prevention and treatment from licensed service providers.

For further assistance visit: <http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml> to view DCF's most Frequently Asked Questions list.

Quick Reference Guide to Involuntary Admissions under the Marchman Act

Admission	How Initiated	Means	Requirements	Length of Stay	Disposition
Protective Custody 397.677, FS	Law Enforcement	LEO Report Initiating Protective Custody	Release by Qualified Professional*	Up to 72 hours	<ul style="list-style-type: none"> Discharge/Refer Voluntarily Remain Retain if petition filed
Emergency Admission 397.679, FS	Adult: physician, spouse, guardian, relative, or other responsible adult Minor: parent, guardian, or legal custodian	Application and Physician's Certificate	Physician assessment & qualified professional* assessment to determine need for further services and approve release	Up to 72 hours or 5 days to a non-residential component	<ul style="list-style-type: none"> Discharge/Refer Voluntarily Remain Retain if petition filed
Alternative Involuntary Admission for Minors 397.6798, FS	Minor's parent, guardian, or legal custodian to Addiction Receiving Facility	Application by eligible person	Assessment by qualified professional*	Up to 72 hours – can be extended to 5 days total upon physician assessment.	<ul style="list-style-type: none"> Discharge to parent, guardian, custodian, DCF, or DJJ Voluntarily Remain Retain if Petition Filed
Court-Ordered Assessment 397.681, FS	Adult: spouse, guardian, relative, private practitioner, director of licensed provider, or 3 adults. Minor: parent, guardian, legal custodian or licensed service provider	Civil Order from a Circuit Judge – can be ex parte or following a scheduled hearing. Sheriff may be ordered to transport	Assessed by qualified professional* and by a physician.	Up to 5 days. Court may grant up to 7 additional days to complete the assessment and stabilization	<ul style="list-style-type: none"> Discharge/Refer Voluntarily Remain Retain if petition filed
Involuntary Treatment: after 1 of the 4 assessments above. 397.693, FS	Adult: spouse, guardian, relative, service provider, or any 3 adults Minor: parent, legal guardian, or service provider	Civil Order from a Circuit Judge. Sheriff may be ordered to transport	Authorizes the provider to require client to undergo treatment that will be beneficial until released by qualified professional	Up to 60 days	<ul style="list-style-type: none"> Discharge/Refer Voluntarily Remain Retain if extension requested
Extension of Involuntary Treatment	Service Provider at least 10 days prior to end of order	Hearing within 15 days and order from a Circuit Judge	Same as involuntary treatment.	Each extension up to 90 days	Same as involuntary treatment
Habitual Abusers 397.701, FS	Agent specified in local ordinance files petition	Hearing within 10 days	Participation in treatment program	Up to 90 days in licensed secure facility with extensions of 180 days each	<ul style="list-style-type: none"> Discharge/Refer Voluntarily Remain Retain if extension requested
Offender Referral 397-705	Court	Court order in addition to any other penalty or sentence	Screening, assessment, and treatment services from licensed service provider	Up top maximum length of sentence for the offense.	
Inmate Programs 397.752 FS	Federal and State Departments of Correction		Individualized treatment	Up top maximum length of sentence for the offense	One month before EOS given options for continuing services

* Qualified Professional: Physician licensed under 458 or 459; or Professional licensed under chapter 490 or 491 (Psychologist, Clinical SW, Marriage & Family Therapist or Mental Health Counselor); or Person who is certified through a DCF recognized certification process for substance abuse treatment services and who holds, at a minimum, a bachelor's degree.

Baker Act and Marchman Act Comparison

Introduction and History	1	Release from Involuntary Placement /	
Definitions	1	Treatment & Notices.....	19
Service Providers	3	Responsibilities of Providers	20
Voluntary Admissions.....	3	Rights: General	21
Involuntary Examination/ Admission Criteria	4	Rights: Individual Dignity.....	21
Procedure for Involuntary Examination/Assessments.....	5	Rights: Treatment.....	21
Transportation Requirements for Involuntary		Rights: Express and Informed Consent.....	22
Examination / Admission	9	Rights: Quality Treatment / Services.....	24
Examination or Assessment	12	Rights: Confidentiality	25
Release or Discharge.....	13	Rights: Communication, Abuse Reporting & Visitation	26
Notice of Release from Involuntary Examination /		Rights: Care & Custody of Personal Effects.....	26
Involuntary Admission	14	Rights: Non-Discrimination.....	27
Involuntary Placement / Involuntary Treatment —		Rights: Voting in Public Elections	27
Procedure for Filing Petitions	15	Rights: Right to Counsel.....	27
Appointment of Counsel.....	17	Rights: Habeas Corpus.....	27
Hearings for Involuntary Placement / Treatment	17	Rights: Separation of Children from Adults.....	28
Initial Order.....	17	Rights: Education of Minors	28
Hearings on Continued Involuntary Placement /		Special Issues	28
Treatment.....	17		

Baker Act	Marchman Act
Introduction and History	
The Baker Act was enacted by the 1971 Florida Legislature and took effect in 1972. It was named after its legislative sponsor, Representative Maxine Baker from Miami. The legislative intent was to provide for the least restrictive form of intervention and to provide a Bill of Rights for persons of all ages who had mental illnesses. It has been frequently amended over the years, but continues to balance liberty interests against safety of individual and society.	Hal S. Marchman Alcohol & Other Drug Services Act of 1993 -- addresses the entire array of substance abuse impairment issues. It replaced the Myers Act (396, FS) -- alcohol abuse only and the Florida Drug Dependency Act (397, FS) which addressed other drugs. The Marchman Act is not just the substance abuse version of the Baker Act.
Definitions	
Baker Act (394.455, FS and 65E-5.100, FAC) Mental Illness means: 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 regardless of etiology; excluding intellectual or developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.	Marchman Act (397.311, FS) Substance Abuse Impairment means: A condition involving the use of alcohol or any psychoactive or mood-altering substance in such a manner as to induce: <ul style="list-style-type: none"> ▪ mental, or ▪ emotional, or ▪ physical problems, and ▪ Cause socially dysfunctional behavior

Baker Act	Marchman Act
Express & Informed Consent	
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.	Informed Consent required for voluntary admission, but not defined in Marchman Act.
Incompetent to Consent	
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.	Not defined in Marchman Act
Qualified Professionals	
394.455(2), (4), (21), (23) and (24), FS 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. Mental Health Counselor: Means a mental health counselor licensed under chapter 491, F.S. 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)	A physician licensed under Chapter 458 or 459, F.S., A practitioner licensed under Chapter 490 or 491, F.S., or A person who is certified through a department-recognized certification process. Individuals who are certified are permitted to serve in the capacity of a qualified professional, but only within the scope of their certification. Reciprocity with other states – meet Florida requirements within 1 year. Grandfather Clause – certified in Florida prior to 1/1/95.

Baker Act	Marchman Act
Service Providers	
<p>Baker Act (394.455(26) and (30), FS)</p> <ul style="list-style-type: none"> Unless designated by DCF, facilities are not permitted to hold or treat persons 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 persons on involuntary status under emergency conditions for psychiatric evaluation and to provide short-term treatment (excludes jails). Treatment Facility: State Mental Health Facilities (state hospitals) Service provider means any public or private receiving facility, an entity under contract with the Department of Children and Family Services to provide mental health services, a clinical psychologist, a clinical social worker, a marriage and family therapist, a mental health counselor, a physician, a psychiatric nurse as defined in subsection (23), or a community mental health center or clinic as defined in this part. 	<p>Marchman Act (397.405, FS)</p> <ul style="list-style-type: none"> Public agencies, Private for-profit or not-for-profit agencies, Specified private practitioners, Hospitals that are DCF licensed or exempt from licensure under the Marchman Act. Exempt from licensure: hospitals, nursing homes, federal facilities, physicians (458/459), psychologists, chapter 491 professionals, DD facilities, churches under certain circumstances, and substance abuse education programs (s.1003.42) – generally limited to voluntary services only. “Detoxification” is a service involving subacute care that is provided on an inpatient or an outpatient basis to assist individuals to withdraw from the physiological and psychological effects of substance abuse and who meet the placement criteria for this component. “Addictions receiving facility” is a secure, acute care facility that provides, at a minimum, detoxification and stabilization services; is operated 24 hours per day, 7 days per week; and is designated by the department to serve individuals found to be substance use impaired as described in s. 397.675 who meet the placement criteria for this component.
Voluntary Admissions	
<p>Baker Act (394.4625, FS and 65E-5.270, FAC)</p> <p>Adults: 394.4625, FS and 65E-5.270, FAC</p> <ul style="list-style-type: none"> Have a mental illness Be suitable for treatment Be competent to provide express and informed consent <p>Minors:</p> <ul style="list-style-type: none"> Have a mental illness (same definition as for adults) Be suitable for treatment Guardian applies 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 	<p>Marchman Act (397.601, FS)</p> <ul style="list-style-type: none"> Any person, regardless of age, who wishes to enter substance abuse treatment may apply to a service provider for voluntary admission if meeting diagnostic criteria for substance abuse related disorders. Disability of minority (under 18) removed solely for purpose of voluntary admission, but not for involuntary when parental participation may be required by the court. Setting must be least restrictive setting appropriate to person’s treatment needs.
Requirements for Voluntary Status:	
<ul style="list-style-type: none"> Must be on involuntary status if a guardian has been appointed by a court or if a person has a healthcare surrogate proxy because a physician has found the person to be incompetent to make his or her own health care decisions. A Certification of Competence must be completed by a physician within 24 hours of arrival or adult must be released or converted to involuntary. 	<p>Upon giving written informed consent, a person on involuntary status may be referred to a service provider for voluntary admission when the provider determines person no longer meets involuntary criteria.</p>

Baker Act	Marchman Act
<p>Release from Voluntary Status:</p> <p>394.4625(2), FS and 65E-5.270, FAC</p> <ul style="list-style-type: none"> ▪ 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 or refusal of treatment is made 	
Involuntary Examination/ Admission Criteria	
<p>Baker Act (394.463(1),FS)</p> <p>The Baker Act provides for an involuntary examination that may be initiated by two non-court procedures or one court procedure. The following criteria is the same regardless of which of the three methods of initiation is used:</p> <ol style="list-style-type: none"> 1. 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: 2. 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 3. 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. <p>Must meet all criteria</p> <p>Initiation of Involuntary Examination: Upon determination that person appears to meet criteria for involuntary examination, the exam may be initiated by any one of the following three means:</p> <ul style="list-style-type: none"> ▪ Court Order - the circuit court may enter an ex parte order; or ▪ A law enforcement officer shall take into custody a person who appears to meet the criteria describing circumstances; or ▪ 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 his/her observations upon which that conclusion is based. <p>More detail on each of the above methods of initiation is found below.</p>	<p>Marchman Act (397.675, FS)</p> <p>The Marchman Act provides three distinct non-court procedures (protective custody, emergency admission, alternative assessment and stabilization of minors) and one court procedure (involuntary assessment and stabilization) for conducting assessments, which may include detoxification, stabilization, and short-term treatment. The criteria is:</p> <p>There is good faith reason to believe the person is substance abuse impaired and, because of such impairment:</p> <ol style="list-style-type: none"> 1. Has lost the power of self-control with respect to substance use; and either 2a. Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; or 2b. Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto; however, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services. <p>Eligibility for initiation of involuntary admission proceedings under the Marchman Act is different depending on the age of the individual and the circumstances:</p> <ul style="list-style-type: none"> ▪ The court may order an involuntary assessment / stabilization, ▪ A law enforcement officer can initiate Protective Custody, ▪ A parent/guardian can initiate assessment of a minor to a JARF, or ▪ a variety of individuals can initiate an Emergency Admission if a physician's certificate has been obtained.

Baker Act	Marchman Act
Procedure for Involuntary Examination/Assessments	
Assessment & Examination Options	
<p>The Baker Act provides that involuntary examinations be conducted only at designated hospital and non-hospital receiving facilities, as well as at hospitals that have provided examination and treatment of emergency medical conditions.</p>	<p>The Marchman Act provides several placement options for assessing persons (e.g., hospitals, addictions receiving facilities, detoxification facilities, less restrictive environments, jail).</p>
Reporting Requirements	
<p>394.459(9), 394.463(2)b, and 400.102(1)(c), FS</p> <p>The Baker Act requires that the ex parte order, law enforcement officer's report, or executed certificate be forwarded to the Agency for Healthcare Administration (AHCA) on the next working day following admission of a person to a receiving facility.</p> <p>Any receiving facility accepting person for involuntary examination must send to BA Reporting Center cover sheet (#3118) and copy of completed initiation form:</p> <ul style="list-style-type: none"> ▪ Ex Parte Petition/Order ▪ Report of Law Enforcement Officer ▪ Certificate of a Professional <p>All court orders for Involuntary Placement must also be sent to the BA Reporting Center within 1 day:</p> <ul style="list-style-type: none"> ▪ Involuntary Inpatient Placement Order ▪ Involuntary Outpatient Placement Order <p>Receiving facilities must 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 governing:</p> <ul style="list-style-type: none"> ▪ Voluntary admission ▪ Involuntary examination ▪ Transportation 	<p>The Marchman Act does not require contact with AHCA regarding involuntary admissions.</p>

Baker Act	Marchman Act
<p>MH/SA Professional Initiation (394.463(2)(a)3, FS and 65E-5.280(3), FAC)</p> <p>The Baker Act permits a physician, clinical psychologist, psychiatric nurse, clinical social worker, mental health counselor, or marriage and family therapist to execute a certificate if a person has been examined within the preceding 48 hours. The Florida Attorney General issued an opinion in 2008 that a Physician Assistant was also eligible to initiate and involuntary examination, but didn't authorize the PA to perform any other activities permitted for a physician.</p> <p>The authorized professional must cite his/her own observations on which his/her conclusion is based on a Certificate of a MH Professional (3052b) form and can't rely only upon the observations or input of others. The individual must be transported to the nearest receiving facility unless the County Commission and DCF have approved a Transportation Exception Plan (can transfer later if appropriate).</p>	<p>Emergency Admissions (397.679, FS)</p> <p>An application for emergency admission may be initiated:</p> <p>For a <u>minor</u> by the parent, guardian or legal custodian or for <u>adults</u> by:</p> <ul style="list-style-type: none"> ▪ Certifying physician ▪ Spouse or guardian ▪ Any relative ▪ Any other responsible adult who has personal knowledge of the person's substance abuse impairment. <p>An application for Emergency Admission must be accompanied by a Physician's Certificate. The Physician's Certificate must include:</p> <ul style="list-style-type: none"> ▪ Name of client ▪ Relationship between client and physician ▪ Relationship between physician and provider ▪ Statement that exam & assessment occurred within 5 days of application date, and ▪ Factual allegations about the need for emergency admission: ▪ Reasons for physician's belief the person meets each criteria for involuntary admission ▪ Recommend the least restrictive type of service ▪ Be signed by the physician ▪ State if transport assistance is required and specify the type needed. ▪ Accompany the person and be in chart with signed copy of application. <p>A person meeting involuntary admission criteria may be admitted for emergency assessment and stabilization upon receipt of a completed application with an attached completed physician's certificate to:</p> <ul style="list-style-type: none"> ▪ A hospital, or ▪ A licensed detox, or ▪ An ARF, or ▪ A less intensive component of a licensed service provider for assessment only
	<p>Release from Emergency Admission:</p> <p>Within 72 hours after emergency residential admission, client must be assessed by attending doctor to determine need for further services (5 days in OP). Based on assessment, a qualified professional* must:</p> <ul style="list-style-type: none"> ▪ Release the client / refer ▪ Retain the client voluntarily ▪ Retain the client and file a petition for involuntary assessment or treatment (authorizes retention pending court order).

Baker Act	Marchman Act
<p>Law Enforcement 384.463(2)(a)2, FS and 65E-5.280(2), FAC</p> <ul style="list-style-type: none"> Law enforcement officer is defined to mean a law enforcement officer as defined in s. 943.10, FS. The Florida Attorney General has issued several opinions excluding various federal law enforcement agencies from this definition because they are not certified by the State of Florida. A Law Enforcement Officer is required to describe the circumstances under which he/she has taken the individual into custody under the involuntary examination provisions of the Baker Act. The officer is not required to personally observe the behavior leading to the Baker Act, as is a Mental Health Profession who initiates the examination. The mandatory Report of Law Enforcement Officer -- Form (3052a) -- must be completed by the officer and accompany the individual to a receiving facility or hospital. Transportation by the law enforcement officer must be to the nearest receiving facility unless the individual has an emergency medical condition. He/she can be transferred later by the facility if appropriate 	<p>Protective Custody (397.677, FS)</p> <p>A law enforcement officer means a law enforcement officer as defined in 943.10(1), FS</p> <p>Law enforcement may implement for adults or minors when involuntary admission criteria appears to be met who is in a public place or is brought to attention of LEO.</p> <p>A person may consent to LEO assistance to:</p> <ul style="list-style-type: none"> home, or hospital, or licensed detox center, or addictions receiving facility, whichever the LEO determines is most appropriate. <p>Law enforcement officer may take person (after considering wishes of person) without consent to:</p> <ul style="list-style-type: none"> Hospital, or Detox, or ARF, or An adult may be taken to jail. Not an arrest and no record made. Jail must notify nearest appropriate licensed provider within 8 hours and shall arrange transport to provider with an available bed. The person must be assessed by jail's attending physician without unnecessary delay but within 72-hours
	<p>Release from Protective Custody must be by a qualified professional* when:</p> <ul style="list-style-type: none"> Client no longer meets the involuntary admission criteria, or The 72-hour period has elapsed; or Client has consented to remain voluntarily, or Petition for involuntary assessment or treatment has been initiated. Timely filing of petition authorizes retention of client pending further order of the court.
No corresponding provision in the Baker Act	<p>Alternative Assessment for Minors</p> <p>Admission to a Juvenile Addiction Receiving Facility (JARF) for a minor meeting involuntary criteria upon application from:</p> <ul style="list-style-type: none"> Parent, Guardian, or Legal custodian <p>Application must establish need for immediate admission and contain specific information, including reasons why applicant believes criteria is met.</p> <ul style="list-style-type: none"> Assessment by qualified professional within 72 hours to determine need for further services. Physician can extend to total of 5 days if further services are needed. Minor must be timely released or referred for further voluntary or involuntary treatment, whichever is most appropriate to minor's needs.

Baker Act	Marchman Act
<p>Circuit Court Order 394.463(2)(a)1, FS and 65E-5.280(1), FAC</p> <ul style="list-style-type: none"> Ex Parte means one-sided communication with the court and is generally used in emergency situations. The judge doesn't hear testimony about the circumstances of the petition, but only considers the information on the petition. The Baker Act requires that an Ex Parte order be based on sworn testimony. This can be as few as one petitioner or as many as needed to inform the circuit court judge that the criteria for involuntary examination appears to be met. Recommended petition form (#3002) may be used by the courts. The petition must be filed with Clerk of the Court (Probate) and no fee can be charged The Ex Parte Order is valid for seven days unless the court has specified a longer or shorter time limit for execution of order Law enforcement can execute the Ex Parte Order any hour of the day, on any day of the week and is authorized to use whatever reasonable force is needed to enter the premises to take the person into custody. Transportation must be to the nearest receiving facility (unless a transportation exception plan has been approved by the Board of County Commissioners and the DCF Secretary) the facility will transfer the individual later to a different facility if appropriate. 	<p>Ex parte Order (397. 681, FS)</p> <p>The Marchman Act permits entering an ex parte order based solely on the contents of a petition for involuntary assessment and stabilization.</p> <p>Petitions (397.6811, FS)</p> <ul style="list-style-type: none"> Petitions filed with Clerk of Court in county where person is located. Circuit court has jurisdiction Chief judge may appoint general or special master. Person has right to counsel at every stage of a petition for involuntary assessment or treatment. Court will appoint counsel if requested or if needed and person cannot afford to pay. Un-represented minor must have court-appointed guardian ad litem to act on the minor's behalf. <p>Adult: Petition may be filed by:</p> <ul style="list-style-type: none"> Spouse, Guardian, Any relative, Private practitioner, Any three adults having personal knowledge of person's condition, or Service provider director/designee. <p>Minor: Petition may be filed by:</p> <ul style="list-style-type: none"> Parent Legal guardian Legal custodian, or Licensed service provider. <p>Providers may initiate petitions for involuntary assessment and stabilization, or involuntary treatment when that provider has direct knowledge of the respondent's substance abuse impairment or when an extension of the involuntary admission period is needed.</p>
	<p>Petition for Assessment & Stabilization (397.6814, FS) must contain:</p> <ul style="list-style-type: none"> Name of applicants and respondent Relationship between them Name of attorney, if known Ability to afford an attorney Facts to support the need for involuntary admission, including why petitioner believes person meets each criteria for involuntary intervention.

Baker Act	Marchman Act
	<p>Role of the Court:</p> <ul style="list-style-type: none"> ▪ Clerk must determine whether person is represented by an attorney, and if not, whether an attorney should be appointed. ▪ Based on a hearing or solely on petition and without an attorney, enter an ex parte order authorizing assessment & stabilization. ▪ If hearing is scheduled, a summons issued to respondent and hearing scheduled within 10 days
	<p>Court Determination (397.6818, FS)</p> <ul style="list-style-type: none"> ▪ Court shall hear all relevant testimony at hearing. ▪ Respondent must be present unless injurious and a guardian advocate is appointed. ▪ Right to examination by court-appointed qualified professional. ▪ Determination by court whether a reasonable basis to believe person meets involuntary admission criteria. ▪ Court may either enter an order authorizing assessment & stabilization or dismiss petition. ▪ Court may initiate Baker Act if condition is due to mental illness other than or in addition to substance abuse ▪ Respondent or court may choose provider ▪ Order must include findings as to availability & appropriateness of least restrictive alternatives & need for attorney to represent respondent. ▪ If court determines that person meets criteria, he/she may be admitted: ▪ Up to 5 days to hospital, detox or ARF for assessment & stabilization, or ▪ Less restrictive licensed setting for assessment only
	<p>Provider Response for Court Ordered Evaluation (397.6819, FS)</p> <ul style="list-style-type: none"> ▪ Licensed provider may admit person for assessment without unnecessary delay, for a period of up to 5 days. ▪ Assessment must be conducted by a “qualified professional”. ▪ Assessment must be reviewed by a physician prior to end of assessment period. ▪ Provider may request court to extend time for assessment & stabilization for 7 more days, if timely filed within the 5-day assessment period. <p>Based upon involuntary assessment (397.822, FS), person may be:</p> <ul style="list-style-type: none"> ▪ Released ▪ Remain voluntarily ▪ Retained if a petition for involuntary treatment has been initiated. <p>Timely petition authorizes retention of client pending further order of the court.</p>

Baker Act

Marchman Act

Transportation Requirements for Involuntary Examination / Admission

Baker Act 394.462, FS and 65E-5.260, FAC

Law enforcement is mandated to provide the transportation of persons under involuntary status to the nearest receiving facility regardless of how the examination was initiated (court, law enforcement or MH professional), except transfers from a hospital that is governed by the federal EMTALA law.

The designated law enforcement agency may decline to transport the person to a receiving facility only if one of the following exceptions applies:

1. The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service or private transport company for transportation of persons to receiving facilities at the sole cost of the county; and the law enforcement agency and the emergency medical transport service or private transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others.
2. When a jurisdiction has entered into a contract with an emergency medical transport service or a private transport company for transportation of persons to receiving facilities, such service or company shall be given preference for transportation of persons from nursing homes, assisted living facilities, adult day care centers, or adult family-care homes, unless the behavior of the person being transported is such that transportation by a law enforcement officer is necessary.
3. When a law enforcement officer takes custody of a person pursuant to this part, the officer may request assistance from emergency medical personnel if such assistance is needed for the safety of the officer or the person in custody.
4. If the law enforcement officer believes that a person has an emergency medical condition as defined in s. 395.002, the person may be first transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated receiving facility.
5. When a member of a mental health overlay program or a mobile crisis response service it may call on the law enforcement agency or other transportation arrangement best suited to the needs of the patient.
6. When a Transportation Exception Plan has been approved by the Board of County Commissioners and the Secretary of DCF.

Criminal Charges:

When any law enforcement officer has custody of a person based on either noncriminal or minor criminal behavior that meets the statutory guidelines for involuntary examination, the law enforcement officer shall transport the person to the nearest receiving facility for examination.

Marchman Act

Transportation for ***Emergency Admission*** may be provided by:

- An applicant for a person's emergency admission, or
- Spouse or guardian, or
- Law enforcement officer, or
- Health officer

The Court may order law enforcement to transport a person to nearest appropriate licensed service provider for a ***court-ordered assessment and stabilization***.

Baker Act	Marchman Act
<p>Baker Act 394.462, FS and 65E-5.260, FAC</p> <p>When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under this part, such person shall first be processed in the same manner as any other criminal suspect. The law enforcement agency shall thereafter immediately notify the nearest <u>public</u> receiving facility, which shall be responsible for promptly arranging for the examination and treatment of the person. A receiving facility is not required to admit a person charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide mental health examination and treatment to the person where he or she is held.</p> <p>Each law enforcement agency shall develop a memorandum of understanding with each receiving facility within the law enforcement agency's jurisdiction which reflects a single set of protocols for the safe and secure transportation of the person and transfer of custody of the person. These protocols must also address crisis intervention measures.</p> <p>The nearest receiving facility must accept persons brought by law enforcement officers for involuntary examination.</p> <p>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. (Right to Individual Dignity)</p> <p>Law enforcement has no responsibility to provide transportation of individuals on voluntary status or to "treatment" facilities.</p> <p>Paperwork Required:</p> <p>Form Initiating Involuntary Exam:</p> <ul style="list-style-type: none"> ▪ BA 52a (Law Enforcement) or ▪ BA 52b (MH Professional) or ▪ Ex Parte Order (Circuit Judge), <u>and</u> ▪ BA 3100 (transportation form) 	

Baker Act

Marchman Act

Admission Notices

Baker Act 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/Guardian Advocate 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.

Case Manager must be notified (65E-5.130(1) and (2), FAC)

- Identity of case manager noted in chart
- 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 district, telephone call may substitute

Other required notices (394.4599, FS) require prompt delivery to:

- Individual
- Representative
- Guardian or Gardian Advocate
- Attorney

Notice to individuals held in facilities must be provided:

- Orally and in writing
- Using language/terminology person can understand
- Using an interpreter if needed

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

Marchman Act

Nearest relative of a minor must be notified by the law enforcement officer of protective custody, as must the nearest relative of an adult, unless the adult requests that there be no notification.

Upon receipt of petition for a court-ordered assessment and stabilization and if a hearing is scheduled, a copy of petition & notice of hearing (394.6815, FS) must be provided to:

- Respondent,
- Attorney,
- Petitioner,
- Spouse or guardian,
- Parent of a minor, and
- Others as directed by the court

Baker Act	Marchman Act
Examination or Assessment	
<p>Baker Act (394.463(2)(f) and 65E-5.2801(1), FAC)</p> <p>The Baker Act provides that a person must be examined within 72 hours of admission by a physician or a clinical psychologist. The person may not be released by the receiving facility without the documented approval of a psychiatrist, a clinical psychologist, or if the receiving facility is a hospital, the release may also be approved by an emergency department physician.</p> <p>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.</p> <p>Minimum standards for Initial Mandatory Involuntary Examination as required in law and rule (394.463(2)(f), FS and 65E-5.2801, FAC) must include:</p> <ul style="list-style-type: none"> ▪ Thorough review of any observations of the person’s recent behavior; ▪ Review “Transportation to Receiving Facility” form (#3100) and ▪ Review one of the following: <ul style="list-style-type: none"> ▪ “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. <p>Within the 72 hour examination period:</p> <ul style="list-style-type: none"> ▪ Person shall be released, unless charged with a crime. If so, returned to law enforcement, or ▪ 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. 	<p>Marchman Act</p> <p>Under protective custody and emergency admission, the assessment must be completed by a physician within 72 hours of admission.</p> <p>For alternative involuntary assessment of a minor, the assessment must be completed by a qualified professional within 72 hours of admission but the minor may be retained for an additional 2 days if further assessment is determined necessary by a physician.</p> <p>For involuntary assessment and stabilization, the assessment must be completed by a “qualified professional” within 5 days of the court’s order with sign-off by a physician. If additional time is needed to complete an assessment the court, if requested by the service provider, may grant an extension not to exceed 7 days after the renewal order.</p>

Baker Act**Marchman Act****Release or Discharge****Baker Act 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, must include:

- Transportation resources
- Access to stable living arrangements
- Assistance in securing need living arrangements or shelter for those at risk of readmission within 3 weeks due to homelessness and prior to discharge shall request a commitment from a shelter provider that assistance will be rendered
- Education and written information about the 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
- Assistance in obtaining a timely aftercare appointment for needed services, including continuation of prescribed psychotropic medications within 7 days of discharge
- Access to psychotropic medications or prescriptions or a combination thereof provided until scheduled aftercare appointment or 21 calendar days

Marchman Act (65E-30.004(22), FAC)

A minor may only be released to:

- Parent, legal guardian or legal custodian
- To DCF pursuant to s.39, FS
- To DJJ pursuant to s.984, FS

Summaries required for all voluntary and involuntary departures from services.

- **Transfer Summary:** Completed immediately for clients transferring between components of same provider and within 5 calendar days when transferring to another provider. Entry must be made in record about circumstances of the transfer signed and dated by primary counselor. A Transfer Summary is defined to mean a written justification of the circumstances of the transfer of a client from one component to another or from one provider to another.
- **Discharge Summary:** A Discharge Summary is legally defined to mean a written narrative of the client's treatment record describing the client's accomplishments and problems during treatment, reasons for discharge, and recommendations for further services. A written discharge summary signed and dated by primary counselor must be completed for clients completing or leaving prior to completion including client's involvement in services, reason for discharge, and services needed following discharge, including aftercare.

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)

Baker Act**Marchman Act****Notice of Release from Involuntary Examination / Involuntary Admission****Baker Act**

Notice of release must be given to the individual's guardian, guardian advocate, attorney, designated representative, to any person who executed a certificate admitting the patient, and to any court which ordered the examination.

Marchman Act

Notice of release must be given to the applicant in the case of emergency admission or an alternative assessment of a minor, or to the petitioner and the court in the case of involuntary assessment and that minor client can only be released to authorized individuals or agencies.

A client involuntarily admitted may be released without further order of the court only by a qualified professional. (397.6758, FS)

Involuntary Placement / Involuntary Treatment — Procedure for Filing Petitions**Baker Act (394.467, FS)**

Criteria: 394.467(1), FS and 65E-5.290, FAC

Finding of the court by clear and convincing evidence that the individual:

- Has a mental illness and because of the mental illness:
- Has 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
- 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

Marchman Act

Criteria: There is good faith reason to believe the person is substance abuse impaired and, because of such impairment:

1. Has lost the power of self-control with respect to substance use; and either
- 2a. Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; or
- 2b. Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto; however, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services.

In addition to meeting the above criteria for involuntary admissions, a person for whom a petition for involuntary treatment is filed must have met additional conditions including:

- Having been placed under protective custody within the previous 10 days;
- Having been subject to an emergency admission within the previous 10 days,
- Having been assessed by a qualified professional within the previous 5 days;
- Having been subject to a court ordered involuntary assessment and stabilization within the previous 12 days
- Having been subject to alternative involuntary admission within the previous 12 days.

Baker Act

Marchman Act

Petition for Involuntary Placement

The Baker Act permits the administrator of a receiving facility to recommend placement in a treatment facility and to file a petition with the court as long as the recommendation is supported by a psychiatrist and a second opinion by another psychiatrist or clinical psychologist, both of whom have personally examined the patient within the preceding 72 hours and the criteria for involuntary examination are met. (2nd opinion may be electronic, maintaining visual & audio communication). Case law requires factual substantiation of each criteria alleged in the petition for involuntary inpatient placement – not just opinions, conclusions, or hearsay

- 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.

Marchman Act (397.6951, FS)

The Marchman Act permits an adult's spouse or guardian, any relative, a service provider, or any three adults that have knowledge of the respondent and prior course of assessment or treatment to file a petition with the court. If the respondent is a minor, the petition may be filed by a parent, legal guardian, or service provider.

The Marchman Act also requires that the respondent have been involved in at least one of the other involuntary admission procedures within specified time frames before a petition can be filed for involuntary treatment:

Contents of Petition must include:

- Name of respondent
- Name of petitioner(s)
- Relationship between the respondent & petitioner
- Name of respondent's attorney
- Statement of petitioner's knowledge of respondent's ability to afford an attorney
- Findings & recommendations of the assessment performed by qualified professional
- Factual allegations presented by the petitioner establishing need for involuntary treatment, including:
- Reason for petitioner's belief that respondent is substance abuse impaired; and
- Reason for petitioner's belief that because of such impairment, respondent has lost power of self-control with respect to substance abuse; and either
- Reason petitioner believes the respondent has inflicted or is likely to inflict physical harm on self/others unless admitted; or
- Reason petitioner believes respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse to be incapable of appreciating need for care and making a rational decision

Duties of the Court

Clerk of Court – provides required copies of the petition to individual, DCF, guardian, or representative, state attorney and public defender

Written notice of filing of petition for involuntary placement must contain: (394.4599(2)(c), FS)

- 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.
- 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.

Marchman Act (397.6955, FS)

- Upon filing of petition with clerk of court, court shall immediately determine if respondent has attorney or if appointment of counsel is appropriate
- Court scheduled hearing w/i 10 days.
- Copy of petition and notice of hearing provided to respondent; attorney, spouse or guardian if applicable, petitioner, (parent, guardian or custodian of a minor), and other persons as the court may direct; and
- Issue a summons to respondent.

Baker Act	Marchman Act
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).	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).
Appointment of Counsel	
<p>The Baker Act sets the time for appointing a Public Defender within 1 court working day, unless the person is otherwise represented by private counsel.</p> <p>The State Attorney's Office is appointed as the "real party in interest" to represent the state.</p>	<p>The Marchman Act requires that the court immediately determine whether the respondent is represented by counsel or whether appointment of an attorney is appropriate. No specific time is specified.</p> <p>Neither the Public Defender nor the State Attorney is assigned responsibility in the Marchman Act or chapter 27, FS.</p>
Hearings for Involuntary Placement / Treatment	
<ul style="list-style-type: none"> Hearing held within 5 court working days unless continuance requested by person, with concurrence of counsel. No waiver of hearing. Held as convenient to person as consistent with orderly procedure and not likely to be injurious to person's condition Judge or magistrate presides Person's attendance at hearing -- any waiver of right to be personally present at hearing must be knowing, intelligent, and voluntary. <p>Witnesses:</p> <ul style="list-style-type: none"> 1 of the 2 examining professionals who executed placement certificate must be a witness Anyone else that has fact testimony to support continued detention. (staff, family, case manager, others) Person may refuse to testify at the hearing Competence to consent to treatment must be considered – If incompetent, guardian advocate appointed 	<p>Marchman Act (397.6957, FS)</p> <ul style="list-style-type: none"> The hearing must occur within 10 days of the petition with no possibility of a continuance. All relevant evidence, including results of all involuntary interventions must be considered Judge or magistrate presides Client to be present unless injurious – if so, court will appoint guardian advocate Petitioner has burden of proving by clear & convincing evidence that all criteria for involuntary admission are met <p>Court will either dismiss petition or order client to involuntary treatment.</p>
Initial Order	
<p>If a court concludes person meets all criteria for involuntary inpatient placement, it shall order person, for a period of <u>up to</u> 6 months:</p> <ul style="list-style-type: none"> Transferred to a treatment facility or, if the person is at a treatment facility, that the person be retained there, or Treated <u>at</u> any other appropriate receiving or treatment facility, or Receive services <u>from</u> a receiving or treatment facility 	<p>Marchman Act (397.697, FS)</p> <ul style="list-style-type: none"> Order for involuntary treatment by licensed provider <u>up to</u> 60 days Order authorizes provider to require client to undergo treatment that will benefit. Order must include court's requirement for notification of proposed release. Court may order Sheriff to transport Court retains jurisdiction over case for further orders.
Hearings on Continued Involuntary Placement / Treatment	
Hearings on petitions for continued placement or extensions are administrative hearings and conducted in accordance with section 120.57(1), F.S. Any order entered by a hearing officer is final and subject to judicial review. Appellate case established that Courts and Division of Administrative Hearings (DOAH) have concurrent jurisdiction within the first six months of an order.	The Marchman Act requires that the petition be filed not more than 10 days prior to the end of the initial period.

Baker Act

Marchman Act

Extension of Order

Baker Act (394.467(6), FS)

The Baker Act provides that petitions on continued placement be filed prior to the expiration of the period the treatment facility is authorized to retain the patient. The Baker Act permits a continued placement extension of up to 6 months.

- If person continues to meet criteria for involuntary inpatient placement, 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
- Waiver of person's presence at hearing may be filed, 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 must be considered. If person is now competent to consent to treatment, the administrative law judge may issue a 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)
- 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, he/she must be released or transferred to voluntary status

Marchman (397.6975, FS)

When criteria still exists, a renewal of involuntary treatment order may be requested if filed at least 10 days prior to the end of the 60-day period.

- Hearing scheduled within 15 days of filing
- Copy of petition to all parties
- If grounds exist, may be ordered for up to 90 additional days.
- Further petitions for 90 day periods may be filed if grounds for involuntary treatment persist.

Baker Act**Marchman Act****Release from Involuntary Placement / Treatment & Notices**

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).

After 60-day involuntary treatment, client automatically discharged unless petition timely filed with court.

- Person may be released by a qualified professional without court order.
- Notice of release provided to applicant for a minor or to petitioner and court if court-ordered.
- Release of minor must be to parent or guardian, DCF or DJJ.
- An involuntarily admitted client may, upon giving written informed consent, be referred to a service provider for voluntary admission when the provider determines that the client no longer meets involuntary criteria.
- When a court ordering involuntary treatment includes requirement in court order for notification of proposed release, provider must notify the original referral source in writing.

Early Release: Client must be released when: (397.6971, FS)

- Basis for involuntary treatment no longer exist
- Converts to voluntary upon informed consent
- No longer in need of services
- Client is beyond safe management of the provider
- Further treatment won't bring about further significant improvements.

Notification shall comply with legally defined conditions and timeframes and conform to federal and state confidentiality regulations.

Baker Act

Marchman Act

Responsibilities of Providers

Baker Act (394.461, FS and 65E-5.350 and 65E-5.180(5), FAC)

- Provide onsite emergency reception, screening & inpatient treatment services 24 hours a day, 7 days a week, regardless of ability to pay
- Accept any person brought by law enforcement for involuntary examination (hospitals must accept regardless of legal status).
- Accept persons of all ages
- Assess all persons for clinical safety, co-occurring disorders, substance abuse, physical/sexual abuse or trauma
- Comply with all EMTALA requirements, if a hospital
- 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. (394.459(11), FS and 65E-5.1304, FAC)
- Failure to have the original form initiating involuntary admission or an original signature on the form is not a basis for refusing an admission.
- The hospital licensing law requires all hospitals that examine or treat an individual of any age who is held under the Baker Act must adhere to all requirements as it applies to that individual, as follows:
 - 395.003(5)(a), FS "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".
 - 395.003(5)(b), FS "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), FS 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), FS "The agency (AHCA) 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".

Marchman Act (397.6751, FS and 65D-30.004, FAC)

Person must be admitted when sufficient evidence exists that:

- Person is substance abuse impaired
- Setting is the least restrictive and most appropriate
- Within licensed capacity
- Medical & behavioral conditions can be safely managed
- Within financial means of person (Other than licensed hospitals per EMTALA)

Providers receiving state funds for substance abuse services can't deny access based on inability to pay if space and sufficient state resources are available.

Access cannot be denied based on race, gender, ethnicity, age, sexual preference, HIV status, disability, use of prescribed medications, prior service departures against medical advice, or number of relapse episodes.

If admission is refused (397.6751, FS) the provider must, in compliance with federal confidentiality regulations:

1. Attempt to contact referral source to discuss circumstances and assist in arranging alternate intervention.
2. Provider must within 1 workday of refusal, report in writing to referral source:
 - Basis for refusal
 - Documentation of provider's efforts to contact the referral source and assist person to access more appropriate services.
3. If medical or behavior can't be safely managed, provider must discharge and assist to secure more appropriate services. Within 72 hours, report to referral source basis for discharge and provider's efforts to assist client.

Persons on involuntarily status can only be placed in licensed service providers in components authorized to accept involuntary clients.

Providers accepting person on involuntary status must provide a description of the eligibility and diagnostic criteria and the placement process to be followed for each of the involuntary placement procedures

Each person involuntarily admitted shall be assessed by a qualified professional to determine need for additional treatment and most appropriate services.

Decision to refuse to admit or to discharge shall be made only by a qualified professional.

Failure to have the original form initiating involuntary admission or an original signature on the form is not a basis for refusing an admission.

Baker Act	Marchman Act
Rights: General	
<ul style="list-style-type: none"> ▪ Written copy of rights at admission ▪ Signed by person ▪ Copies to significant others ▪ Discussion of rights during hospitalization ▪ Posting of rights & phone numbers near phone: ▪ Abuse Registry / Hotline ▪ Disabilities Rights Florida, Inc. ▪ ADA ▪ Copy of Baker Act statute & rules on each unit 	<p>Marchman Act (397.501, FS and 65D-30.004, FAC)</p> <p>Clients receiving substance abuse services from any service provider are guaranteed protection of fundamental human, civil, constitutional and statutory rights including those specified in the Marchman Act unless otherwise expressly provided, and service providers must ensure the protection of such rights.</p> <p>Basic client rights include provisions for informing the client, family member, or authorized guardian of their rights and responsibilities, assisting in the exercise of those rights, and an accessible grievance system for resolution of conflicts;</p>
Rights: Individual Dignity	
<p>Baker Act (394.459(1), FS and 65E-5.150 FAC)</p> <ul style="list-style-type: none"> ▪ All Constitutional Rights ▪ 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 ▪ 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 	<p>Marchman Act 397.501(1), FS</p> <ul style="list-style-type: none"> ▪ Guaranteed the protection of all fundamental human, civil, constitutional, and statutory rights. ▪ Respect at all times, including when admitted, retained, or transported. ▪ Cannot be placed in jail unless accused of a crime except for adults under protective custody. ▪ Must permit grievances to be filed for any reason
Rights: Treatment	
<p>Baker Act (394.459(2), FS and 65E-5.160, FAC)</p> <ul style="list-style-type: none"> ▪ 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 	<p>Marchman Act</p> <ul style="list-style-type: none"> ▪ See right to quality services below ▪ Services suited to client’s needs, administered skillfully, safely, humanely, with full respect for dignity/integrity, and in compliance with all laws and requirements. ▪ Opportunity to participate in formulation & review of individualized treatment / service plan.

Baker Act	Marchman Act
<p>Treatment Planning (394.459(2)(d), FS and 65E-5.160 (2), FAC) must include:</p> <ul style="list-style-type: none"> ▪ 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 	<p>"Treatment Plan" means an individualized, written plan of action that directs all treatment services and is based upon information from the assessment and input from the client served. The plan establishes client goals and corresponding measurable objectives, time frames for completing objectives, and the type and frequency of services to be provided.</p> <p>Each client shall be afforded the opportunity to participate in the development and subsequent review of the treatment plan. The treatment plan shall include:</p> <ul style="list-style-type: none"> ▪ Goals and related measurable behavioral objectives to be achieved by the client, ▪ Tasks involved in achieving those objectives, ▪ Type and frequency of services to be provided, and ▪ Expected dates of completion. <p>The treatment plan shall be signed and dated by the person providing the service, and signed and dated by the client. If the treatment plan is completed by other than a qualified professional, the treatment plan shall be reviewed, countersigned, and dated by a qualified professional within 10 calendar days of completion.</p>
Rights: Express and Informed Consent	
<p>Baker Act 394.459(3), FS and 65E-5.170, FAC</p> <p>Competence is well reasoned, willful & knowing decision-making. Prior to requesting consent to treatment, the following must be provided and explained in plain language:</p> <ul style="list-style-type: none"> ▪ 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 ▪ 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. 	<p>Informed consent required, but not separately defined or described in Marchman Act.</p>

Baker Act	Marchman Act
Who can give consent? <ul style="list-style-type: none"> Competent adult Guardian of a child Court Appointed Guardian Court Order Letters of Guardianship Guardian advocate / court order Health care surrogate or proxy / Advance Directive <p>If competent to consent, person is competent to refuse or revoke consent!</p> <p>If incompetent to consent, person is incompetent to refuse or revoke consent and a substitute decision-maker must be appointed.</p>	Who can give consent? <ul style="list-style-type: none"> Adults Minors
Authorization for Treatment 65E-5.170(2), FAC General Authorization for Treatment (#3042a) <ul style="list-style-type: none"> Routine medical care Psychiatric assessment Assessment/treatment other than medications Specific Authorization for Psychotropic Medications (#3042b) <ul style="list-style-type: none"> Disclosure by qualified personnel Completed prior to administration By authorized decision-maker 	No corresponding provisions
Emergency Treatment Orders 394.463(2)(f), 394.4625(5), FS and 65E-5.1703, FAC <ul style="list-style-type: none"> 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 	No corresponding provisions
Petition for Guardian Advocate: <ul style="list-style-type: none"> 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. 	No corresponding provisions

Baker Act	Marchman Act
Rights: Quality Treatment / Services	
<p>Baker Act 394.459(4), FS and 65E-5.180, FAC</p> <p>Receiving and treatment facilities are required to maintain in a form accessible to and readily understandable:</p> <ul style="list-style-type: none"> Criteria, procedures, & staff training required for any 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. 	<p>Marchman Act 397.501(3), FS</p> <p>Least restrictive and most appropriate services, based on needs and best interests of client.</p> <p>Services suited to client's needs, administered skillfully, safely, humanely, with full respect for dignity/integrity, and in compliance with all laws and requirements.</p> <p>Methods used to control aggressive client behavior that pose an immediate threat to the client or others – used by staff trained & authorized to do so – in accordance with rule.</p> <p>Opportunity to participate in formulation & review of individualized treatment / service plan.</p>
<p>Emergency Orders</p> <p>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:</p> <ul style="list-style-type: none"> Baker Act law and rules --Baker Act rules governing restraints & seclusion rewritten in 2008. Joint Commission on Accreditation of Healthcare Organizations or CARF Federal Conditions of Participation (CMS) Facility policies and procedures 	

Baker Act	Marchman Act
Rights: Confidentiality	
<p>Variety of federal/state statutes and case law govern confidentiality:</p> <ul style="list-style-type: none"> ▪ Baker Act ▪ Psychotherapist / patient privilege ▪ Substance Abuse ▪ HIPAA (treatment, operations and payment exempted) ▪ Substitute Decision-Makers ▪ Communicable Diseases ▪ Duty to report abuse, neglect & exploitation of children & vulnerable adults ▪ Foreign Nationals – Consular Notification & Access <p>Unless person, guardian, guardian advocate, or surrogate/proxy waives by express and informed consent, confidentiality of record shall not be lost.</p> <p>Information from record may be released:</p> <ul style="list-style-type: none"> ▪ By court order after good cause hearing ▪ After declaration of intent to harm – may release sufficient information to adequately warn person threatened. Tarasoff warning not required in Florida ▪ Inform guardians of threats by minors ▪ Warn of threats of future harm, but not confessions of past crimes <p>Person has right of reasonable access to own clinical record unless determined by physician to be harmful. If restricted:</p> <ul style="list-style-type: none"> ▪ Recorded, with reasons, in clinical record ▪ Notice to person, attorney, and others ▪ Expires in 7 days but can be renewed <p>Facility policies should identify:</p> <ul style="list-style-type: none"> ▪ What is reasonable access? ▪ Is this all “persons” – minors? incapacitated? ▪ Who will review for harmfulness? ▪ How, where & with whom actual review will take place? 	<p>Identity, diagnosis, prognosis, and service provision to any client is confidential.</p> <ul style="list-style-type: none"> ▪ Disclosure requires written consent of client, except: ▪ Medical personnel in emergency ▪ Provider staff on “need to know” to carry out duties to client. ▪ DCF Secretary/designee for research (non-identifying) ▪ Audit or evaluation by federal, state, local governments, or 3rd party payor ▪ Court order for good cause based on whether public interest/need for disclosure outweigh potential injury to client or provider to authorize disclosure but subpoena then required to compel. <p>Other Confidentiality Considerations:</p> <ul style="list-style-type: none"> ▪ Restrictions inapplicable to reporting of suspected child abuse. ▪ Minor may consent to own disclosure – consent can only be given by the minor ▪ If consent of guardian required to obtain services for minor, both minor & guardian must consent to disclosure ▪ 42 CFR (Code of Federal Regulations) and HIPAA also control how information can be released – most stringent prevails. <p>Release to Law Enforcement directly related to commission of a crime on premises or against staff or threat to do so. Limited to:</p> <ul style="list-style-type: none"> ▪ Client’s name and address ▪ Circumstances of incident ▪ Client status ▪ Client’s last known whereabouts. <p>Court can authorize for criminal investigation or prosecution only if all the following criteria are met:</p> <ul style="list-style-type: none"> ▪ Crime is extremely dangerous ▪ Records will be of substantial value ▪ No other methods available or effective ▪ Potential injury to client or program outweighed by public interest and need to know <p>Confidentiality and the Court:</p> <ul style="list-style-type: none"> ▪ Court order authorizes but does not compel disclosure of client identifying data. ▪ Subpoena must then be issued to compel disclosure. ▪ Client and provider must be given notice and opportunity to respond or to appear to provide evidence. ▪ Oral argument, review of evidence or hearing in chambers.

Baker Act

Marchman Act

Patient and personnel records in hospitals; copies; examination

Baker Act (395.3025(2), FS)

This section of the hospital statute 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.

Marchman 395.3025(3), FS

This section of the hospital statute does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.

Rights: Communication, Abuse Reporting & Visitation

Baker Act 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.

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

Marchman Act 397.501(4), FS

- Free & private communication within limits imposed by provider policies.
- Close supervision of all communication & correspondence required.
- Reasonable rules for mail, telephone & visitation to ensure the well-being of clients, staff & community.
- Clients and families must be informed about provider rules related to communication and correspondence

Rights: Care & Custody of Personal Effects

Baker Act 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 and when amended

Marchman Act 397.501(5), FS

- Right to possess clothing and other personal effects.
- Provider may take temporary custody of personal effects only when required for medical or safety reasons.
- If removed, reasons for taking custody and a list of the personal effects must be recorded in clinical record.

Baker Act	Marchman Act								
Rights: Non-Discrimination									
<p>Baker Act</p> <p>No corresponding provision.</p>	<p>Marchman Act (2)</p> <p>Service providers may not deny a client access to substance abuse services solely on the basis of race, gender, ethnicity, age, sexual preference, HIV status, prior service departures against medical advice, disability, or number of relapse episodes. Service providers may not deny a client who takes medication prescribed by a physician access to substance abuse services solely on that basis. Service providers who receive state funds to provide substance abuse services may not, provided space and sufficient state resources are available, deny a client access to services based solely on inability to pay.</p>								
Rights: Voting in Public Elections									
<p>Baker Act 394.459(7), FS and 65E-5.210, FAC</p> <ul style="list-style-type: none"> ▪ 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 	<p>Marchman Act</p> <p>No corresponding provisions</p>								
Rights: Right to Counsel									
<p>Baker Act (394.467(4), FS)</p> <p>The Public Defender is responsible for representing all persons on involuntary placement status unless represented by private counsel</p>	<p>Marchman Act 397.501(8), FS</p> <ul style="list-style-type: none"> ▪ Client must be informed of right to counsel at every stage of involuntary proceedings. ▪ May be represented by counsel in any involuntary proceeding for assessment, stabilization, or treatment. ▪ Person (or guardian of a minor) may immediately apply to court to have attorney appointed, if unable to afford one. ▪ No reference to Public Defender in Marchman Act or Chapter 27, FS. 								
Rights: Habeas Corpus									
<p>Baker Act 394.459(8), FA and 65E-5.220, FAC</p> <p>Each person (any age or legal status) admitted to a receiving or treatment facility must have written notice of right to petition (#3036) for writ:</p> <ul style="list-style-type: none"> ▪ Cause and legality of detention ▪ Unjustly denied a right or privilege ▪ Abuse of procedure authorized in law <p>Petition (#3090) filed any time/without notice by:</p> <table data-bbox="201 1728 633 1881"> <tr> <td>Individual</td><td>Guardian Advocate</td></tr> <tr> <td>Relative</td><td>Representative</td></tr> <tr> <td>Friend</td><td>Attorney</td></tr> <tr> <td>Guardian</td><td>DCF</td></tr> </table> <p>Facility files petition (any format preferred by the individual) with clerk of court on next working day. No fee charged</p>	Individual	Guardian Advocate	Relative	Representative	Friend	Attorney	Guardian	DCF	<p>Marchman Act 397.501(9), FS</p> <ul style="list-style-type: none"> ▪ Filed at any time and without notice ▪ Filed by client involuntarily retained or parent, guardian, custodian, or attorney on behalf of client ▪ May petition for writ to question cause and legality of retention and request the court to issue a writ for client's release
Individual	Guardian Advocate								
Relative	Representative								
Friend	Attorney								
Guardian	DCF								

Baker Act

Marchman Act

Rights: Separation of Children from Adults

Baker Act 394.4785, FS and 65E-12, FAC

No corresponding provisions

Hospitals:

- Age 0-13 no contact with adults
- Age 14-17 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

Rights: Education of Minors

No corresponding provision.

Each minor client in a residential service component is guaranteed education and training appropriate to his or her needs. The service provider shall coordinate with local education agencies to ensure that education and training is provided to each minor client in accordance with other applicable laws and regulations and that parental responsibilities related to such education and training are established within the provisions of such applicable laws and regulations. Nothing in this chapter may be construed to relieve any local education authority of its obligation under law to provide a free and appropriate education to every child.

Special Issues

Sexual Misconduct Prohibited

Baker Act 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.

Marchman Act

No corresponding provisions

Baker Act	Marchman Act
Complaints and Grievances	
<p>Baker Act 394.459(4)(b)3, FS and 65E-5.180 FAC</p> <p>Policy/procedures required to receive, review, investigate, track, manage and respond to formal/informal complaints by person or others.</p> <ul style="list-style-type: none"> Process explained verbally at orientation and provided in writing; How complaints can be addressed informally and formally with staff Informed of Abuse Registry, Advocacy Center or others to request assistance Process, including phone numbers for above posted next to phones. Life-safety issues acted upon immediately <p>Formal complaints:</p> <ul style="list-style-type: none"> 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 <p>All formal complaints must contain:</p> <ul style="list-style-type: none"> 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 <p>Written disposition of formal complaint.</p> <ul style="list-style-type: none"> 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. <p>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.</p>	<p>Marchman Act (65D-30.004 (29) FAC)</p> <p>Grievance procedure must include:</p> <ul style="list-style-type: none"> Provisions assuring that a grievance may be filed for any reason with cause; The prominent posting of notices informing clients of the grievance system; Access to grievance submission forms; Education of staff in the importance of the grievance system and client rights; Specific levels of appeal with corresponding time frames for resolution; Timely receipt of a filed grievance; The logging and tracking of filed grievances until resolved or concluded by actions of the provider's governing body; Written notification of the decision to the appellant; and Analysis of trends to identify opportunities for improvement.
Client Responsibility for Cost of Care	
<p>Chapter 394, Part I, FS, the Baker Act, makes no reference to payment for care and treatment. However, the Florida Attorney General has issued opinions stating that DCF (with county matching funds) is responsible for establishing public receiving facilities but that persons served in private receiving facilities are responsible for their own cost of care.</p>	<p>Marchman Act (397.431, FS)</p> <ul style="list-style-type: none"> Publicly funded providers must have a fee system based upon a client's ability to pay, and if space and sufficient state resources are available, may not deny a client access to services solely on the basis of client's inability to pay. Full cost and fee charged must be disclosed to client Client (or guardian of minor) required to contribute toward costs, based on ability to pay Guardian of minor not liable if services provided without parent consent unless guardian ordered to pay

Baker Act

Marchman Act

Parental Responsibility

No corresponding provisions other than the consent to treatment for the minor and the application for voluntary admission must be filed by the parent or guardian with the agreement (*assent*) of the minor.

Parental Participation (397.6759, FS)

A parent, legal guardian, or legal custodian who seeks involuntary admission of a minor to substance abuse treatment is required to participate in all aspects of treatment as determined appropriate by the director of the licensed service provider.

Designated Representative

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

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 Designated Representative:

- To receive notice of individual's admission;
- To receive notice of proceedings affecting the individual;
- To have immediate access to the individual held or admitted for mental health treatment, unless such access is documented to be detrimental to the individual;
- To receive notice of any restriction of the individual's right to communicate or receive visitors;
- To receive copy of the inventory of personal effects upon the individual's admission and to request amendment to the inventory at any time;
- To receive disposition of the individual's clothing and personal effects, if not returned to the individual, or to approve an alternate plan;
- To petition on behalf of the individual for a writ of habeas corpus
- To apply for a change of venue for the individual's involuntary placement hearing for the convenience of the parties or witnesses or because of the condition of the individual;
- To receive written notice of any restriction of the individual's right to inspect his or her clinical record;
- To receive notice of release of the individual from a receiving facility where an involuntary examination was performed;
- To receive a copy of any petition for the individual's involuntary placement filed with the court; and
- To be informed by the court of the individual's right to an independent expert evaluation, pursuant to involuntary placement procedures.

No corresponding provisions in the Marchman Act

Baker Act	Marchman Act
<i>Guardian Advocate</i>	
<p>Baker Act 394.4598, FS and 65E-5.230, FAC</p> <p>Duties begin after appointment by court and completion of training</p> <p>Duties terminate upon person's discharge, transfer to voluntary status, restoration of competency, or expiration of involuntary placement order.</p>	<p>Marchman Act</p> <p>No corresponding provisions in the Marchman Act</p>
<p>Prior to appointment:</p> <ul style="list-style-type: none"> ▪ Receive information about duties/ethics of medical decision-making ▪ Agree to serve <p>Prior to decision-making:</p> <ul style="list-style-type: none"> ▪ 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 <p>Authority:</p> <ul style="list-style-type: none"> ▪ Mental health decisions and court may also authorize medical decisions. 	
<p>Extraordinary decisions after separate hearing (#3108-3109) for the following:</p> <ul style="list-style-type: none"> ▪ Electroconvulsive treatment ▪ Experimental treatments not approved by IRB ▪ Sterilization ▪ Abortion ▪ Psychosurgery <p>Decisions by guardian advocate may be reviewed by court, upon petition of person's attorney, family or facility administrator</p> <p>Replacement guardian advocate can be appointed by the court</p>	

Baker Act

Marchman Act

Health Care Surrogates & Proxies

Baker Act 765 FS and 65E-5.2301, FAC

Advance Directive: instruction given by a person expressing his/her desires about health care, including the 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 person'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.

Marchman Act

No corresponding provisions in the Marchman Act. However, a health care surrogate or proxy provided under chapter 765, FS is authorized to make any and all health care decision for an individual who has been found by a physician to be incompetent/incapacitated to make his/her own health care decisions. Substitute Judgment required if preference of individual is known.

Baker Act	Marchman Act
<p>Authority:</p> <ul style="list-style-type: none"> ▪ To make all health care decisions, including mental health, based on the decisions the person would have made if competent to do so – “Substitute Judgment” ▪ Apply for benefits ▪ Access person’s clinical record ▪ Authorize release of information and clinical records ▪ Authorize transfer to another facility. <p>Prohibited Procedures:</p> <ul style="list-style-type: none"> ▪ Voluntary admission to MH facility ▪ Consent to treatment for persons on voluntary status ▪ ECT ▪ Experimental treatment not approved by IRB ▪ Sterilization ▪ Abortion ▪ Psychosurgery <p>Process:</p> <ul style="list-style-type: none"> ▪ Attending physician documents incapacity of person ▪ Surrogate or proxy notified in writing that authority has commenced (#3122) ▪ Proxy signs Affidavit (#3123) ▪ Authority in effect until determination that person 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 ▪ Ensure surrogate or proxy talks with individual and physician in person if possible, if not, by telephone ▪ Surrogate or proxy given full disclosure prior to requesting authorization for treatment ▪ Advance Directives can be revoked at any time by a competent person <p>Decisions of a health care surrogate or proxy may be reviewed by a judge at the request of the persons’ family, the facility, or physician, or other interested person</p>	

Baker Act

Marchman Act

Restraints & Seclusion

Baker Act 394.459(4), FS65E-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 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.

Prohibitions

- Can't be based on person's history or on PRN or standing order
- Can't be restrained in prone position unless required to prevent imminent serious harm
- 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.

Prior to Restraint or Seclusion

- Staff must be trained as part of orientation and on annual basis. Specific required training itemized in rule.
- Personal Safety Plan (3124) address individual triggers leading to psychiatric crisis 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

Marchman Act (65D-30.005(14), FAC)

Restraint means:

- Any manual method used or physical or mechanical device, material, or equipment attached or adjacent to a client's body that he or she cannot easily remove and that restricts freedom of movement or normal access to one's body; and
- A drug used to control a client's behavior when that drug is not a standard treatment for the client's condition.

Seclusion means the use of a secure, private room designed to isolate a client who has been determined by a physician to pose an immediate threat of physical harm to self or others.

Baker Act	Marchman Act
<p>Initiating Restraint or Seclusion</p> <ul style="list-style-type: none"> ▪ 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. 	
<p>Orders for Restraint or Seclusion</p> <ul style="list-style-type: none"> ▪ 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. 	

Baker Act	Marchman Act
<p>During Restraint and Seclusion</p> <ul style="list-style-type: none"> ▪ 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. ▪ 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. 	
<p>During Restraint and Seclusion (continued)</p> <ul style="list-style-type: none"> ▪ 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. 	

Baker Act	Marchman Act
Release from Restraint and Seclusion <ul style="list-style-type: none"> 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. Review incident with person, giving opportunity to process the S/R event ASAP – at least within 24 hours of release. Review incident with all staff involved and supervisors ASAP after the event and address: <ul style="list-style-type: none"> 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. Review documented for continuous performance improvement/monitoring. Review findings forwarded to Oversight Committee, and 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. 	
Reporting Restraints and Seclusion <ul style="list-style-type: none"> All facilities must electronically report monthly S/R events to DCF - Webinar training to be scheduled when reporting process is finalized All facilities subject to CoP's must report by telephone by next business day to CMS (written report to DCF) any death that occurs: <ul style="list-style-type: none"> 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. 	Not Applicable
Immunity (consult with your attorney)	
<ul style="list-style-type: none"> 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) No professional is required to accept persons for treatment of mental, emotional, or behavioral disorders. Such participation is voluntary (394.460) 	<ul style="list-style-type: none"> A LEO acting in good faith pursuant to the Marchman Act protective custody provisions may not be held criminally or civilly liable for false imprisonment. All persons acting in good faith, reasonably, and without negligence in connection with the preparation of petitions, applications, certificates, or other documents or the apprehension, detention, discharge, examination, transportation or treatment under the Marchman Act shall be free from all liability, civil or criminal, by reason of such acts

Baker Act

Marchman Act

Training Resources

Baker Act

<http://myflfamilies.com/service-programs/substance-abuse/baker-act-manual>

- Copy of Baker Act law (394, Part I, FS) and rules (65E-5, FAC and 65E-12, 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
- List of all public and private receiving facilities throughout the state
- Mental Health Advance Directives
- Other relevant materials

Online Training www.bakeracttraining.org

- On demand - at your convenience
- Up-to-date material
- No fee
- Certificate of Achievement
- CEC's offered @ low cost

Courses Offered:

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

Marchman Act

<http://myflfamilies.com/service-programs/substance-abuse/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
- Quick Reference Guide for Involuntary Provisions
- 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

Array of substance abuse related courses funded by DCF and offered through FADAA, FADAA@FADAA.org.

Resources

The following sites may contain information that may be of interest to you in a professional or advocacy capacity. This list does not constitute endorsement. Information accurate as of December 15, 2013.

Many communities have adopted the “211” toll-free information programs that can guide a person in seeking any type of health and social service program. Some of these programs are operated on a 24-hour a day, 7-day a week basis.

There are several resources that you may turn to for help in implementing the Baker Act and in protecting the rights of persons served under the Act. In most instances, problems can be resolved with facility staff and ultimately, the facility administrator. However, any one of the following may be helpful.

Department of Children & Family Services

The Department (DCF) is designated by the Florida Legislature as the State’s Mental Health Authority. It is responsible for designating receiving facilities to serve persons under the Baker Act. It shares responsibility with the Agency for Health Care Administration to supervise all mental health facilities, programs and services. DCF office phone numbers can be found at the front of this Handbook. Visit <http://www.dcf.state.fl.us/programs/samh/mentalhealth/index.shtml/>

Managing Entities

The Florida Legislature amended Chapter 394.9082, FS in 2008 authorizing behavioral health managing entities under contract with DCF to manage the day-to-day operational delivery of behavioral health services through an organized system of care. This is accomplished through “Provider networks” that are the direct service agencies that are under contract with a managing entity and that together constitute a comprehensive array of emergency, acute care, residential, outpatient, recovery support, and consumer support services. While private receiving facilities are generally overseen directly by DCF, those designated as public receiving facilities that benefit from legislatively appropriated Baker Act funds are overseen by the local Managing Entity.

Baker Act Website

The primary DCF website is <http://www.MyFlorida.com>. To access extensive Baker Act information, visit <http://www.dcf.state.fl.us/programs/samh/mentalhealth/laws/index.shtml>.

Updated information about the Baker Act can also be found at the Baker Act Reporting Center website (<http://bakeract.fmhi.usf.edu>).

Receiving Facility List

The Baker Act Receiving Facility List and table describing Transportation Exception Plans are no longer contained within the manual. This is because of the changing nature of this information and the desire to make the most up to date information available. Documents containing this information can be found online at <http://bakeract.fmhi.usf.edu>

Baker Act Training Online

As a substitute for attending a face to face training, you may wish to take the online courses instead. Continuing Education credits are available for licensed professionals for a fee. There is NO FEE for this training! To get started, please visit: <http://www.bakeracttraining.org>

Florida Abuse Registry

The Registry, operated by the Department of Children and Families, accepts calls reporting abuse, neglect or exploitation of vulnerable persons, including children, elders, and disabled adults. The statewide toll-free Registry is available at all times at 1-800-96-ABUSE.

Agency for Health Care Administration

AHCA is responsible for licensing all hospitals, crisis stabilization units, and residential treatment facilities in Florida, as well as other types of health care facilities and programs. It is also responsible to the federal Centers for Medicare and Medicaid Services (CMS) for ensuring hospitals’ compliance with all applicable federal laws and regulations. AHCA’s statewide toll-free complaint telephone number is 1-888-419-3456.

Professional Regulation

Reports on physicians, psychologists, social workers, and other mental health professionals can be directed to The Florida Department of Health, Office of Medical Quality Assurance, at a statewide, toll-free number 1-888-419-3456. Reports on nurses can be directed to The Florida Board of Nursing in Jacksonville at 1-850-245-4125, press #6.

Other State Agencies

Official Portal for the State of Florida

<http://www.myflorida.com>

State of Florida Agencies

<http://www.myflorida.com/directory/>

Department of Mental Health Law & Policy

Louis de la Parte Florida Mental Health Institute
USF College of Behavioral & Community Sciences
813-974-4510
<http://mhlp.fmhi.usf.edu>

Baker Act Reporting Center

<http://bakeract.fmhi.usf.edu/>

Florida Department of Corrections

<http://www.dc.state.fl.us>

Florida Department of Elder Affairs

4040 Esplanade Way, Tallahassee, FL 32399-7000
850-414-2000
<http://elderaffairs.state.fl.us>

Florida Department of Juvenile Justice

850-488-1850
<http://www.djj.state.fl.us>

Federal Agencies

The Centers for Disease Control and Prevention (CDC)

<http://www.cdc.gov/>

Center for Substance Abuse Treatment (CSAT)

<http://csat.samhsa.gov/>

Federal Food and Drug Administration

MedWatch is a service of the federal FDA Medical Products Reporting Program for professionals and consumers to report problems with medications and other products.
5600 Fishers Lane
Rockville, MD 20857-9787
1-800-FDA-1088
<http://www.fda.gov/Safety/MedWatch/default.htm>

National Coalition of Hispanic Health & Human Services Organizations

1501 16th Street NW
Washington, DC 20036
202-387-5000
<http://www.cossmho.org>

National Criminal Justice Reference Service

<http://www.ncjrs.org>

National Domestic Violence Hotline

800-799-SAFE (7233)
<http://www.thehotline.org/>

National Health Information Center

P.O. Box 1133
Washington, DC 20013-1133
240-453-8280
email: info@nhic.org
<http://www.health.gov/nhic>

National Institute on Justice

<http://www.nij.gov/Pages/welcome.aspx>

National Institute of Mental Health

<http://www.nimh.nih.gov>

Office of Juvenile Justice and Delinquency Prevention

<http://www.ojjdp.gov/>

Social Security Administration

<http://www.ssa.gov>

Society for Prevention Research

<http://www.preventionresearch.org>

Substance Abuse and Mental Health Service Administration

U.S. Department of Health and Human Services
<http://www.samhsa.gov>
Treatment locator: www.findtreatment.samhsa.gov

U.S. Department of Health and Human Services

<http://www.hhs.gov>

Advocacy Organizations

Disability Rights Florida, Inc.

The Disability Rights Florida, Inc. is a private non-profit organization that receives federal funding to protect and advocate for the rights of persons of all ages who have disabilities. The Center provides a wide range of services to persons who have mental illnesses who believe they have experienced serious incidents of abuse or neglect, or civil rights violations related to their disabilities. The Center prioritizes services to people in institutional, inpatient, or residential treatment settings, but also provides services to individuals living in their communities, as resources allow. The Center has offices in Tallahassee, Tampa, and Ft. Lauderdale, from which it serves the entire state of Florida. The statewide toll-free phone number is 1-800-342-0823. <http://www.disabilityrightsflorida.org/>

Bazelon Center for Mental Health Law

The Bazelon Center for Mental Health Law is a nonprofit organization devoted to improving the lives of people with mental illnesses through changes in policy and law.

The Bazelon Center envisions an America where people who have mental disabilities exercise their own life choices and have access to the resources that enable them to participate fully in their communities. <http://www.bazelon.org>

Florida Partners in Crisis

Florida Partners in Crisis is a unique statewide organization. Membership includes judges, law enforcement, prosecutors, public defenders, mental health and substance abuse providers, hospital administrators, people recovering from mental illnesses and/or substance use disorders and their families and loved ones. Membership in Partners is a way to stay informed of mental health, substance abuse and criminal justice system policy developments and funding decisions. It also offers members opportunities for effective advocacy on behalf of mental health and substance abuse services for people in need. <http://www.flpic.org/>

Family Support

National Alliance on Mental Illness of Florida

NAMI has its state office in Tallahassee, which can be reached at 850-671-4445. Local chapters of NAMI are located throughout the state. www.nami.org

Al-Anon/Alateen Family Group

<http://www.al-anon.alateen.org/>

Bi-Polar and Depressive Alliance

Check phone book for chapter in your area. www.dbsalliance.org/

Families Anonymous

<http://www.familiesanonymous.org>

Florida's Center for the Advancement of Child Welfare Practice

The Center's mission is to support and facilitate the identification, expansion, and transfer of expert knowledge and best practices in child welfare case practice, direct services, management, finances, policy, and organizational development to child welfare and child protection stakeholders throughout Florida.

<http://centerforchildwelfare.fmhi.usf.edu>

Mental Health America

(formerly: National Mental Health Association)

From its inception in 1909, MHA has been dedicated to improving the lives of individuals and families affected by mental illness.

<http://www.mentalhealthamerica.net/>

Florida Affiliates

MHA of Broward County

<http://www.mhabroward.org/>

MHA of Central Florida, Inc.

<http://www.mhacf.org/>

MHA of Greater Tampa Bay, Inc.

<http://www.mhagreatertampabay.org/>

MHA of Indian River County

<http://www.mhairc.org/>

MHA of Northeast Florida, Inc.

<http://www.mhajax.org/>

MHA of Okaloosa & Walton Counties

<http://www.mhaow.org/>

MHA of Palm County

<http://www.mhapbc.org/index.cfm>

MHA of Southwest Florida

<http://www.mhaswfl.org/>

MHA of Volusia and Flagler Counties

<http://www.mhavalusia.org/>

MHA of West Florida, Inc.

<http://www.mhawfl.org/>

Older Adults

AARP Health Advocacy Services

601 E Street, NW
Washington, DC 20049
1-888-OUR-AARP (1-888-687-2277)

AARP Policy & Research

AARP's staff of policy analysts, economists, attorneys, researchers and industry experts specializes in a vast range of topics relating to older adults and aging both domestically and globally.
<http://www.aarp.org/research/>

Aging Related Web Sites

<http://www.publichealth.uga.edu/geron/>

Area Agencies on Aging (Aging Resource Center)

<http://elderaffairs.state.fl.us/docaa/aaa.php>

Clearinghouse on Abuse and Neglect of the Elderly (CANE)

Department of Consumer Studies and Research
University of Delaware
297 Graham Hall
Newark, DE 19716
<http://www.cane.udel.edu/>

Elder Helpline

1-800-96-Elder (1-800-963-5337)

Institute for Memory Impairments and Neurological Disorders

<http://www.alz.uci.edu>

National Center on Elder Abuse

Part of the federal Administration on Aging, the National Center on Elder Abuse (NCEA) serves as a national resource center dedicated to the prevention of elder mistreatment.
<http://www.ncea.aoa.gov/>

National Institute on Aging Information Center

Building 31, Room 5C27
31 Center Drive, MSC 2292
Bethesda, MD 20892
800 222-4225
<http://www.nia.nih.gov/>

Senior Citizens' Resources

Official information and services from the U.S. government
<http://www.usa.gov/Topics/Seniors.shtml>

Addictions

Alcoholics Anonymous World Services Inc

475 Riverside Drive at West 120th St.
New York, NY 10115
212 870-3400
<http://www.aa.org>

Center for Substance Abuse Treatment

National Drug & Alcohol Treatment Referral Service
800 662-HELP (4357)
<http://beta.samhsa.gov/about-us/who-we-are/offices-centers/csat>

Florida Alcohol and Drug Abuse Association

<http://www.fadaa.org>

National Association of Drug Court Professionals (NADCP)

<http://www.nadcp.org/>

Gamblers Anonymous

P.O. Box 17173, Los Angeles, CA 90017
626-960-3500
<http://www.gamblersanonymous.org/>

Narcotics Anonymous

<http://www.na.org/index.php>

National Families in Action

<http://www.nationalfamilies.org>

National Institute on Alcoholism and Alcohol Abuse (NIAAA)

<http://www.niaaa.nih.gov/>

Overeaters Anonymous

<http://www.oa.org>

Other Resources

Criminal Justice/Mental Health Justice Center The Council of State Governments

CSG Center: <http://csgjusticecenter.org/mental-health/>

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation

<http://gainscenter.samhsa.gov/>

National Association of State Mental Health Program Directors (NASMHPD)

<http://www.nasmhpd.org/index.aspx>

Center for the Study and Prevention of Violence (CSPV)

The CSPV, a research program of the Institute of Behavioral Science at the University of Colorado at Boulder, was founded in 1992 to provide informed assistance to groups committed to understanding and preventing violence, particularly adolescent violence. Since that time, our mission has expanded to encompass violence across the life course.

<http://www.colorado.edu/cspv/index.html>

Florida Council for Community Mental Health

The Florida Council for Community Mental Health (FCCMH) is a statewide association of 70 community-based mental health and substance abuse agencies.

<http://www.fccmh.org/>

National Strategy for Suicide Prevention

A collaborative effort of

SAMHSA, CDC, NIH, HRSA, HIS

<http://www.samhsa.gov/prevention/suicide.aspx>

National Suicide Prevention Lifeline

1-800-273-TALK (8255)

<http://www.suicidepreventionlifeline.org/>

Baker Act Online Training

Training is available online. This training was developed by the Louis de la Parte Florida Mental Health Institute staff and faculty at the University of South Florida with funds from the Florida Department of Children and Families. The online training consists of seven training modules, as well as four Web Events that were recorded and are available for viewing online.

The online training is free. Continuing education credits are available for a wide variety of professionals. There is a fee for the administration of the continuing education credits.

Training is available at <http://www.bakeracttraining.org/>

Online Training Modules

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

Recorded Web Events Available Online

Seclusion & Restraint

Kevin Huckshorn, PhD, RN, MSN, CAP, ICADC

Trauma Series

Norin Dollard, PhD., & Victoria Hummer, LCSW

Why People Die by Suicide

Thomas Joiner, PhD

Baker Act & Marchman Act Comparison & Co-Occurring Disorders

Martha Lenderman, MSW & Holly Hills, PhD

Online Guardian Advocate Training

This training was developed by the same faculty/staff who developed the Baker Act online training mentioned above. As of December 2013, this Guardian Advocate training has been approved for Florida Judicial Circuits 2, 3, 5, 7, 8, 9, 11, 12, 13, 14, 17 and 20. The Guardian Advocate Training is available at this site: <http://flguardianadvocate.org/>.

Military Service Members and Veterans

Some people subject to various aspects of the Baker Act, such as involuntary examination or inpatient placement, may be serving or may have served in the US military. Services, benefits and information available to veterans may be considered for these individuals. Some of the resources mentioned below may also be relevant to those who are still in the military. Although, with a few exceptions, services offered by the Veterans' Health Administration are not available to those who have not yet separated from the military.

There are many services, exemptions and designations available to veterans. However, these usually require proof of veteran status. How people, various agencies, and particular laws or rules define the term "veteran" varies. Not all people who served in the US Armed Forces are considered veterans based on the definition some use for the term "veteran." Further, not all veterans are eligible for VA Benefits, such as pensions or VA health care. Eligibility for such services is based on a set of complicated factors, including length of service, nature of service, era of service, income, disability status according to the VA, and discharge status. Discharge status can be:

- Honorable
- General (Honorable Conditions)
- General (Without Honorable Conditions)
- Other than Honorable
- Bad Conduct
- Dishonorable

Just because a person does not have an Honorable discharge does not mean he/she has a Dishonorable discharge. There are some VA funded services available to people with less than an Honorable, but more than a Dishonorable discharge status. Further, there is a process that can be pursued to try to get a person's discharge status reclassified. The Real Warrior site describes this reclassification process: <http://www.realwarriors.net/veterans/discharge/upgrade.php>

DD-214

Getting access to benefits and other offers available to veterans usually requires proof of veteran status. This often means having a DD-214 – the "Report of Separation." This document lists, among other things, the person's discharge status. DD-214s may be requested via the National Archives in St. Louis (see <http://www.archives.gov/veterans/>). The process for emergency requests is described here: <http://www.archives.gov/veterans/military-service-records/#emergency>.

Identifying Veterans

Providers would ideally have a systematic way to identify veterans. The question "are you a veteran?" is not the best question to ask in order to determine if someone is a veteran. Rather, asking "have you ever served in the US Armed Force?" is a better question. This is because some people who are veterans may not consider themselves veterans. This may be because they think they must access benefits or health care at the VA to be considered a veteran. Some people also may have discharge statuses that are not Honorable, so do not consider themselves veterans because of their discharge status.

Asking if a person has served in the US Armed Forces is the broadest question. It will allow agency staff to determine if a person is currently in the armed forces or if he/she has ever been in the armed forces. For people who say they served in the US armed forces in the past, then asking about discharge status, if they have a DD-214, if they have accessed VA services, and where they access these VA services may be helpful. If the person does not have a DD-214 assisting him/her to order one may be helpful. One suggestion is to keep copies of the form used to request a DD-214 on hand to give to veterans, and if needed, to assist them to fill it out and fax it. For form see: <http://www.archives.gov/veterans/military-service-records/>

A GAINS Center report that focuses on justice involved veterans has a helpful set of suggested questions to gather information about veteran status. It is available at: http://gainscenter.samhsa.gov/pdfs/veterans/CVTJS_Report.pdf

Organizations

It is helpful to establish contacts with various agencies/organizations to address issues for veterans. Some of these organizations are listed below.

Florida Department of Veterans Affairs (FDVA)

- Mission: "To advocate with purpose and passion for Florida veterans and link them to superior services, benefits and support."
- Vision: "FDVA is the premier point of entry for Florida veterans to accessed earned services, benefits and support."
- The FDVAs Florida Veterans' Benefits Guide may be found here: http://floridavets.org/?page_id=110. The FDVA website has a wealth of information that can be helpful to veterans and their families.

- The “Resources” section of the FDVAs website a wealth of information: http://floridavets.org/?page_id=31
- Locations and phone numbers for FDVAs 24 Claim Examiner Sites can be found here: http://floridavets.org/?page_id=91

US Veterans’ Administration

- The US Veterans’ Administration is composed of three organizational parts: a) VBA (Veteran Benefit Administration), VHA (Veteran Health Administration), and the VA National Cemetery Administration. Vet Centers, discussed later in this appendix, are separate from the US Veterans’ Administration.
- A list of and links to a variety of services offered by the United States Department of Veterans’ Affairs is available at http://www.va.gov/directory/guide/fac_list_by_state.cfm?State=FL&dnum=1&isflash=0. This includes
 - » VA Medical Centers
 - » Outpatient Clinics
 - » Community Service Programs
 - » Community Based Outpatient Clinics
 - » Vet Centers

Links to the VBA or Veteran Benefit Administration Offices in Florida are also listed on this web page.

- An interactive search to find services offered by the VA can be done here: <http://www.va.gov/directory/guide/home.asp?isflash=1>. This will search locations for the following services:
 - » VHA Facilities (Health Care, as well as Homeless programs)
 - » VBA Facilities (Benefits)
 - » Vet Centers
 - » PTSD Programs
 - » Substance Use Disorder (SUD) Programs
- Facilities in Florida are listed here: http://www2.va.gov/directory/guide/fac_list_by_state.cfm?State=FL

County Veteran Service Officers

Each of Florida’s 67 counties has a Veteran Service Office. A list of these may be found at: http://floridavets.org/wp-content/uploads/2013/10/CVSO_Directory_1-October-2013.pdf

Florida’s Veteran Service Organizations

Florida has several congressionally designated Veteran Service Organizations. These organizations have departments, posts and chapters in Florida. They serve Florida’s veterans in a variety of ways. Below is a list of some of these organizations. This list can also be found at the Florida Department of Veteran Affairs website at http://floridavets.org/?page_id=52

- American Gold Star Mothers
<http://www.goldstarmoms.com/Depts/AllDepts/AllDepts.htm>
- American Legion
<http://floridalegion.org/>
- AMVETS
<http://amvets.org/>
- Disabled American Veterans
<http://www.davmembersportal.org/fl/>
- Korean War Veterans Association
<http://dfl.kwva.org/>
- Military Officers Association of America
<http://www.moaaf.org/>
- Military Order of the Purple Heart
<http://www.floridapurpleheart.org/>
- Paralyzed Veterans of America
<http://www.pva.org/site/c.ajIRK9NJJLcJ2E/b.6463495/k.C5D5/Florida.htm>
- Veterans of Foreign Wars
<http://myfloridavfw.org/>
- Vietnam Veterans of America
<http://vvafsc.org/>

Specific Populations

Combat Veterans

- Vet Centers offers services, but are separate from the VA Health Administration, including VA Health Centers. Vet Centers focus their services on “War Zone Veterans” (see <http://www.vetcenter.va.gov/Eligibility.asp> for eligibility).
- Vet Centers also offer assessment and referral for Military Sexual Trauma Counseling offered by VA Health Centers. This assessment and referral service is available at Vet Centers not just War Zone Veterans, but for any veteran who has experienced this type of trauma (see http://www.vetcenter.va.gov/Military_Sexual_Trauma.asp).
- Vet Centers also offer services to family members who meet certain eligibility requirements.
- Vet Center information during normal business hours is available at 1-800-905-4675.

- Information in Spanish is available at: <http://www.vetcenter.va.gov/Servicios.asp>

Women

- The Women Veterans Call Center number is 1-855-VA-WOMEN or 1-855-829-6636
- Woman Veterans Program Information can be found at <http://www.va.gov/womenvet/>

Justice Involved Veterans

- Each VA Medical Center has at least one Veteran Justice Outreach (VJO) specialist. If a person has justice system involvement, the VJO may be a resource. Additional information about justice involved veterans, as well as contact information for VJOs is available at <http://www.va.gov/HOMELESS/VJO.asp>

In 2012, language was added to the Florida Statutes specific to military veterans and service members court programs.

394.47891 Military veterans and service members court programs

The chief judge of each judicial circuit may establish a Military Veterans and Service members Court Program under which veterans, as defined in s. 1.01, and service members, as defined in s. 250.01, who are convicted of a criminal offense and who suffer from a military-related mental illness, traumatic brain injury, substance abuse disorder, or psychological problem can be sentenced in accordance with chapter 921 in a manner that appropriately addresses the severity of the mental illness, traumatic brain injury, substance abuse disorder, or psychological problem through services tailored to the individual needs of the participant. Entry into any Military Veterans and Service Members Court Program must be based upon the sentencing court's assessment of the defendant's criminal history, military service, substance abuse treatment needs, mental health treatment needs, amenability to the services of the program, the recommendation of the state attorney and the victim, if any, and the defendant's agreement to enter the program.

OEF/OIF/OND Veterans

- Links to VA resources and other information for people who served in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and/or Operation New Dawn (OND) are available at <http://www.oefoif.va.gov/>
- VA Medical Centers have people working as OEF/OIF Coordinators. Links to the OEF/OIF resources at each of Florida's six VA Medical Centers can be found here: <http://www.oefoif.va.gov/map.asp>

Veterans who Experienced Trauma

- The National Center for PTSD has many resources related to trauma (see: <http://www.ptsd.va.gov/index.asp>)

Veterans Who Experienced Military Sexual Trauma

- Information about many resources for veterans who experienced Military Sexual Trauma are available here: <http://www.mentalhealth.va.gov/msthome.asp>

Veterans Who Are Homeless or Who Are At Risk for Homelessness

- Over the past several years the VA has put a great deal of focus on ending homelessness among veterans. Several programs – such as HUD-VASH and Grants-Per-Diem are available to veterans (see <http://www.va.gov/homeless/index.asp> or call 1-877-424-3838).

Veterans Health Initiative

- While most of the resources in this appendix address information, referral, assessment and service provision for veterans, the VHI focuses on training for professional.
- The VHI website states that the “VA developed the Veterans Health Initiative (VHI) independent study courses to increase VA providers’ knowledge of military service-related diseases and illnesses. The VHI study guides are useful as well for non-VA providers, VA employees (through the VA Talent Management System), Veterans and the public. The courses are accredited and meet medical licensure requirements” (see <http://www.publichealth.va.gov/vethealthinitiative/index.asp>).
- This includes information on a variety of topics:
 - » Agent Orange
 - » Traumatic Brain Injury (TBI)
 - » Traumatic Amputation
 - » Military Sexual Trauma
 - » Hearing Impairment
 - » Visual Impairment
 - » Gulf War
 - » War Wounded (OEF/OIF/OND)
 - » Post-Traumatic Stress Disorder

Veterans' Crisis Line

The Veterans' Crisis Line's website has text stating that it "connects Veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs responders through a confidential toll-free hotline, online chat, or text. Veterans and their loved ones can call 1-800-273-8255 and Press 1, chat online, or send a text message to 838255 to receive confidential support 24 hours a day, 7 days a week, 365 days a year." (See <http://veteranscrisisline.net/>)

Support for deaf and hard of hearing individuals is available.

- TTY Number: 1-800-799-4889

Key Phone Numbers

Veterans' Crisis Line	1-800-799-4899; TTY 1-800-799-4889
VA Benefits	1-800-827-1000
VA Homeless Programs	1-877-424-3838
VA Women Veterans Call Center	1-855-VA-WOMEN or 1-855-829-6636
Vet Centers	1-800-905-4675
Florida Department of Veterans Affairs (FDVA)	1-805-487-1533

Veteran's Issues and the Baker Act

There are two sections of the Baker Act that directly address issues specific to veterans. Information on the Military Veterans and Service Members Court Program (394.47891, F.S.) was mentioned on page Q-3. Below is the other section of the Baker Act that addresses veterans.

394.4672 Procedure for placement of veteran with federal agency.

(1) Whenever it is determined by the court that a person meets the criteria for involuntary placement and it appears that such person is eligible for care or treatment by the United States Department of Veterans Affairs or other agency of the United States Government, the court, upon receipt of a certificate from the United States Department of Veterans Affairs or such other agency showing that facilities are available and that the person is eligible for care or treatment therein, may place that person with the United States Department of Veterans Affairs or other federal agency. The person whose placement is sought shall be personally served with notice of the pending placement proceeding in the manner as provided in this part, and nothing in this section shall affect his or her right to appear and be heard in the proceeding. Upon placement, the person shall be subject to the rules and regulations of the United States Department of Veterans Affairs or other federal agency.

(2) The judgment or order of placement by a court of competent jurisdiction of another state or of the District of Columbia, placing a person with the United States Department of Veterans Affairs or other federal agency for care or treatment, shall have the same force and effect in this state as in the jurisdiction of the court entering the judgment or making the order; and the courts of the placing state or of the District of Columbia shall be deemed to have retained jurisdiction of the person so placed. Consent is hereby given

to the application of the law of the placing state or district with respect to the authority of the chief officer of any facility of the United States Department of Veterans Affairs or other federal agency operated in this state to retain custody or to transfer, parole, or discharge the person.

(3) Upon receipt of a certificate of the United States Department of Veterans Affairs or such other federal agency that facilities are available for the care or treatment of mentally ill persons and that the person is eligible for care or treatment, the administrator of the receiving or treatment facility may cause the transfer of that person to the United States Department of Veterans Affairs or other federal agency. Upon effecting such transfer, the committing court shall be notified by the transferring agency. No person shall be transferred to the United States Department of Veterans Affairs or other federal agency if he or she is confined pursuant to the conviction of any felony or misdemeanor or if he or she has been acquitted of the charge solely on the ground of insanity, unless prior to transfer the court placing such person enters an order for the transfer after appropriate motion and hearing and without objection by the United States Department of Veterans Affairs.

(4) Any person transferred as provided in this section shall be deemed to be placed with the United States Department of Veterans Affairs or other federal agency pursuant to the original placement.

Frequently Asked Baker Act Questions

Frequently Asked Questions can be found on the States Baker Act internet site located at www.dcf.state.fl.us/programs/samh/mentalhealth/laws/index.shtml.

Nearly a thousand pages of Frequently Asked Questions about the Baker Act and related issues categorized in 21 major groups and up to 17 subgroups are posted to the DCF Mental Health Program website. These FAQs may provide significant guidance, but do not represent legal advice. These are all real questions that have been asked and answered over the years with all identifiers removed.

Baker Act Forms

Clinical Records & Confidentiality

- Clinical Record
- Confidentiality
- HIPAA
- Public Records

Discharge Planning

Emergency Medical Conditions, EMTALA, Hospital Transfers

- Emergency Medical Condition Defined
- Medical Conditions of Persons under the Baker Act
- EMTALA Applicability
- Medical Clearance
- EMTALA / Medical Screening
- Baker Act Involuntary Examination
- Stabilization
- Informed Consent for Transfer
- Forms / Paperwork
- Transfers
- Nearest Facility for Transfer
- Transfers under the Baker Act
- Crisis Stabilization Units (CSU's)
- EMTALA / Reverse Dumping

- EMTALA / Insurance
- Transportation
- Law Enforcement

Emergency Treatment Orders

- Restraints
- Chemical Restraints
- Initiation of Emergency Treatment
- Emergency Medications
- Guardian Advocates & Other Substitute Decision-Makers
- PRN & Standing Orders Prohibited
- Forms
- Involuntary Placement Petition
- ETO's for Medical Treatment

Express and Informed Consent

- Competence to Consent
- Incompetence to Consent
- Disclosure
- Consent to Treatment
- Initiation of Psychiatric Treatment
- Mental Health Advance Directives
- Electroconvulsive Therapy
- Consent to Medical Treatment

Guardian Advocates & Other Substitute Decision Makers

- General
- Court Appointed Guardians (Chapter 744, FS)
- Guardian Advocates
- Health Care Surrogates & Proxies
- Other Substitute Decision Makers
- Medical Consent

Involuntary Examinations

- Professional Credentials
- Criteria
- Initiation
- Transport
- Acceptance

- Examination
- Conversion to Voluntary Status
- Release from Involuntary Examination
- Transfers
- Baker Act Reporting
- Nursing Home / ALF Initiations
- Notices
- Medical Conditions
- Elopement
- Miscellaneous

Involuntary Inpatient Placement

- Criteria
- Initiation & Filing of Petitions
- Public Defender & State Attorney
- Witnesses
- Continuances
- Waiver of Hearings
- Conversion to Voluntary Status
- Hearings
- Involuntary Placement Orders
- Continued Involuntary Inpatient Placement
- Baker Act Forms
- Elopements
- Transfers of Persons under Involuntary Placement
- State Treatment Facilities & Transfer Evaluations
- Discharge of Persons under Involuntary Placement
- Convalescent Status

Involuntary Outpatient Placement

Law Enforcement

- Definition of Law Enforcement Officer
- Voluntary Admissions
- Initiation of Involuntary Examination
- Execution of Involuntary Examination
- Criminal Charges
- Restraining Devices
- Receiving Facility Responsibilities
- Paperwork Required
- Rights of Persons
- Consular Notification & Access
- Training
- Warrantless Entry

Long-Term Care Facilities

- Alternatives to the Baker Act
- Voluntary Admissions
- Involuntary Examination
- Transportation
- Transfers
- Refusal to Accept Back

Marchman Act

- General
- Protective Custody – Law Enforcement
- Transportation
- Licensed Substance Abuse Facilities
- Responsibilities of Licensed Facilities
- Emergency Medical Conditions
- Involuntary Admissions
- Involuntary Treatment
- Appellate Cases

Minors

- Minority Defined
- Informed Consent for Treatment
- Voluntary Admissions
- Involuntary Examinations
- Transportation & Transfers
- Involuntary Placement
- Separation of Minors from Adults
- Juvenile Delinquency
- Receiving Facilities

Professional Credentials

- General
- Physicians
- Physician Assistants
- Psychologists
- Psychiatric Nurses
- Chapter 491 Professionals
- Veteran's Affairs
- Involuntary Placement

Receiving Facilities

- General
- Designation
- Public Receiving Facilities & CSU's
- Involuntary Status
- Inducements
- State Hospital Transfers

Rights of Persons in Mental Health Facilities

- General
- Right to Dignity & Privacy
- Advance Directives
- Right to Treatment
- Communication Restrictions
- Clinical Records & Confidentiality
- Custody of Personal Possessions
- Designated Representatives
- Habeas Corpus
- Right to Discharge

Training

Transportation under the Baker Act

- General
- Transportation Exception Plans
- Voluntary Status
- Responsibility of Receiving Facilities & Hospitals
- Nearest Receiving Facility
- Criminal Charges
- Delegation of Transportation to Medical Transport
- Transfers
- EMTALA/Transportation
- Transport to State Hospitals (Treatment Facilities)
- Juvenile Justice
- Transport for Involuntary Placement
- Marchman Act

Voluntary Admissions – Adults

- Requirements for Voluntary Admission
- Competence to Provide Express & Informed Consent
- Right to Request Release
- Guardians & Other Substitute Decision-Makers
- Transfers in Legal Status
- Requirements for Voluntary Admission
- Access to State Mental Health Facilities

Weapons & Contraband

- Weapons in Field
- Weapons at Psychiatric Hospitals
- Contraband

Baker Act Forms – Table of Contents

Form #	Title	Page #
3001*	Ex Parte Order for Involuntary Examination	1
3002*	Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination (2-sided; 4 pages)	3
3008*	Order for Involuntary Inpatient Placement	7
3021*	Notice of Petition for Involuntary Placement	9
3022*	Application for Appointment of Independent Expert Examiner	11
3024*	Notice of Petition for Continued Involuntary Inpatient Placement	13
3031*	Order for Continued Involuntary Inpatient Placement or for Release	15
3032*	Petition for Involuntary Inpatient Placement (2-sided; 3 pages)	17
3033*	Notification to Court of Withdrawal of Petition for Hearing on Involuntary Inpatient or Involuntary Outpatient Placement	21
3035*	Petition Requesting Authorization for Continued involuntary Inpatient Placement (2-sided 2 pages)	23
3036*	Notice of Right to Petition for Writ oh Habeas Corpus or for Redress of Grievances	25
3038*	Notice of Release or Discharge	27
3040*	Application for Voluntary Admission of an Adult (Receiving Facility)	29
3042a*	General Authorization for Treatment Except Psychotropic Medications	31
3042b*	Specific Authorization for Psychotropic Medications	33
3043*	Inventory of Personal Effects	35
3044*	Authorization for Release of Information	37
3045*	Notice of Person's Admission for Involuntary Examination	39
3046*	Application for and Notice of Transfer to Another Receiving or Treatment Facility	41
3048*	Confidentiality Agreement	43
3049*	Restriction of Communication or Visitors	45
3051a*	Notice of Right of Person on Voluntary Status to Request Discharge From a Receiving Facility (2-sided; 2 pages)	47
3051b*	Notice of Right of Person on Voluntary Status to Request Discharge From a Treatment Facility (2-sided; 2 pages)	49
3052a**	Report of Law Enforcement Officer Initiating Involuntary Examination (MANDATORY)	55
3052b**	Certificate of Professional Initiating Involuntary Examination (2-sided; 2 pages) (MANDATORY)	53
3057*	Authorization for Electroconvulsive Treatment	55
3084**	Baker Act Service Eligibility (MANDATORY)	57
3089*	Transfer Evaluation (To a State Mental Health Treatment Facility) (MANDATORY)	59
3090*	Petition for Writ of Habeas Corpus or for Redress of Grievances (2-sided; 2-pages)	61
3097*	Application for Voluntary Admission –Minors	63
3098*	Application for Voluntary Admission (State Treatment Facility)	65
3099*	Certification of Ability to Provide Express and Informed Consent for Voluntary Admission and Treatment of Selected Persons From Facilities Licensed Under Chapter 400, F.S.	67
3100**	Transportation to Receiving Facility (2-sided; 2 pages) (Mandatory)	69
3101 *	Hospital Determination That Person Does Not Meet Involuntary Placement Criteria	71
3102*	Request for Involuntary Examination After Stabilization of Emergency Medical Condition	73

* Recommended **Mandatory

Form #	Title	Page #
3103*	Rights of Persons in Mental Health Facilities and Programs (2-sided; 2 pages)	75
3104*	Certification of Person's Competence to Provide Express and Informed Consent	77
3105*	Refusal or Revocation of Consent to Treatment	79
3106*	Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate (2- pages; 2 sided)	81
3107*	Order Appointing Guardian Advocate	83
3108*	Petition Requesting Court Approval for Guardian Advocate to Consent to Extraordinary Treatment	85
3109*	Order Authorizing Guardian Advocate to Consent to Extraordinary Treatment	87
3110*	Restriction of Person's Access to Own Record	89
3111*	Approval for Release of Person on Involuntary Status from a Receiving a Facility	91
3113*	Notice to Court Request for Continuance of Involuntary Placement Hearing	93
3114*	Order Requiring Involuntary Assessment and Stabilization for Substance and for Baker-Act Discharge of Person	95
3115*	Order Requiring Evaluation for Involuntary Outpatient Placement	97
3116*	Findings and Recommended Order Restoring Person's Competence to Consent to Treatment and Discharging the Guardian Advocate	99
3118**	Cover Sheet to Agency for Health Care Administration (MANDATORY)	101
3119*	Notification of a Facility's Non-Compliance	103
3120*	Certification of Guardian Advocate Training Completion	105
3121*	Notification to Court of Person's Competence to Consent to Treatment and Discharge of Guardian Advocate	107
3122*	Certification of Person's Incompetence to Consent to Treatment and Notification of Health Care Surrogate/Proxy (2-sided; 2 pages)	109
3123*	Affidavit of Health Care Proxy	111
3124*	Personal Safety Plan (2-sided; 3 pages)	113
3125**	Application for Designation as a Receiving Facility (2-sided; 3 pages) (MANDATORY)	117
3130*	Petition for Involuntary Outpatient Placement (2-sided; 4 pages)	121
3140*	Designation of Service Provider for Involuntary Outpatient Placement	125
3145*	Proposed Individualized Treatment Plan for Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement	127
3150*	Notice to Department of Children and Families of Non-Filing of Petition for Involuntary Outpatient Placement or Diminished Treatment Plan Due to Non- Availability of Services or Funding	129
3155*	Order for Involuntary Outpatient Placement or Continued Involuntary Outpatient Placement	131
3160*	Notice to Court of Modification to Treatment Plan for Involuntary Outpatient Placement and/or Petition Requesting Approval of Material Modifications to Plan	133
3170*	Petition for Termination of Involuntary Outpatient Placement Order	135
3180*	Petition Requesting Authorization for Continued Involuntary Outpatient Placement (2-sided; 2 pages)	137
3185*	Notice to Court of Waiver of Continued Involuntary Outpatient Placement Hearing and Request for an Order	139
7000*	State Mental Health Facility Admission Form (2-sided; 6 pages)	141
7001*	State Mental Health Facility Discharge Form (2-sided; 12 pages)	147
7002*	Physician to Physician Transfer Form	149

* Recommended **Mandatory

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT

IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

Ex Parte Order for Involuntary Examination

Pursuant to Section 394.463(2)(a)1, Florida Statutes, this Court having received sworn testimony, states that the above-named person, presently within the county, appears to meet the following criteria for involuntary examination:

1. There is reason to believe the above-named person has a mental illness as defined in Section 394.455 (18), F.S., and because of this mental illness said person:
☐ (a) has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **or**
☐ (b) is unable to determine for himself/herself whether examination is necessary, **AND**
2. Either (Check a and/or b)
☐ (a) without care or treatment the above-named person is likely to suffer from neglect or refuse to care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **OR**
☐ (b) There is substantial likelihood that without care or treatment the above-named person will cause serious bodily harm to
☐ himself or herself or ☐ another person in the near future, as evidenced by recent behavior.

One or more Petitions and Affidavits Seeking Order Requiring Involuntary Examination (CF-MH 3002 or equivalent) on which the above conclusion is based is attached.

Additional information upon which this order is based is: _____

Therefore, it is

ORDERED

That a law enforcement officer, or designated agent of the Court take the above-named person into custody and deliver or arrange for the delivery of said person to the **nearest** receiving facility for involuntary examination, and that this order and petition be made part of said person's clinical record. A law enforcement officer or agent may serve and execute this order on any day of the week, at any time of the day or night. A law enforcement officer or agent may use such reasonable physical force as is necessary to gain entry to the premises, and any dwellings, buildings, or other structures located on the premises, and to take custody of the person who is the subject of this ex parte order.

This order expires in _____ days. If no time limit is specified in this order, the order shall be valid for 7 days after the date that the order was signed.

ORDERED THIS _____ day of _____, _____
Date Month Year

Printed Name of Circuit Court Judge

Signature of Circuit Court Judge

See s. 394.463, Florida Statutes
CF-MH 3001, Jan 98 (obsoletes previous editions) (Recommended Form)

BAKER ACT

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA
IN RE: _____ CASE NO.: _____

Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination

I, _____, being duly sworn, am filing this sworn statement requesting a court order for the
Print Name of Petitioner
involuntary examination of _____ (hereinafter referred to as PERSON).
Print Name of Person

This petition and affidavit will be included in the PERSON's clinical record and may be viewed by the PERSON.

I understand that by filling out this form, the PERSON may be taken by law enforcement to a mental health facility for an examination.

I SWEAR that the answers to the following questions are given honestly, in good faith, and to the best of my knowledge.

1. a. I live at: (Print Your Full Residence Address and Phone Number) Phone: (_____) _____
Street Address: _____ City _____ ST _____ Zip _____
b. I work as a: (Occupation) _____ Work Phone: (_____) _____
Work Street Address: _____ City _____ ST _____ Zip _____
c. The PERSON lives at, or may be found at, the following address(es):
Street Address: _____ City _____
Street Address: _____ City _____
Street Address: _____ City _____
2. I have the following relationship with the PERSON: _____

3. (Check the one box that applies)
☐ a. I or a family member ☐ have or ☐ have not previously made allegations to law enforcement involving this PERSON on _____ (Date) such as domestic violence, trespassing, battery, child abuse or neglect, Baker Act, neighborhood disputes, etc. as described: _____

☐ b. This PERSON ☐ has or ☐ has not previously made allegations to law enforcement about me or my family on _____ (Date) such as domestic violence, trespassing, battery, child abuse or neglect, Baker Act, etc. as described: _____

CONTINUED OVER

Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination (Page 2)

4. (Check the one box that applies)
- ☐ a. I or a family member are not now, and have not in the past, been involved in a court case with the PERSON.
- ☐ b. I or a family member am now, or was, involved in a court case with the PERSON. This case is/was a _____ in _____
- Type of Case When
- Explain: _____
- _____
5. I am on good terms with the PERSON at the present time. (Check one box) ☐ Yes ☐ No If "no", please explain: _____
- _____
6. I have known the PERSON for _____ (how long).
- ☐ a. The PERSON has only recently displayed unusual kinds of behavior.
- ☐ b. The PERSON has, over a period of time, always acted in a strange manner.
- ☐ c. The PERSON's behavior has developed over a period of time.

COMPLETE THE FOLLOWING ONLY IF THE SECTION APPLIES TO THIS CASE:

7. I have seen the following behavior, which causes me to believe that there is a good chance that the PERSON will cause serious bodily harm to himself/herself or others. On _____ at approximately _____ am pm,
- I saw the PERSON: _____
- _____
- _____
8. Other similar behavior I have personally seen is as follows: _____
- _____
- _____
- _____
9. ☐ To my knowledge or belief, ☐ I do ☐ I do not believe these actions were a result of retardation, developmental disability, intoxication, or conditions resulting from antisocial behavior or substance abuse impairment.

CHECK AND/OR ANSWER APPLICABLE SECTIONS

10. ☐ a. I have attempted to get the PERSON to agree to seek assistance for a mental or emotional problem(s). I explained the purpose of the examination (describe when, who was present, and whether you or another person explained the need for the examination): _____
- _____
- ☐ b. I did not try to get the PERSON to agree to a voluntary examination because: _____
- _____
- ☐ c. The PERSON refused a voluntary examination because: _____
- _____

CONTINUED

Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination (Page 3)

11. The following steps were taken to get the PERSON to go to a hospital for mental health care: _____

These steps did not work because: _____

12. I believe that the PERSON is unable to determine for himself/herself, why the examination is necessary because:

13. I believe that the PERSON has a mental illness which will keep the PERSON from being able to meet the ordinary demands of living because: _____

14. I believe that without care or treatment, the PERSON is likely to suffer from neglect or refuse to care for himself/ herself, because: _____

15. I believe that this lack of care or neglect will lead to the PERSON hurting himself or herself because:

16. Can family or close friends now provide enough care to avoid harm to the PERSON? ☐ Yes ☐ No, If not, why?

CONTINUED OVER

Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination (Page 4)

Provide the following identifying information about the person (if known) if it is determined necessary to take the person into custody for examination:

County of Residence:	Social Security No.:	Date of Birth:	
Sex : <input type="checkbox"/> Male <input type="checkbox"/> Female	Race:	Attach a picture of the PERSON if possible. Picture attached: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Height:	Weight:	Hair Color:	Eye Color:
Does the PERSON have access to any weapons? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe:			
Is the PERSON violent now? <input type="checkbox"/> No <input type="checkbox"/> Yes Has the person been violent in the recent past? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Describe:			
Does the PERSON have any pending criminal charges against him/her? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe:			

GUARDIANSHIP:

1) Does the PERSON have a legal guardian? ☐ No ☐ Yes

2) Is there a pending petition to determine the PERSON's capacity and for the appointment of a guardian? ☐ No ☐ Yes
If YES to either of the above, provide the name, address and phone number of the current or proposed guardian.

Name: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

PHYSICIAN: Name: _____ Phone: (_____) _____

MEDICATIONS: Provide name of medications if known.

CASE MANAGEMENT: Provide name and phone number of case manager or case management agency, if known.

I understand that this sworn statement is given under oath and will be treated as though it was made before a judge in a court of law. I understand that any information in this sworn statement which is not to the best of my knowledge and done in good faith may expose me to a penalty for perjury and other possible penalties under the statutes of the State of Florida.

Under penalties of perjury, I declare that I have read the foregoing document and that the facts stated in it are true.

Signature of Affiant/Petitioner: _____

SWORN TO AND SUBSCRIBED before me

OR

SWORN TO AND SUBSCRIBED before me

this _____ day of _____, _____
Day Month Year
by _____ who is personally known
to me or presented _____ as identification.

Notary Public - State of Florida

My Commission expires: Date _____

this _____ day of _____, _____
Day Month Year

Clerk of Circuit Court

_____ County, Florida

By: _____
Deputy Clerk

A copy of the petition(s) must be attached to an Ex Parte Order for Involuntary Examination and accompany the person to the nearest receiving facility.

See s. 394.463, Florida Statutes
CF-MH 3002, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

Order for Involuntary Inpatient Placement

This matter came to be heard pursuant to a Petition for Involuntary Inpatient Placement filed herein on the issue of whether the above-named person should be involuntarily placed in a mental health treatment or receiving facility, and the Court being fully advised in the premises, finds by clear and convincing evidence, as follows:

1. Said person has been represented by counsel; Said person ☐ appeared at the hearing, or
☐ said person's presence at the hearing was waived, without objection of said person's counsel.
2. Said person meets the following criteria for involuntary inpatient placement pursuant to s. 394.467(1), F.S. :
 - (a) He or she is mentally ill and because of a mental illness:
 - (1) has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or
 - (2) is unable to determine for himself or herself whether placement is necessary; **AND**
 - (b) Either
 - (1) He or she 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 himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or
 - (2) There is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and
 - (c) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.
3. The nature and extent of the above-named person's mental illness is as follows: _____

4. The Court considered testimony and evidence regarding the person's competence to consent to treatment. The person was found to be
☐ competent ☐ incompetent to consent to treatment. If found to be incompetent, _____
_____ was appointed as guardian advocate.
(name and address)
5. If the petition was referred to and heard by a general master, the Master's Report and Recommendation are attached, incorporated by reference, and/or adopted by the Court.

ORDERED

That the above-named person be placed in a designated mental health receiving or treatment facility on an involuntary basis for a period of up to _____, not to exceed 6 months from the date of this order, or until discharged by the administrator or transferred to voluntary status.

DONE AND ORDERED in _____ County, Florida, this _____ day of _____, _____.

Printed Name of Circuit Court Judge

Signature of Circuit Court Judge

This form must accompany person to the treatment facility.

See s. 394.467(1), Florida Statutes
CF-MH 3008, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

Notice of Petition for Involuntary Placement

YOU ARE HEREBY NOTIFIED that a petition for a hearing has been filed with the _____ Circuit Court in _____ County, Florida where the above-named person is hospitalized on the question of whether he/she should be ordered or confined for:

- ☐ Involuntary Inpatient Placement
☐ Involuntary Outpatient Placement
☐ Continued Involuntary Outpatient Placement

Said person will be represented by the Public Defender if he/she is not otherwise represented by counsel.

A hearing has been scheduled by the court and will be conducted pursuant to Section 394.467, F.S., on _____ at _____ am pm
Date Time
at _____
Place/address

At least one of the following examining experts will testify in support of continued detention:

In addition to at least one of the professionals listed above, the following persons are also expected to testify in support of involuntary inpatient placement or involuntary outpatient placement or continued involuntary outpatient placement:

	Guardian or Representative	Other Witness	Other Witness
Name:	_____	_____	_____
Relationship	_____	_____	_____
Address	_____	_____	_____
Telephone:	(____) _____	(____) _____	(____) _____

The person, the person's guardian, or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the person.

The person has a right to an independent expert examination and if he/she cannot afford such an examination the Court shall provide for one.

Signature of Court Date Time am pm

Printed Name of Court

Certificate of Mailing

I hereby certify that I mailed the above and foregoing notice to the named parties by depositing the same in the United States Post Office on the _____ day of _____, _____. In addition, I sent this notice by registered or certified mail to each person listed below who was not given a copy by hand delivery.

Signature of Court Date Time am pm

This form may be completed and mailed by the Receiving Facility instead of the Court, with the court's concurrence.

cc: ☐ Person ☐ Guardian ☐ Representative ☐ Public Defender or ☐ Private Attorney

See s. 394.4599(2)(a), (c), Florida Statutes
CF-MH 3021, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

Application for Appointment of Independent Expert Examiner

I, _____ hereby petition the Court to
order an independent expert examination pursuant to:

- ☐ Involuntary Inpatient Placement (s.394.467(6)(a)2, FS)
- ☐ Involuntary Outpatient Placement (s.394.4655(6)(a)2, FS)
- ☐ Continued Involuntary Outpatient Placement (s.394.4599(2)(c)5, FS)

Signature of Person or Representative

Date

Typed or Printed Name of Person or Representative

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Representative		am pm	

IN RE: _____ CASE NO.: _____

Notice of Petition for Continued Involuntary Inpatient Placement

YOU ARE HEREBY NOTIFIED that a petition for a hearing has been filed with the State Division of Administrative Hearings on the question of whether _____ who is hospitalized at _____ should be ordered for continued involuntary inpatient placement.

The person will be represented by the Public Defender if the person is not otherwise represented by counsel.

A hearing will be conducted pursuant to Section 394.467 (7), F.S., at _____ am pm on _____ (date) at _____

The following physician(s) or clinical psychologist(s) are expected to testify in support of continued detention:

In addition, the following persons are also expected to testify in support of continued involuntary inpatient placement:

Name:	_____	_____	_____
Relationship	_____	_____	_____
Address	_____	_____	_____
Telephone:	(____) _____	(____) _____	(____) _____

The person, the person's guardian, or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the person.

The person has a right to an independent expert examination and if he/she cannot afford such an examination, one shall be provided for him or her.

Signature of Administrative Law Judge

Date

Time

am pm

Typed or Printed Name of Administrative Law Judge

Certificate of Mailing

I hereby certify that I mailed the above and foregoing notice to the named parties by depositing the same in the United States Post Office on the _____ day of _____, _____. In addition, I sent this notice by registered or certified mail to each person listed below who was not given a copy by hand delivery.

Signature of Administrative Law Judge

cc: Check when applicable ☐ Person ☐ Guardian ☐ Guardian Advocate ☐ Representative ☐ Public Defender or ☐ Private Attorney

See s. 394.4599(2)(a), (c), 394.467(7), Florida Statutes
CF-MH 3024, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Order for Continued Involuntary Inpatient Placement or for Release

This matter coming on to be heard, pursuant to the requirements of Section 394.467(7), Florida Statutes, that the mental status and necessity to continue involuntary inpatient placement of persons be periodically reviewed, and the person having ☐ appeared in person ☐ appeared through counsel, the following findings of fact are made from the evidence designated:

1. The person, on _____, was involuntarily placed on a Court order.
Date
2. The person ☐ does ☐ does not continue to meet the criteria for involuntary inpatient placement. This finding is determined from the testimony of _____ and _____. As evidenced by:

Based on the above findings of fact, the Administrative Law Judge makes the following conclusions:

On the basis of the above, it is hereby

ORDERED

- ☐ The person be returned to involuntary inpatient placement pending the next periodic review required by Section 394.467, Florida Statutes.
- ☐ The person be processed for release from involuntary inpatient placement and be completely discharged from the facility.
- ☐ The person is eligible for and has applied for voluntary status.

ORDERED at

this _____ day of _____, _____.
Date Month Year

Printed Name of Administrative Law Judge

Signature of Administrative Law Judge

cc: Check when applicable

☐ Person ☐ Guardian ☐ Guardian Advocate ☐ Representative ☐ Public Defender ☐ Facility Administrator

See s. 394.467(7), Florida Statutes
CF-MH 3031, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

Petition for Involuntary Inpatient Placement

COMES NOW the Petitioner, _____, and alleges:

1. That Petitioner is Administrator of _____
Name of Facility Facility Address
2. That (Name of Person) _____, is a
patient of said facility and has been examined at such facility.
3. The person's social security number is _____ and date of birth is: _____
Date
4. That this petition is being filed within the following time frames: (Check one below)
☐ A. This person was admitted for involuntary examination and this petition is being filed within the 72-hour examination period, or if the examination period ends on a weekend or legal holiday, on the next court working day
OR
☐ B. This person was transferred to involuntary status after examination or after refusing/revoking consent to treatment or requesting discharge from the facility and this petition is filed within two court working days.
5. That attached hereto and by reference made a part hereof, are two (2) opinions regarding the mental health of said person necessitating involuntary inpatient placement.
6. That based thereon Petitioner recommends that the person/respondent be involuntarily placed in
_____, a (public/private) designated receiving or treatment facility.
7. In addition to at least one of the two experts whose opinions are attached, the following persons may testify:

	Guardian or Representative	Other Witness	Other Witness
Name:	_____	_____	_____
Relationship	_____	_____	_____
Address	_____	_____	_____
	_____	_____	_____
Telephone:	(_____) _____	(_____) _____	(_____) _____

CONTINUED OVER

Petition for Involuntary Placement (Page 2)

COMES NOW THE PETITIONER and further alleges that:

- ☐ 1. A Guardian Advocate is necessary to act on the person's behalf on issues related to express and informed consent to mental health or medical treatment and a Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate is attached; OR
- ☐ 2. The person/respondent is competent to provide express and informed consent to his or her own treatment or the person has a guardian authorized to consent to treatment and no Guardian Advocate is requested.

Signature of Facility Administrator or Designee Date _____ Time _____ am pm

Typed or Printed Name of Administrator or Designee

The person ☐ does or ☐ does not have a private attorney. If so, the name and address of the private attorney is:

Private Attorney Name: _____

Private Attorney Address: _____

cc: The Clerk of the Court shall provide a copy of this petition to the: (Check when applicable and initial/date/time when copy provided)

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Public Defender		am pm	
<input type="checkbox"/> Representative		am pm	
<input type="checkbox"/> State Attorney		am pm	
<input type="checkbox"/> Dept. of Children & Families		am pm	

CONTINUED / SUPPORTING OPINIONS ON PAGE 3

Petition for Involuntary Placement (Page 3)

First Opinion Supporting the Petition

I, _____ a psychiatrist authorized to practice in the State of Florida, have personally examined _____ on _____ (within 72 hours of the signing hereof) and find from such

Name of Person

Date

examination that the person meets the following criteria for involuntary placement:

1. Said person is mentally ill and because of a mental illness (check one):

- ☐ a. Said person has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; OR
- ☐ b. Said person is unable to determine for himself/herself whether placement is necessary:

AND

2. Either (Check one or both):

- ☐ a. Said person is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alliterative services, and without treatment, he/she is likely to suffer from neglect or refuse to care for himself/herself and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; OR
- ☐ b. There is substantial likelihood that in the near future said person will inflict serious bodily harm on himself/herself or another person 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 said person's condition have been judged to be inappropriate based on contact with the following programs/agencies: _____

Observations which support this opinion are:

Signature of Psychiatrist Date Time _____ am pm

Typed or Printed Name of Psychiatrist License Number

Second Opinion Supporting the Petition

I, _____, a ☐ psychiatrist, ☐ clinical psychologist, ☐ licensed physician *,
☐ psychiatric nurse *, authorized to provide a second opinion on this petition pursuant to Section 394.467 (2), F.S., have personally examined

_____ on _____, (within 72 hours of signing hereof), and

Name of Person

Date

find that he/she meets the criteria for involuntary inpatient placement as stated in this petition. Observations which support this opinion are:

Signature of Examiner Date Time _____ am pm

Typed or Printed Name of Examiner Profession License Number

I certify that the county in which the person is detained has less than 50,000 population and no psychiatrist or psychologist is available to provide the second opinion.

Printed Name and Signature of Administrator or Designee Date

*** A licensed physician or psychiatric nurse may only provide such second opinion in counties of less than 50,000 population in cases where the facility administrator certifies that no psychiatrist or clinical psychologist is available to provide the second opinion (by countersigning above).**

See s. 394.4599(2)(c)3, 394.467, Florida Statutes
CF-MH 3032, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

**Notification to Court of Withdrawal of Petition
For Hearing on Involuntary Inpatient or involuntary Outpatient Placement**

YOU ARE HEREBY INFORMED THAT _____
Name of Person
at _____
Facility Name and Address

- ☐ has made application by express and informed consent for voluntary admission, due to an improvement in his/her condition.
- ☐ was discharged on _____ to _____
Date Destination (if known)
- ☐ was transferred on _____ to _____
Date Destination (if known)
- ☐ was converted to Marchman Act on _____
Date
- ☐ Other (specify): _____

Please withdraw my Petition for:

- ☐ Involuntary Inpatient Placement
☐ Involuntary Outpatient Placement
☐ Continued Involuntary Outpatient Placement

filed on _____ (date). The Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate, if any, is also being withdrawn.

Signature of Administrator or Designee Date _____ Time _____ am pm

Printed Name of Administrator or Designee

cc: ☐ Clerk of the Court (Probate Division) ☐ Person ☐ Guardian
☐ Assistant State Attorney ☐ Representative ☐ Person's Attorney

When a petition for involuntary placement is withdrawn, the court, state attorney, public defender or other attorney for the person, and guardian or representative must be notified by telephone within one business day of the decision, unless such decision is made within 24 hours prior to the hearing. In such cases, the notification must be made immediately.

See s. 394.467, 394.4685, 394.469, Florida Statutes
CF-MH 3033, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

IN RE: _____ CASE NO.: _____

Petition Requesting Authorization for Continued Involuntary Inpatient Placement

The petition of _____ who is the Administrator of
_____ Facility shows that:

1. The above named person, _____ of _____ County,
Florida, is currently in the aforesaid facility and was admitted to this facility on _____ .
Date
2. That according to the provisions of Section 394.467 (7), F.S., this person may not be retained after
_____, (Date) without an order authorizing continued involuntary inpatient placement.
3. That the person continues to meet the criteria for involuntary inpatient placement pursuant to Section 394.467(1), F.S., and
☐ that legally authorized period has nearly expired, or
☐ the person was admitted while serving a criminal sentence whose sentence will expire on _____ , or
Date
☐ the person was placed while a minor and will reach the age of majority on _____ .
Date

Wherefore, it is requested an Order be issued authorizing this Facility to retain the person for a period not to exceed six (6) months.

Signature of Administrator or Designee Date _____ am pm
Time

Printed or Typed Name of Administrator or Designee

CONTINUED OVER

Physician's or Clinical Psychologist's Statement

I hereby state that the above named person continues to meet the criteria for involuntary placement. Behavior which supports this opinion is: _____

Person's treatment during placement was: _____

Less restrictive settings which were investigated and the reasons they were ruled out are as follows: _____

- ☐ Support for facts in this statement is attached.
☐ The individualized treatment plan for the person is attached.

Signature of ☐ Physician ☐ Clinical Psychologist _____ Date _____ Time _____ am pm

Printed Name of Physician/Clinical Psychologist _____ License Number _____

File this completed form with the Administrative Law Judge.

Person ☐ does or ☐ does not have a private attorney. If so, the name and address of the private attorney is:

Private Attorney Name: _____

Private Attorney Address: _____

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Guardian Advocate		am pm	
<input type="checkbox"/> Representative		am pm	
<input type="checkbox"/> Public Defender or		am pm	
<input type="checkbox"/> Private Attorney			

See s. 394.467(7), Florida Statutes
CF-MH 3035, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances

To: _____

PLEASE BE ADVISED that you may petition the Circuit Court for a Writ of Habeas Corpus to question the cause and legality of your detention. Furthermore, a petition may be filed in the Circuit Court in the county in which you are placed for Redress of Grievances alleging that you are being unjustly denied a right or privilege or that an authorized procedure is being abused.

A Petition for Writ of Habeas Corpus and Redress of Grievances (CF MH Form 3090) may be used for this purpose. A petition must be signed by either you, your relative, friend, guardian, guardian advocate, representative, attorney, or the Department of Children and Families.

Staff of this facility will provide a copy of the Writ form to you immediately upon your request. Staff will assist you in completing this Writ form if you request such help. The Petition for a Writ will be submitted by the staff to the Circuit Court no later than the next working day after you submit the form.

Signature of Administrator or Designee

Date

Time

am pm

This completed form must be given to all persons admitted to a facility and to those individuals listed below as applicable.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Guardian Advocate		am pm	
<input type="checkbox"/> Representative		am pm	
<input type="checkbox"/> Health Care Surrogate/Proxy		am pm	

See s. 394.459(8), Florida Statutes
CF-MH 3036, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Notice of Release or Discharge

IN RE: _____ CASE NO. _____

YOU ARE HEREBY NOTIFIED that _____, admitted for

- ☐ Involuntary examination
- ☐ Involuntary inpatient placement
- ☐ Involuntary outpatient placement

has this _____ day of _____, 20__ been released or discharged from this facility and or order.

Any guardian advocate appointed to provide express and informed consent to treatment on the person's behalf, if any, has been discharged from his or her duties, unless the person was released from involuntary inpatient placement to involuntary outpatient placement and the appointment of the guardian advocate was continued by the court.

Signature of Administrator or Designee

Date

Time

am pm

Printed Name of Administrator or Designee

Name of Facility

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Guardian Advocate		am pm	
<input type="checkbox"/> Representative		am pm	
<input type="checkbox"/> Person's Attorney		am pm	
<input type="checkbox"/> Initiating Person		am pm	
<input type="checkbox"/> Circuit Court		am pm	
<input type="checkbox"/> Person's Clinical Record		am pm	

See s. 394.4599, 394.463(3), Florida Statutes
CF-MH 3038, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Application for Voluntary Admission of an Adult (Receiving Facility)

I, _____ do hereby apply for admission to
Full printed name of person whose admission is being requested

Fill in name of facility

for observation, diagnosis, care, and treatment of a mental illness, and I certify that the information given on this application is true and correct to the best of my knowledge and belief.

I am making this application for voluntary admission after sufficient explanation and disclosure to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. The reason for my admission to this facility is:

I am a competent adult with the capacity to make well-reasoned, willful, and knowing decisions concerning my medical or mental health treatment. I do not have a guardian, guardian advocate, or currently have a health care surrogate/proxy making health care decisions for me.

I ☐ have ☐ have not provided a copy of advance directive(s).

If so, the advance directives include my:

- ☐ Living Will
☐ Health Care Surrogate,
☐ Mental Health Care Surrogate,
☐ Other as specified:

I have been provided with a written explanation of my rights as a person on voluntary status and they have been fully explained to me. **I understand that this facility is authorized by law to detain me without my consent for up to 24 hours after I make a request for discharge;** unless a petition for involuntary inpatient placement or involuntary outpatient placement is filed with the Court within two (2) court working days of my request for discharge in which case I may be held pending a hearing on the petition.

I understand that I may be billed for the cost of my treatment.

Signature of Competent Adult

Date

Time

am pm

Printed Name of Witness

Signature of Witness

Date

Time

am pm

No notice of this admission is to be made without the consent of the person except in case of an emergency. The use of this form for a voluntary admission requires that a "Certification of Person's Competence to Provide Express and Informed Consent" be completed within 24 hours and if the form is used for a transfer of a person from involuntary to voluntary status, the "Certification" must be completed prior to the "Application". The "Application" and "Certification" must be placed in the person's clinical record.

General Authorization for Treatment Except Psychotropic Medications

I, the undersigned, a ☐ competent adult, ☐ guardian, ☐ guardian advocate, or ☐ health care surrogate/proxy hereby authorize the professional staff of this facility to administer assessment and treatment specified below.

- ☐ Routine medical care _____ (Initials of Person or Authorized Decision Maker)
- ☐ Psychiatric Assessment _____ (Initials of Person or Authorized Decision Maker)
- ☐ Other (Specify & Initial) _____
- _____
- _____

I understand that more information will be provided to me before my informed consent will be requested for the administration of any psychotropic medications.

I understand that my consent can be revoked orally or in writing prior to, or during the treatment period.

I have read and had this information fully explained to me and I have had the opportunity to ask questions and receive answers about the treatment.

Signature of Competent Adult

Date

Time

am pm

Signature of Witness for Person

Date

Time

am pm

Signature of: (check one when applicable) _____ Date _____ Time _____ am pm

☐ Guardian ☐ Guardian Advocate
☐ Health Care Surrogate ☐ Health Care Proxy

If I am the guardian advocate, health care surrogate, or health care proxy for the person, I certify that I have met and talked with the person and the person's physician in person, if at all possible, and by telephone, if not about the proposed treatment prior to signing this form.

Talked to person on: _____ (date) ☐ In person ☐ By telephone. If not in person, explain why not. _____

Talked to person's physician on: _____ (date) ☐ In person ☐ By telephone. If not in person, explain why not. _____

Signature of: (check one when applicable) _____ Date _____ Time _____ am pm

☐ Guardian ☐ Guardian Advocate
☐ Health Care Surrogate ☐ Health Care Proxy

Signature of Witness for Substitute Decision-Maker

Date

Time

am pm

The person shall always be asked to sign this authorization form. However, if the person is a minor, is incapacitated, or is incompetent to consent to treatment, the consent of his or her guardian, guardian advocate, or health care surrogate/proxy is required. Court orders, letters of guardianship, or advance directives must be retained in the clinical record if an individual other than the person signs the consent to treatment. The guardian, guardian advocate, or health care surrogate/proxy must agree to keep the facility informed of their whereabouts during the term of the hospitalization.

Discussion of psychotropic medication should occur within the context of the person's medical history and current overall medication regimen.

I have been given detailed information about:

- Baker Act Forms - 33

Inventory of Personal Effects

The following person _____ has retained these articles in his or her own custody:

The person has, for medical and safety reasons, placed the following articles in the temporary custody of this facility. (Attach additional sheets if necessary)

This is a correct listing of my personal effects and belongings which I hereby place in custody of the facility.

Signature of Person Date Time _____ am pm

Signature/Title of Witness to Inventory Date Time _____ am pm

Signature/Title of Witness to Inventory Date Time _____ am pm

If the person is unable or unwilling to sign the above, the reason(s) are as follows: _____

_____.

Amendment to the above inventory shall be made on a separate Inventory form, signed by the person, and witnessed by two persons.

This inventory must be amended upon the request of the person, guardian, guardian advocate or representative. All effects held by the facility shall be returned to the person immediately upon the person's discharge or transfer from the facility, unless such return would be detrimental to the person. If not returned to the person, the reason must be documented in the clinical record along with the disposition of the personal effects. The inventory form must be filed in the person's clinical record.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initial of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Guardian Advocate		am pm	
<input type="checkbox"/> Representative		am pm	

See s. 394.459(6), Florida Statutes
CF-MH 3043, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Authorization for Release of Information

I hereby request and authorize:

Name of Person(s) or Agency Holding the Information

Address

to release written or verbal information specified below:

To: _____
Name of Person(s) or Agency Requesting the Information

Address

For the purpose of: _____

I understand that this form may be used to release information related to mental health treatment, including assessments and lab reports. Any release of substance abuse information must be pursuant to 42 CFR. There are other special restrictions which apply to the release of information regarding HIV, abuse reports, etc.

I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information.

Expiration Date: _____ Social Security Number of Person: _____

Signature of Competent Adult Printed Name of Competent Adult Date _____ am pm

When applicable, Signature of: Printed Name of Substitute Decision Maker Date _____ am pm
☐ Guardian, ☐ Guardian Advocate, ☐ Health Care Surrogate/Proxy,
or ☐ Personal Representative/Equivalent (if deceased)

Signature of Witness Printed Name of Witness Date _____ am pm

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited unless the person provides specific written consent for the subsequent disclosure of this information. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

Any release of information must be in compliance with the federal HIPAA law and state laws governing such releases.

See s. 394.4615(1), Florida Statutes
CF-MH 3044, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Notice of Person's Admission for Involuntary Examination

Name of Guardian or Representative: _____

YOU ARE HEREBY NOTIFIED THAT _____

Printed Name of Person Admitted for Examination

Was admitted to: _____ (Name of Facility)

Facility Address _____ City _____ State _____ Zip Code _____

(_____) on _____ for an involuntary examination.

Facility Telephone Number _____ Date _____

You are notified of this admission because you have been designated as the person's ☐ representative and the person did not object to you being notified or as his or her ☐ guardian. Prompt notice by ☐ telephone or ☐ in person was given to you within 24 hours of the person's arrival at the facility.

You will be informed of his/her legal proceedings, rights and any restriction of these rights, and of the person's discharge or transfer to another facility. You have the legal right to petition the Court on the person's behalf, question the cause and legality of his/her detention in a facility or if you believe the person is being unjustly denied a right or privilege.

Signature of Administrator or Designee Date _____ Time _____ am pm

Printed or Typed Name of Administrator or Designee

Notice to the local Florida Local Advocacy Council must be given for all persons on involuntary status; such notice may not be waived. A person may choose his or her representative. Only if the person is unable to unwilling to designate a representative, the facility shall select a representative. When the facility selects the representative, the selection shall be made from the following list in the order of listing:

1. Health Care Surrogate
2. Person's Spouse
3. Person's Adult Child
4. Person's Parent
5. Person's Adult Next of Kin
6. Person's Adult Friend
7. Florida Local Advocacy Council

The person shall be consulted with regard to the selection of a representative by the receiving or treatment facility and shall have authority to request that any such representative be replaced. The following shall not be appointed as the person's representative: a licensed professional providing services to the person, an employee of a facility providing direct services to the person, an employee of the Department of Children and Families, an individual providing other substantial services to a person in a professional or business capacity, or a creditor of the person.

Distribution: Check when applicable and initial/date/time when copy is provided.

Individual	Date Copy Provided	Method Copy Provided	Time Copy Provided	Initials of Person Providing Copy
<input type="checkbox"/> Guardian			am pm	
<input type="checkbox"/> Representative			am pm	
<input type="checkbox"/> Florida Local Advocacy Council			am pm	
<input type="checkbox"/> Person's clinical record			am pm	

See s. 394.4597, 394.4599, Florida Statutes
CF-MH 3045, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

IN RE: _____

Application for and Notice of Transfer to Another Receiving or Treatment Facility

Part I - Application for Transfer

I, _____, hereby apply for transfer from
_____ to _____

on or before _____, _____

I understand that in transfers:

☐ From a public receiving facility to a private receiving facility, I am responsible for the cost of transportation and personnel required to assist with the transfer.

☐ From a private receiving facility to a public receiving facility, the cost of transfer is the responsibility of the private facility if the transfer is requested by the private facility.

Signature of ☐ Person, ☐ Guardian, ☐ Guardian Advocate _____ Date _____ Time _____ am pm
☐ Health Care Surrogate ☐ Health Care Proxy

Part II - Notice of Transfer to Another Facility

YOU ARE HEREBY NOTIFIED that _____ will be transferred from
_____, to _____ located at
_____ on _____
Date

Signature of Administrator or Designee _____ Date _____ Time _____ am pm

Part I is to be completed by the person or other authorized person to request a transfer. Part II is completed by the sending facility administrator prior to the date of transfer. Only Part II is completed when the transfer is initiated by the facility administrator rather than by the person or other person authorized to act on the person's behalf.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Guardian Advocate		am pm	
<input type="checkbox"/> Representative		am pm	
<input type="checkbox"/> Attorney		am pm	

See s. 394.4685, Florida Statutes
CF-MH 3046, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Confidentiality Agreement

While receiving services at _____ Facility, you have the right to decide who may and who may not receive information about your presence and treatment in this facility. This form is for you to document your choices. Please initial indicating your choice in the following areas:

Visitors:

_____ I choose to have visitors

_____ I choose to limit the specific visitors to the following:

_____ I choose to have no visitors

Telephone Use:

_____ I choose to receive all phone calls

_____ I choose to limit my calls to specific callers, including:

_____ I choose to receive no phone calls

Medical Records:

_____ I choose not to limit access to my medical records

_____ I choose to limit access to my medical records to the following:

_____ I choose that my records be accessible only by staff and people in the profession involved in my treatment

Other:

_____ I understand that federal and state laws, courts, and medical conditions may limit any of the above decisions

_____ I understand that though these are my present choices, I may change this document at any time, and that it will be placed in my clinical record while treatment continues.

Signature of Person

Printed Name of Person

Date

Name of Witness

See s. 394.459(5), Florida Statutes
CF-MH 3048, Feb 05 (Recommended Form)

BAKER ACT

Restriction of Communication or Visitors

Notice is hereby given to _____
Full Name of Person

this date, that under the provisions of s.394.459(5)(c), Florida Statutes, a restriction on communications has been placed for a period of _____ days, starting at _____ am pm on (Date) _____ and ending at _____ am pm on (Date) _____

The nature of the restriction is as follows: _____

The restriction has been ordered because _____

This restriction of communication shall be reviewed at least every 7 days and lifted as soon as possible.

Signature of Administrator or Designee Date _____ am pm

A person's right to report an alleged abuse or to contact and to receive communication from his/her attorney shall not be limited. This completed form must be placed in the person's clinical record as individualized justification for depriving the person of his/her right to communicate with others. Any renewal of this restriction shall be justified. A copy of this form and any renewal of the restriction shall be provided to all persons listed below, as applicable. The right to communicate or receive visitors shall not be restricted as a means of punishment.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initial of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Guardian Advocate		am pm	
<input type="checkbox"/> Representative		am pm	
<input type="checkbox"/> Attorney		am pm	
<input type="checkbox"/> Health Care Surrogate/Proxy		am pm	

Part I
Notice of Right of Person on Voluntary Status
To Request Discharge From a Receiving Facility

A person on voluntary status or a relative, friend, or attorney of the person may request discharge either orally or in writing at any time following admission to the facility. If the request for discharge is made by a person other than the person, the discharge may depend on the express and informed consent of the person.

If you request discharge, your doctor will be notified and you will be discharged within 24 hours after your request for discharge unless you withdraw your request or you meet the criteria for involuntary inpatient placement or involuntary outpatient placement. If you meet the criteria for involuntary inpatient or outpatient placement, the facility administrator may file a petition with the court for your continued detention within two (2) court working days and you will be detained without your consent, pending a court hearing.

If you wish to request discharge at any time during your stay at this facility, complete the Application for Discharge on the reverse side of page. No action on your part is required, unless you wish to make arrangements for release.

The procedure for requesting discharge has been explained to me and I have had the opportunity to ask questions and receive answers about my right to request discharge.

<hr/> Printed Name of Person	<hr/> Signature of Person	<hr/> Date	<hr/> Time am pm
<hr/> Printed Name of Guardian of Minor	<hr/> Signature of Guardian of Minor	<hr/> Date	<hr/> Time am pm
<hr/> Printed or Typed Name of Witness	<hr/> Signature of Witness	<hr/> Date	<hr/> Time am pm

cc: Check when applicable and provide date/time/initial when copy provided:

<input type="checkbox"/> Person	Date:	Time: am pm	Initial:
<input type="checkbox"/> Guardian of Child	Date:	Time: am pm	Initial:

Parts II and Part III are continued on back

Part III Withdrawal of Application for Discharge

Notice of Right of Person on Voluntary Status To Request Discharge from a Treatment Facility

Part I

A person on voluntary status or a relative, friend, or attorney of the person may request discharge either orally or in writing at any time following admission to the facility. If the request for discharge is made by an individual other than the person, the discharge may depend on the express and informed consent of the person.

If you request discharge, your doctor will be notified and you will be discharged within 3 days, not including weekends and holidays, after your request for discharge unless you withdraw your request or you meet the criteria for involuntary inpatient placement or involuntary outpatient placement. If you meet the criteria for involuntary placement, the facility administrator may file a petition with the Court for your continued detention within two (2) court working days and you will be detained without your consent, pending a court hearing.

If you wish to request discharge at any time during your stay at this facility, complete the Application for Discharge on reverse side of page. No action on your part is required, unless you wish to make arrangements for release.

_____ Printed or Typed Name of Person	_____ Signature of Person	_____ Date	_____ Time
			am pm

_____ Printed or Typed Name of Witness	_____ Signature of Witness	_____ Date	_____ Time
			am pm

cc: Check when applicable and date/time/initial when copy provided:

<input type="checkbox"/> Person	Date:	Time:	am pm Initials:
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Parts II and III are continued on back

Part II Application for Discharge

Pursuant to Section 394.4625 (2), Florida Statutes, I, _____
 hereby apply for my release or that of _____
 who is on voluntary status at (Name of Facility) _____.
 My relationship to the said person is that of (Relationship) _____.

 Signature of Person or Authorized Individual Date _____ Time _____ am pm

An oral request for discharge was made by _____ on _____ am pm
 Name of Requester Date Time

 Signature of Staff Printed Name of Staff Date _____ Time _____ am pm

If this request was made by someone other than me, I concur with the above request for my discharge. If not, I have completed Part III below.

 Signature of Person Date _____ Time _____ am pm

 Signature of Witness Date _____ Time _____ am pm

cc: Check when applicable and date/time/initial when copy provided:

<input type="checkbox"/> Person	Date: _____	Time: _____ am pm	Initials: _____
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Part III Withdrawal of Application for Discharge

I, _____, freely and voluntarily rescind my previous oral or written Application for Discharge. No force, fraud, deceit, duress, or other form of constraint or coercion were used to obtain this withdrawal of my Application for Discharge.

 Signature of Person Date _____ Time _____ am pm

 Signature of Witness Credentials of Witness Date _____ Time _____ am pm

cc: Check when applicable and date/time/initial when copy provided:

<input type="checkbox"/> Person	Date: _____	Time: _____ am pm	Initials: _____
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See s. 394.455(9), 394.4625(2), (3), Florida Statutes
 CF-MH 3051b, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

State of Florida, County of _____, Florida

_____ appears to meet the following criteria for involuntary examination:

☐ b. Person is unable to determine for himself/herself whether examination is necessary, **AND**

☐ b There is substantial likelihood that without care or treatment the person will cause serious bodily harm to (check one or both) ☐ **self** ☐ **others** in the near future, as evidenced by recent behavior.

[illegible]

Law Enforcement Case Number

Certificate of Professional Initiating Involuntary Examination

All sections of this form must be completed and legible (please print)

I have personally examined (printed name of person) _____ at time _____ am pm (time must be within the preceding 48 hours) on ____/____/20____ in _____ **County** and that person appears to meet criteria for involuntary examination **OR** I am a physician who has determined that (printed name of person) _____ has failed or has refused to comply with the treatment ordered by the court, and, in my clinical judgment, efforts were made to solicit compliance and the person appears to meet the criteria for involuntary examination. Section IV of this form is completed to document the requirements of the law.

This is to certify that my **professional license number** is:

and I am a (check one box)

- ☐ Psychiatrist ☐ Physician (non-psychiatric) ☐ Clinical Psychologist ☐ Psychiatric Nurse ☐ Clinical Social Worker
☐ Mental Health Counselor ☐ Marriage and Family Therapist Each as defined in s.394.455, F.S.

Section I: CRITERIA

There is reason to believe person has a mental illness as defined in Section 394.455(18), Florida Statutes (excludes retardation or developmental disabilities, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment).

Diagnosis of Mental Illness is:
List all mental health diagnoses applicable to this person

DSM Code(s)
(if known)

AND BECAUSE OF MENTAL ILLNESS

- ☐ A. Person has refused voluntary examination after conscientious explanation of disclosure of the purpose of examination
- OR
Statute requires that at least one be checked, but both may be checked if both apply
- ☐ B. Person is unable to determine for himself/herself whether examination is necessary
- ☐ A. Without care and treatment the person is likely to suffer from neglect or refuse to care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services
- AND EITHER
(A and/or B)
- ☐ B. There is substantial likelihood that without care or treatment the person will cause serious bodily harm to (check one or both):
- ☐ self ☐ others
- in the near future, as evidenced by recent behaviors (describe behaviors at top of page 2)

Section II: SUPPORTING EVIDENCE

A. My observations supporting these criteria including the person's behaviors and statements, specifically those related to suicidal ideation, previous suicide attempts, homicidal ideation or self-injury are as follows:

CONTINUED OVER

Certificate of Professional Initiating Involuntary Examination (Page 2)

Section III: OTHER INFORMATION

Other information, including source relied upon to reach this conclusion is as follows. If information is obtained from other persons, describe these sources (e.g., reports of family, friends, other mental health professionals or law enforcement officers, as well as medical or mental health records).

Section IV: NON-COMPLIANCE WITH INVOLUNTARY OUTPATIENT PLACEMENT ORDER

Complete this section if you are a physician who is documenting non-compliance with an involuntary outpatient placement order:
This is to certify that I am a physician, as defined in Florida Statutes 394.455(21), F.S. and in my clinical judgment, the person has failed or has refused to comply with the treatment ordered by the court, and the following efforts have been made to solicit compliance with the treatment plan:

Section V: INFORMATION FOR LAW ENFORCEMENT

Provide identifying information (if known) if needed by law enforcement to find the person so he/she may be taken into custody for examination:

Age: _____ ☐ Male ☐ Female Race/ethnicity: _____

Other details (such as height, weight, hair color, clothing worn when last seen, where last seen):

If relevant, information such as access to weapon, recent violence or pending criminal charges:

This form must be transported with the person to the receiving facility to be retained in the clinical record. Copies may be retained by the initiating professional and by the law enforcement agency transporting the person to the receiving facility.

Section VI: SIGNATURE

Signature of Professional:	Date Signed
Typed or Printed Name of Professional:	Phone ()
Address of Professional:	

By Authority of s. 394.455(18), 394.463(2)(a)3, 394.4655, Florida Statutes
CF-MH 3052b, Sept 06 (obsoletes previous editions) (Mandatory Form)

BAKER ACT

Authorization for Electroconvulsive Treatment

As the physician for this person, I have recommended a series of _____ electroconvulsive treatments and have provided sufficient information to ensure express and informed consent to the treatment.

Signature of Physician Printed Name of Physician Date _____ am pm

I have agreed with the need for this series of _____ electroconvulsive treatments after
☐ examination of the person or ☐ review of the person's treatment records. I am not directly involved with the person.

Signature of Second Physician Printed Name of Second Physician Date _____ am pm

I, the undersigned, ☐ competent adult, ☐ guardian, ☐ guardian advocate, ☐ health care surrogate

authorize _____ **Electroconvulsive Treatments** for _____
Number of treatments authorized Name of Person to Receive Treatment

a person in _____
Name of Facility

The information provided to the person to make the decision to consent to electroconvulsive treatment (which must include the purpose of the procedure, the common side effects, alternative treatments, and the approximate number of procedures considered necessary and that my consent may be revoked prior to or between treatments) is:

I have read and understood the information provided to me above and have been given an opportunity to ask questions and receive answers about the procedures. Knowing the above, I hereby consent to the treatment described.

Signature of Competent Adult Date _____ am pm

Signature, * as appropriate, of: Date _____ am pm
☐ Guardian, ☐ Guardian Advocate,
☐ Parent of a Minor, ☐ Health Care Surrogate

Signature of Witness Date _____ am pm

Facility should attach information about or copies of educational materials provided to the person and/or substitute decision maker.

*** A guardian shall produce letters of guardianship prior to authorizing ECT to demonstrate authority to provide consent. A guardian advocate requires express Court approval to provide consent to this procedure. A health care surrogate requires an advance directive expressly delegating such authority to the surrogate. In the absence of such an advance directive, a health care surrogate or proxy require express court approval to consent to ECT. The authorizing documentation must be validated by staff and filed in the person's clinical record.**

Baker Act Service Eligibility

Public Receiving Facility Name: _____

1. IDENTIFYING INFORMATION:

Person's Name: _____
Date of Birth: _____ Gender: ☐ Male ☐ Female Race: _____

2. FINANCIAL INFORMATION: Prospective monthly income (6-month average) \$ _____
Number of Family Members: _____ Title XX Eligible: ☐ Yes ☐ No

3. LEGAL STATUS: ☐ Voluntary Admission ☐ Involuntary Examination

4. CRITERIA: (check the appropriate criteria)

- ☐ There is reason to believe the above-named person has a mental illness, as defined in 394.455(18), **AND**
☐ Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself, such neglect or refusal poses a real and present threat of substantial harm to his or her well-being, and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services,
OR
☐ There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

5. MOST RECENT DSM OR ICD ADMISSION DIAGNOSIS AND CODE NUMBER: _____

6. SUMMARY: Behavioral manifestations justifying diagnosis. (A completed CF-MH 3052a or 3052b or Ex Parte Order may be attached for persons on involuntary status)

7. RECOMMENDED DISPOSITION / PLACEMENT:

8. WHY IS A LESS RESTRICTIVE PLACEMENT NOT BEING UTILIZED?

9. APPROVAL OF DISPOSITION/PLACEMENT ☐ does ☐ does not include authorization for payment of contracted 24-hour care.

Signature of Administrator or Designee

Date

Time

am pm

Printed Name of Administrator or Designee

By authority of s. 394.74, 394.875, 394.879, Florida Statutes

CF-MH 3084, Feb 05 (obsoletes previous editions) (Mandatory Form for Public Receiving Facilities)

BAKER ACT

Transfer Evaluation
(To a State Mental Health Treatment Facility)

I, _____ ☐ concur ☐ do not concur
Full Name of Mental Health Center/Clinic Director or Chief Clinical Officer

that _____, residing at _____
Full Name of Person Name and Address of Receiving Facility

meets statutory criteria for ☐ voluntary or ☐ involuntary admission to a state mental health treatment facility.
I find that less restrictive community based treatment alternatives have been considered for this person and were determined to be
(Check one): ☐ inappropriate ☐ unavailable ☐ appropriate and available.

If placement at a State Mental Health Treatment Facility is recommended, specify the reason for the recommendation:

If it is determined that the person does not meet criteria for admission to a state mental health treatment facility, and consequently a diversion to a less restrictive voluntary community-based service is appropriate, specify the recommended facility and type of service:

Signature of Evaluator Printed Name and Title of Evaluator Date _____ am pm
Time of Evaluation

Original Signature of _____ Date _____ Time _____ am pm
☐ Executive Director or ☐ Chief Clinical Officer

Name and Address of Community Mental Health Center or Clinic (_____) _____
Telephone Number

This form is to be completed by a designated staff member employed by a Community Mental Health Center or Clinic whenever a person is being considered for admission to a state mental health treatment facility either on a voluntary or involuntary basis. In the case of potential involuntary admission, the original copy of this form shall be provided for the Court's consideration prior to the hearing on the petition for involuntary placement. The evaluator or another knowledgeable person from the center or clinic shall be present at the court hearing to provide testimony as desired by the court.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input type="checkbox"/> Circuit Court		am pm	
<input type="checkbox"/> District DCF Mental Health Office		am pm	

By Authority of s. 394.455(29), 394.461, Florida Statutes
CF-MH 3089, Feb 05 (obsoletes previous editions) (Mandatory Form)

BAKER ACT

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

_____,
Petitioner,

vs.

_____,
Administrator,

_____,
Facility Respondent.

Petition for Writ of Habeas Corpus or for Redress of Grievances

1. This Court has jurisdiction pursuant to Section 394.459 (8), Florida Statutes.
2. Petitioner is being held by _____, (Administrator) in _____, (Facility), in _____ (City), Florida.
3. ☐ Petitioner believes that he/she is being deprived of her/his freedom for invalid and illegal reasons. Petitioner believes that her/his confinement is illegal because: _____

and/or
4. ☐ Petitioner believes that he/she is being unjustly denied a right or privilege or that a procedure authorized by law is being abused. Petitioner believes that he/she is being unjustly denied a right or privilege or that a procedure authorized by law is being abused because: _____

5. Petitioner is unable to afford counsel and would like the Office of the Public Defender or other counsel to be appointed to represent her/him in the above captioned matter.

CONTINUED OVER

Petition for Writ of Habeas Corpus or for Redress of Grievances (Page 2)

WHEREFORE, Petitioner respectfully requests that this Court:

- ☐ Appoint the Office of Public Defender or other counsel to represent your Petitioner in these proceedings; and
- ☐ Enter an Order setting a return hearing on this Petition for Writ of Habeas Corpus for respondent to show by what legal authority he/she holds petitioner, and/or
- ☐ Set a hearing for the purpose of a judicial inquiry into the allegations of this Petition for Redress of Grievances and for ordering a correction of abuse of rights or privileges granted under Chapter 394, Part I, F.S.

I HEREBY CERTIFY that the above stated matters In the Petition for Writ of Habeas Corpus and Redress of Grievances are true and correct to the best of my information, knowledge, and belief.

Signature of Petitioner

Date

Time

am pm

Printed Name of Petitioner

There ☐ is or ☐ is not a petition for involuntary placement pending.

The person ☐ is or ☐ is not currently represented by counsel.

Facilities must provide this form to any person making a verbal request for access to the Court. The completed form must be filed with the Clerk of the Court no later than the next working day and a copy retained in the person's clinical record. A copy of the completed Petition for Writ must be provided immediately to the person and copies of the Petition provided to those listed below, as applicable.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Guardian Advocate		am pm	
<input type="checkbox"/> Representative		am pm	
<input type="checkbox"/> Attorney		am pm	
<input type="checkbox"/> Health Care Surrogate/Proxy		am pm	

See s. 394.459(8), Florida Statutes
CF-MH 3090, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Application for Voluntary Admission - Minors

I _____ do hereby apply on behalf of
Full printed name of guardian of minor whose admission is being requested

_____ for admission to _____
Full printed name of minor Name of facility

for observation, diagnosis, care, and treatment of a mental illness, and I certify that the information given on this application is true and correct to the best of my knowledge and belief.

I am making this application for voluntary admission after sufficient explanation and disclosure so me and the minor so we can make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. The reason for admission to this facility is: _____

As guardian of this minor, I am a competent adult with the capacity to make well-reasoned, willful, and knowing decisions concerning medical or mental health treatment. I understand that I must keep the facility informed of my whereabouts during the time of this admission.

The minor and I have been provided with a written explanation of rights of a person on voluntary status and they have been fully explained to us. I understand that this facility is authorized by law to detain the minor without my consent for up to 24 hours after I or the minor make a request for discharge from a receiving facility; unless a petition for involuntary placement is filed with the Court as required by law within two (2) court working days of the request for discharge.

I understand that I may be billed for the cost of the minor's treatment.

Printed Name of Guardian Signature of Guardian Date _____ am pm

Printed Name of Witness Signature of Witness Date _____ am pm

I agree with the decision for me to be voluntarily admitted to this facility. This agreement is being given without any element of force, fraud, deceit, duress, or other form of constraint or coercion. I have been provided with a written explanation of my rights and they have been fully explained to me.

Printed Name of Minor Signature of Minor Date _____ am pm

Printed Name of Witness Signature of Witness Date _____ am pm

No notice of this admission is to be made without the consent of the minor's guardian except in case of an emergency. The original of this signed form must be filed in the clinical record.

Application for Voluntary Admission (State Treatment Facility)

I, _____ do hereby apply for admission to
Full printed name of person whose admission is being requested

Fill in name of facility

for observation, diagnosis, care, and treatment of a mental illness, and I certify that the information given on this application is true and correct to the best of my knowledge and belief.

I am making this application for voluntary admission after sufficient explanation and disclosure to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. The reason for my admission to this facility is:

I am a competent adult with the capacity to make well-reasoned, willful, and knowing decisions concerning my medical or mental health treatment. I do not have a guardian, guardian advocate, or currently a health care surrogate/proxy making health care decisions for me.

I ☐ have ☐ have not provided a copy of advance directive(s). If so, the advance directives include my
☐ Living Will,
☐ Health Care Surrogate,
☐ Mental Health Care Surrogate, or
☐ Other as specified: _____.

I have been provided with a written explanation of my rights as a person on voluntary status and they have been fully explained to me. I understand that this facility is authorized by law to detain me without my consent for up to 3 days, not including weekends and holidays, after I make a request for discharge unless a petition for involuntary placement is filed with the Court within two (2) court working days of my request for discharge.

I understand that I will be asked to complete a financial disclosure form and may be billed for the cost of my treatment.

I understand that the facility is authorized by law to transfer me to another departmental facility when it is necessary to meet my medical needs or for the efficient use of the department's facilities. I understand that prior to transfer, the administrator of the facility will give me written notice.

Signature of Adult

Date

Time

am pm

Printed Name of Witness

Signature of Witness

Date

_____ am pm
Time

No notice of this admission is to be made without the consent of the person except in case of an emergency. The use of this form for a voluntary admission requires that a “Certification of Person’s Competence to Provide Express and Informed Consent” be completed within 24 hours and if the form is used for a transfer of a person from involuntary to voluntary status, the “Certification” must be completed prior to the “Application”. The “Application” and “Certification” must be placed in the person’s clinical record.

**Certification of Ability to Provide Express and Informed Consent
For Voluntary Admission and Treatment of Selected Persons
From Facilities Licensed under Chapter 400, F.S.**

On _____, at _____ (a.m.) (p.m.) _____,
Date Time Print Name of the Person

who resides at _____
Person's Residence Name and Address

made application by express and informed consent for voluntary admission to _____
facility located at _____
Address of Facility

He or she is: (Check the box that applies)

- ☐ A person 60 years of age or older diagnosed with dementia for whom transfer is being sought from nursing home, assisted living facility, adult day-care center, or adult family-care home.
- ☐ A person 60 years of age or older for whom emergency transfer is being sought from a nursing home pursuant to s. 400.0255(6).
- ☐ 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, F.S.

He/she ☐ does or ☐ does not have the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.

He/she ☐ has or ☐ has not consented in writing, after sufficient explanation and disclosure of the need for admission, without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

The observations on which I have reached this conclusion are:

Signature of Assessor * Date of Assessment _____ Time of Assessment _____ am pm

Typed or Printed Name of Assessor Profession License Number (if any)*

*** If publicly funded assessor is not licensed, specify the name, profession and license number of supervising professional:**

Name: _____ Profession: _____ License #: _____

Name of Mental Health Overlay Program (a service provided under contract with the Department of Children & Families and attached to a public receiving facility): _____

Name of Mobile Crisis Response Service (a service provided under contract with the Department of Children & Families and attached to a public receiving facility): _____

Name of Community Mental Health Center or Clinic (publicly funded, not-for-profit center under contract with the Department of Children & Families): _____

OVER FOR USE BY INDEPENDENT PROFESSIONAL

**Certification of Ability to Provide Express and Informed Consent
For Voluntary Admission and Treatment of Selected Persons
From Facilities Licensed Under Chapter 400, F.S. (Page 2)**

When an initial assessment of the ability of a person to give express and informed consent to treatment is required and a mobile crisis response service does not or cannot respond to the request for an assessment within two (2) hours after the request is made, the requesting facility may arrange for assessment by any licensed professional authorized to initiate an involuntary examination, pursuant to s. 394.463 who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made. I certify that the mobile crisis service, if one exists, has been contacted and cannot respond within the 2-hour period and that I have no conflict of interest as defined above.

NOTICE: Under the provisions of s. 400 F.S. and 394.4625(1)(c), it is unlawful for this assessment to be conducted by any professional who is employed by, under contract with, or who has a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made.

The person applying for voluntary admission ☐ does or ☐ does not have the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.

He/she ☐ has or ☐ has not consented in writing, after sufficient explanation and disclosure of the need for admission, without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

The observations on which I have reached this conclusion are:

Signature of Independent Professional Date _____ am pm
Time of Assessment

Typed or Printed Name of Professional Profession * License Number

* Physician, Clinical Psychologist, Clinical Social Worker, or Psychiatric Nurse whose education, training, experience, and licensure comply with statutory provisions of s. 394.455, F.S. A Licensed Mental Health Counselor is also authorized to perform this assessment on or after July 1, 2005.

Distribution: ☐ Original to the Receiving Facility for retention in person's clinical record
☐ Facility at which the person was assessed
☐ Assessor

See s. 395.455(9), 394.4625(1)(a), (b), (c), Florida Statutes
CF-MH 3099, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Transportation to Receiving Facility

Part I: General Information

The circumstances, under which (Name of Person) _____ was taken into custody are as follows:

Time: _____ am pm

Date: _____

Place or Facility Name: _____

Pick Up Address: _____

Family members or others present when person was taken into custody

Name	Address	Relationship	Phone Number

Next of Kin (if known)

Indicate personal knowledge by family members and others about the person's condition.

Delivered to (Nearest Receiving Facility): _____

Basis for Custody: (Check one) ☐ Ex Parte Order ☐ Certificate of Mental Health Professional ☐ Report of Law Enforcement Officer

Signature of Law Enforcement Officer

Date

Time _____ am pm

Printed Name of Law Enforcement Officer

Full Name of Law Enforcement Agency

Badge or ID Number

Law Enforcement Case Number

CONTINUED OVER

**Part II - Used When Law Enforcement Consigns Persons to Contract Transport (Page 2)
or to Emergency Medical Personnel**

If transport is used due to the medical condition of the person or due to a county-funded contract with a transport company, print the name of the company _____ which will transport the person to the nearest emergency room in the case of a medical emergency or, if not a medical emergency, to the nearest designated receiving facility _____.
(specify facility to which person is to be taken)

The law enforcement agency and the transport service must agree that the continued presence of law enforcement personnel is not expected at the time of consignment to be necessary for the safety of the person or others.

I, _____ of the _____
Printed Name of Law Enforcement Officer Printed Name of Law Enforcement Agency

and

I, _____ of the _____
Printed Name of Medical Transport Service Representative Printed Name of Medical Transport Service

agree that the continued presence of the law enforcement agency is not expected to be necessary for the safety of _____ or others. By affixing my legal signature and date/time of signing below, I understand that continued transporting of the person named above to a receiving facility is no longer the responsibility of law enforcement agency. The responsibility is assumed by the medical transport service in accordance with s. 394.462 (1), F.S.

Signature of Law Enforcement Officer Date Signed _____ Time Signed _____ am pm

Signature of Representative of Medical Transport Service Date Signed _____ Time Signed _____ am pm

This form must be delivered with the person to the receiving facility for inclusion in the clinical record. A copy may be retained by the law enforcement agency and by the medical transport service.

By Authority of s. 394.462(18), 394.463, Florida Statutes
CF-MH 3100, Feb 05 (obsoletes previous editions) (Mandatory Form)

BAKER ACT

Hospital Determination That Person Does Not Meet Involuntary Placement Criteria

☐ I have personally examined _____, a person for whom an involuntary examination has been initiated pursuant to 394.463 who was brought to _____ Hospital (**not designated as a Baker Act receiving facility**) for evaluation or treatment of an emergency medical condition.

☐ I have conducted the initial mandatory involuntary examination, including documenting observations of the person's recent behavior, reviewing the form initiating this examination and the transportation form, conducting a brief psychiatric history, and conducting a face-to-face examination of the person.

Check at least one box from each of the two categories below:

I have determined that he/she does **NOT** meet the criteria for involuntary **inpatient** placement pursuant to 394.467 based upon one or more of the following reasons:

- ☐ Does not suffer from a mental illness, as defined in s. 394.455(18)
- ☐ Has not refused placement or is able to determine for himself or herself that placement is necessary
- ☐ Is not likely to suffer from neglect posing a real and present threat of substantial harm nor is there substantial likelihood that in the near future he/she will inflict serious bodily harm on self or others as evidenced by recent behavior causing, attempting, or threatening such harm.
- ☐ There are available less restrictive treatment alternatives offering an opportunity for improvement of his/her condition

AND

I have determined that he/she does **NOT** meet the criteria for involuntary **outpatient** placement pursuant to 394.4655 based upon one or more of the following reasons:

- ☐ Person is under age 18;
- ☐ Does not suffer from a mental illness, as defined in s. 394.455(18)
- ☐ Person is likely to survive safely in the community without supervision, based on my clinical determination;
- ☐ Person has no history of lacking compliance with treatment for a mental illness
- ☐ Person has not within the preceding 36 months been involuntarily admitted to a Baker Act receiving or treatment facility, or received mental health services in a forensic correctional facility or engaged in one or more acts of serious violent behavior toward self or other, or attempts at serious bodily harm to self/others;
- ☐ Person has not been found to be unlikely to voluntarily participate in recommended treatment and has not either refused voluntary placement or been found to be unable to determine whether placement is necessary;
- ☐ Person hasn't been found, based on his/her treatment history and current behavior, to need involuntary outpatient placement 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;
- ☐ There has been no finding that it is likely the person will benefit from involuntary outpatient placement; **or**
- ☐ There are less restrictive treatment alternatives available that offer an opportunity for improvement of his/her condition

This examination was conducted at _____ a.m. p.m. on _____.
Time of Examination Date of Examination

As a physician or licensed clinical psychologist and recognized by this hospital as eligible to perform the involuntary examination, I have: ☐ Offered voluntary placement of this person OR ☐ Approved the direct release of this person from the hospital.

Signature of ☐ Physician ☐ Clinical Psychologist _____ Date _____ Time _____ am pm

Typed or Printed Name of Examiner _____ License Number _____

If a person is released from a hospital after being evaluated or treated for an emergency medical condition, this completed form or its equivalent must be completed and retained in the person's clinical record and a Notice of Release or Discharge (CF-MH 3038 or equivalent) must be given or sent to the person, the person's guardian, to any person who executed a Certificate, and to any Court which ordered the person's examination.

See s. 394.455(2), (18), (21), 394.463(2)(f), (g), (h), 394.467, Florida Statutes
CF-MH 3101, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Request for Involuntary Examination after Stabilization of Emergency Medical Condition

The following person _____, for whom an involuntary examination has been initiated has been evaluated or treated at _____ Hospital located at _____ for an emergency medical condition.

- a. The person arrived at this hospital at: _____ am pm on _____, 20____.
- b. The attending physician documented that the person had an emergency medical condition at:

- _____ am pm on _____, 20____.
- c. The attending physician documented at _____ am pm on _____, 20____

- ☐ That the person's medical condition had stabilized, or
- ☐ That an emergency medical condition did not exist

This hospital is notifying _____, a designated receiving facility or the psychiatric unit within this hospital, within two (2) hours of the time noted in (c) above that the person must be examined by a designated receiving facility and released; or the person must be transferred to a designated receiving facility in which appropriate medical treatment is available.

Within 12 hours of the time noted in (c) above, the designated receiving facility: (check one or both boxes)

- ☐ Shall perform the involuntary examination at this hospital or,
- ☐ Shall, if it has available the appropriate medical treatment, accept transfer of the person.

The nature and extent of this person's current medical problems: _____

This hospital, pursuant to federal and state statutes, will provide or secure transport of this person via: _____

with expected time of arrival of: _____ am pm on _____, 20____ unless other methods of transportation have been arranged as specified:

Signature of Administrator or Designee Credentials Date _____ am pm
Time

Typed or Printed Name Name of Hospital

*** Transfers of persons in a psychiatric emergency must be performed in compliance with the federal EMTALA law. This completed form must be given to the receiving facility with the form initiating the involuntary examination prior to or at the time of the transfer of the person with a copy retained in the clinical record. The person shall not be held for involuntary examination longer than a total of 72 hours plus the period during which an emergency medical condition was declared by the attending physician.**

Rights of Persons

In Mental Health Facilities and Programs

The following rights are guaranteed to you under Florida law. These will be fully explained to you at the time of and following admission to this facility. A copy of this form will be given to you to keep. You have the right to read the Baker Act law and rules at any time. Your signature on the form, if you choose to sign, only acknowledges that you have had the rights explained and that a copy of this form was provided to you.

Individual Dignity

You have the right to individual dignity and access to all constitutional rights. The federal Americans with Disabilities Act (ADA) applies to persons in this facility.

Right to Request Discharge by Persons on Voluntary Status

If you request discharge, your doctor will be notified and you will be discharged within 24 hours from a designated community facility and within 3 working days from a state hospital, unless you withdraw your request or you meet the criteria for involuntary placement. If you meet the criteria for involuntary inpatient placement or involuntary outpatient placement, the hospital administrator must file a petition with the Court for your continued stay within two (2) working days of your request for discharge.

Designation of Representative

You will be asked to identify a person to be notified in case of an emergency. Further, if you are at this facility for involuntary examination and do not have a guardian appointed by the court, you will be asked to designate a person of your choice to receive notification of your presence in this facility, unless you request that no notification be made. If you do not or cannot designate a representative, a representative will be selected for you by the facility from a prioritized list of persons. You have the right to be consulted about the person selected by the facility and you can request that such a representative be replaced.

Communication

You have the right to communicate openly and privately by phone, mail, or visitation with persons of your choice during your stay at this facility. You have the right to make free local calls and will be given access to a long distance service for collect calls. If communication is restricted, you will be given a written notice including the reasons for the restrictions. This facility is required to develop reasonable rules governing visitors, visiting hours, and the use of telephones but you cannot be limited in your access to your attorney, to a phone for the purpose of reporting abuse, in contacting the Florida Local Advocacy Council or the Advocacy Center for Persons with Disabilities. Several toll-free telephone numbers you may wish to keep are:

Florida Abuse Registry	1 800 96-ABUSE (962-2873) TDD: 1-800-453-5145
Advocacy Center for Persons with Disabilities	1 800 342-0823

Confidentiality of Information and Records

Information about your stay in this facility is confidential and may not be released, except under special circumstances, without your consent (or the consent of your guardian or guardian advocate or health care surrogate/proxy if you have one). Special circumstances include release of information to your attorney, in response to a court order, to an aftercare treatment provider, or after a threat of harm to another person. You have the right of reasonable access to your clinical record unless such access is determined to be harmful to you by your physician.

Treatment

You have the right to receive the least restrictive, available, appropriate treatment in this facility. You will get a physical examination within 24 hours of arrival and you will be asked to help develop a treatment plan to meet your individual needs. The criteria, procedures, and required staff training used by this facility for restraints, seclusion, isolation, emergency treatment orders, close levels of supervision, or physical management are available for your review. Such interventions may never be used for punishment, convenience of staff, or to compensate for inadequate staffing.

Advance Directives

You have the right to prepare an advance directive when competent to do so that specifies the mental health care you want or don't want and to designate a health care surrogate to make those decisions for you at the time of crisis. The facility is required to make reasonable efforts to honor those choices or transfer you to another facility that will honor your choices. The facility must document whether you have an advance directive and inform you of its policies about advance directives. There are organizations that can help you prepare an advance directive.

(Continued Over)

Rights of Persons

In Mental Health Facilities and Programs (page 2)

Informed Consent

Before any treatment is given to you, you will be given information about the proposed treatment, the purpose of the treatment, the common side effects of medication you receive, alternative treatments, the approximate length of care, and that any consent given may be revoked at any time by you, your guardian your guardian advocate, or your health care surrogate/proxy. There are additional disclosures that must be made for medications you receive. If the treatment for which you have given consent is changed at any time during your stay in this facility, it will be fully explained by the staff prior to asking for your written consent to the revised treatment.

Clothing and Personal Effects

You have the right to keep your clothing and personal effects unless they are removed for safety or medical reasons. If they are taken from you, an inventory of the possessions will be prepared and given to you to sign. The possessions will be immediately returned to you or your representative upon your discharge or transfer from this facility.

Habeas Corpus

You or your representative has the right to ask the Court to review the cause and legality of your detention in this facility or if you believe you have been unjustly denied a legal right or privilege or an authorized procedure is being abused. A petition form will be given to you by staff upon your request. If you wish to file a habeas corpus petition, you can submit it to a facility staff member, and it will be filed with the court for you by the facility no later than the next court working day.

Voting

You have the right to register to vote and to cast your vote in any elections unless the court has removed this right from you. Staff will assist you in arranging for registration or voting.

Discharge

You have the right to seek treatment from the professional or agency of your choice after your discharge from this facility.

_____	_____	_____	am pm
Person's Signature	Date	Time	
Signature, if applicable, of <input type="checkbox"/> Guardian <input type="checkbox"/> Guardian Advocate	_____	_____	am pm
<input type="checkbox"/> Representative <input type="checkbox"/> Health Care Surrogate/Proxy	Date	Time	
_____	_____	_____	am pm
Witness Signature	Date	Time	

This form must be retained in the clinical record as a receipt that the person received notice of his/her rights at the time of admission. A copy must be given to the person and to any authorized decision-maker for persons incompetent or incapacitated by age or disability.

cc: Check when applicable and initial/date/time when copy provided

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Guardian Advocate		a m pm	
<input type="checkbox"/> Representative		am pm	
<input type="checkbox"/> Health Care Surrogate/Proxy		am pm	

See s. 394.459, 394.4615, Florida Statutes
CF-MH 3103, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Certification of Person's Competence To Provide Express and Informed Consent

I have personally examined _____, a person being served at _____
_____ facility on _____, 20____ at _____ am pm.

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.

This person is 18 years of age or older, is not now known to be incapacitated with a guardian, is not now known to be incompetent to consent to treatment with a guardian advocate, and does not have a health care surrogate or proxy currently making medical treatment decisions. I have found this person to be one of the following:

- ☐ Competent to provide express and informed consent, as defined above, for voluntary admission to this facility and is competent to provide express and informed consent for treatment. He/she has the consistent capacity to make well reasoned, willful, and knowing decisions concerning his or her medical or mental health treatment. The person fully and consistently understands the purpose of the admission for examination/placement and is fully capable of personally exercising all rights assured under section 394.459, F.S.
- ☐ Incompetent to provide express and informed consent to voluntary admission. and thus is incompetent to provide express and informed consent to treatment. The person must be transferred to involuntary status and a petition for a guardian advocate filed with the Circuit Court. .
- ☐ Refusing to provide express and informed consent to voluntary admission but is competent to provide express and informed consent for treatment. The person must be discharged or transferred to involuntary status.

Signature of Physician

License Number

Typed or Printed Name of Physician

Date

Time am pm

Form shall be completed within 24 hours of a person's arrival at the receiving facility and filed in the clinical record of each person:

1. Admitted on a voluntary basis
2. Permitted to provide express and informed consent to his/her own treatment.
3. Allowed to transfer from involuntary to voluntary status
4. Prior to permitting a person to consent to his or her own treatment after having been previously found incompetent to consent to treatment.

See s. 394.459(3), 394.4625(1)(f), Florida Statutes
CF-MH 3104, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Refusal or Revocation of Consent to Treatment

PART I

_____, a person in this facility, ☐ refuses consent ☐ revokes previous consent;

OR _____, the ☐ guardian, ☐ guardian advocate, or ☐ health care surrogate/proxy for _____, a person who is incapacitated or incompetent to consent to treatment in this facility,

☐ refuses consent ☐ revokes previous consent for: ☐ All treatment, **or** ☐ The following treatment:

The reason given for this refusal/revocation, if any, is: _____

Signature of Competent Adult (or staff if oral refusal) Date _____ Time _____ am pm

If incompetent, signature of ☐ Guardian, ☐ Guardian Advocate, Date _____ Time _____ am pm
☐ Health Care Surrogate, ☐ Health Care Proxy

PART II Facility Response

A person on voluntary status 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 or unless the refusal or revocation is freely and voluntarily rescinded by the person. The guardian, guardian advocate, or health care surrogate/proxy has the right to refuse or revoke consent to treatment. The decision of the guardian, guardian advocate, or health care surrogate/proxy may be reviewed by the court, upon petition of the person's attorney, the person's family, or the facility administrator.

The facility's response to the refusal/revocation of consent was: _____

Staff Signature Profession _____

Typed or Printed Name of Staff Date _____ Time _____ am pm

PART III Withdrawal of Refusal or Revocation of Consent to Treatment

I, _____, freely and voluntarily rescind my previous refusal or revocation of consent to

treatment for the following reason(s): _____

Signature of Authorized Decision-Maker Date _____ Time _____ am pm

☐ Person, ☐ Guardian, ☐ Guardian Advocate,
☐ Health Care Surrogate, ☐ Health Care Proxy

Signature of Witness Credentials _____ Date _____ Time _____ am pm

IN RE: _____

CASE NO.: _____

**Petition for Adjudication of Incompetence to Consent to Treatment
and Appointment of a Guardian Advocate**

PART I

I, _____, Administrator of

Name of Facility

Facility Address

hereby recommend that _____ be
adjudicated incompetent to consent to:

☐ Mental health treatment

☐ Medical treatment

and that a guardian advocate be appointed to make such health care decisions for the person. The person is presently
placed in the County of _____ and has residence in the County of _____.

OR

Is presently ordered to involuntary outpatient placement in the County of : _____.

PART II Psychiatric Opinion Supporting the Petition

I, _____, a psychiatrist authorized to practice in the
State of Florida, have personally examined _____

Name of Person Examined

on _____, and found his/her judgment to be so affected by a mental illness that he/she lacks the
Date

capacity to make a well-reasoned, willful, and knowing decision concerning his/her ☐ medical and/or ☐ mental
health care. Observations which support this opinion are: _____

Signature of Psychiatrist

Date

Time

am pm

Typed or Printed Name of Psychiatrist

License Number

CONTINUED OVER

**Petition for Adjudication of Incompetence to Consent to Treatment
and Appointment of a Guardian Advocate (Page 2)**

PART III - Proposed Guardian Advocate

_____, who resides at _____ and whose relationship to the person is _____, has agreed to serve as guardian advocate. He/she has been provided with information about the duties and responsibilities of guardian advocates, including the information about the ethics of medical decision-making.

Signature of Administrator or Designee

Date

Time

am pm

Typed or Printed Name of Administrator or Designee

Complete Parts I, II, and III to Petition for a Guardian Advocate

Complete Part I only to petition the Court to expand a current guardian advocate's authority to provide consent to medical treatment in addition to mental health treatment.

Complete Part I and Part III to request the circuit court to appoint a substitute guardian advocate for one who cannot or will not perform his or her duties.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initial of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Representative		am pm	
<input type="checkbox"/> Current Guardian Advocate		am pm	
<input type="checkbox"/> Prospective Guardian Advocate		am pm	
<input type="checkbox"/> Person's Attorney		am pm	

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

Order Appointing Guardian Advocate

This matter came to be heard on the issue of whether the above-named person should be adjudicated incompetent to consent to treatment, and the Court finds by clear and convincing evidence as follows:

1. Said person has been represented by counsel.
2. Said person is not presently adjudicated incapacitated with a duly appointed guardian with authority to consent to treatment.
3. Said person meets the definition for being incompetent to consent to treatment pursuant to Section 394.455 (15), Florida Statutes.

This finding is determined from the testimony of _____. The court has considered testimony and other evidence regarding said person's competence to consent to treatment and based on such testimony and evidence has concluded that said person is not competent to consent to treatment.

On the basis of these findings, it is hereby,
ORDERED

That the above-named person presently within the county, is incompetent to consent to treatment because his/her judgment is so affected by a mental illness that he/she lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical and/or mental health treatment.

_____, whose relationship to the person is:
Name of Guardian Advocate

- | | | | |
|--|---|--|---|
| 1. <input type="checkbox"/> Health Care Surrogate | 2. <input type="checkbox"/> Person's Spouse | 3. <input type="checkbox"/> Person's Adult Child | 4. <input type="checkbox"/> Person's Parent |
| 5. <input type="checkbox"/> Person's Adult Next of Kin | 6. <input type="checkbox"/> Person's Adult Friend | 7. <input type="checkbox"/> Adult Trained and Willing to Serve | |

Has agreed to serve as guardian advocate and:

- a. Will obtain from the facility sufficient information in order to decide whether to give express and informed consent to the treatment, including information that the treatment is essential to the care of the person, and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects.
- b. Has agreed to meet and talk to the person and the person's physician in person, if at all possible, and by telephone if not, before giving consent to treatment.
- c. Has or will undergo a training course approved by this Court prior to exercising this authority, unless waived by this Court.
- d. Will be provided access to the appropriate clinical records of the person.

This guardian advocate has been given authority by this Court to consent, refuse consent, or revoke consent for:

☐ mental health treatment ☐ medical treatment

but may not consent to abortion, sterilization, electroconvulsive treatment, psychosurgery, or experimental treatments unless express Court approval in a separate proceeding is given.

This appointment as Guardian Advocate shall terminate upon the discharge of the person from an order for involuntary outpatient placement or involuntary inpatient placement or the transfer of the person to voluntary status, or an order of the court restoring the person's competence.

DONE AND ORDERED this _____ day of _____, _____

Printed Name of Circuit Court Judge

Signature of Circuit Court Judge

cc: ☐ Person _____ ☐ Guardian Advocate _____ ☐ Representative _____ ☐ Facility Administrator _____ ☐ Person's Attorney _____

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

**Petition Requesting Court Approval for
Guardian Advocate to Consent to Extraordinary Treatment**

_____, guardian advocate appointed on _____
Name of Guardian Advocate Date

for _____,
Name of Person.

Said person is presently:

☐ Placed on an inpatient basis in _____ a receiving or treatment facility in
_____ County and has residence in _____ County, or

☐ Involuntarily placed on an outpatient basis in _____ County. The service provider is: _____

Psychiatric or Medical Opinion Supporting the Petition

I, _____, a psychiatrist or physician authorized to practice in the State of Florida,
Name of Psychiatrist or Physician
have personally examined _____ on _____, and found
Name of Person Date
that he/she is in need of the following treatment or procedure: _____

Observations which support this opinion are: _____

This treatment or procedure is essential to the care of the person and the treatment does not present an unreasonable risk of serious,
hazardous, or irreversible side effects.

Signature of: ☐ Psychiatrist ☐ Physician _____ Date _____ Time _____ am pm

Typed or Printed Name of Psychiatrist or Physician _____ License Number _____

Guardian Advocate's Signature _____ Date _____ Time _____ am pm

Typed or Printed Name of Guardian Advocate _____

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian Advocate		am pm	
<input type="checkbox"/> Representative		am pm	
<input type="checkbox"/> Person's Attorney		am pm	
<input type="checkbox"/> Facility Administrator		am pm	

See s. 394.4598(6), Florida Statutes
CF-MH 3108, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

IN RE: _____ CASE NO.: _____

Order Authorizing Guardian Advocate to Consent to Extraordinary Treatment

This matter came to be heard on the issue of whether _____ guardian
Name of Guardian Advocate
advocate for the above-named person who is involuntarily placed should be given express court approval for extraordinary
treatment. Upon the evidence presented, the Court finds as follows:

1. The petitioner was appointed as the guardian advocate for the above-named person by order previously entered in this cause after an earlier hearing.
2. The person has been represented by counsel.
3. The treatment or procedure approved herein is essential to the care of the person and the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects.

On the basis of these findings, it is hereby,
ORDERED

That the above-named guardian advocate for the above-named person, presently within the county, is authorized to provide
consent for:

The Guardian Advocate's appointment shall terminate upon the discharge of the person from an order for involuntary outpatient placement or involuntary inpatient placement, or when the person is transferred to voluntary status, or by order of the court restoring the person's competence.

DONE AND ORDERED this _____ day of _____, _____.

Printed Name of Circuit Court Judge

Signature of Circuit Court Judge

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initial of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian Advocate		am pm	
<input type="checkbox"/> Person's Attorney		am pm	
<input type="checkbox"/> Facility Administrator		am pm	

See s. 394.4598(6), Florida Statutes
CF-MH 3109, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Restriction of Person's Access to Own Record

_____, served currently or in the past by this facility made a request on _____ (Date) to inspect his /her clinical record. The clinical record means all parts of the record required to be maintained and includes all medical records, progress notes, charts, and admission and discharge data, and all other information recorded by a facility which pertains to the person's hospitalization and treatment. This access was restricted in the following way: _____

The reasons for this restriction were: _____

The harm to the person as a result of such access was determined by the person's physician to be: _____

This restriction will expire on _____ (Date) (automatically expires after 7 days but may be renewed after review for subsequent 7 day periods).

Signature of Person's Physician Date Time am pm

Typed or Printed Name License Number

This form must be completed and filed in the person's clinical record at any time an oral or written request is made by a person to see his/her record and the facility does not produce the requested information. Facility policies and procedure shall govern criteria for determining what information may be harmful to persons served by the facility, establishing a reasonable time for responding to requests for access, identifying methods of providing access that ensure clinical support to the person while securing the integrity of the record, etc. Any renewal of the restriction of access shall require written justification.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Guardian Advocate		am pm	
<input type="checkbox"/> Representative		am pm	
<input type="checkbox"/> Attorney		am pm	

See s. 394.455(3), 394.4615(9), Florida Statutes
CF-MH 3110, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Approval for Release of Person on Involuntary Status From a Receiving Facility

I approve the release of _____, a person brought to _____
Receiving Facility for involuntary examination pursuant to s. 394.463.

Check at least one box from each of the two categories below

I have determined that he/she does not meet the criteria for involuntary inpatient placement pursuant to 394.467 based upon one or more of the following reasons:

- ☐ Does not suffer from a mental illness, as defined in s. 394.455(18)
- ☐ Has not refused placement **OR** is able to determine for himself or herself that placement is necessary
- ☐ Is not likely to suffer from neglect posing a real and present threat of substantial harm nor is there substantial likelihood that in the near future he/she will inflict serious bodily harm to self or others as evidenced by recent behavior causing, attempting, or threatening such harm
- ☐ There are less restrictive treatment alternatives available offering an opportunity for improvement of his/her condition. Specify: _____

☐ Other. Specify _____

AND

I have further determined that he/she does **NOT** meet the criteria for involuntary outpatient placement pursuant to 394.4655 based upon one or more of the following reasons:

- ☐ Person is under age 18;
- ☐ Does not suffer from a mental illness, as defined in s. 394.455(18)
- ☐ Person is likely to survive safely in the community without supervision, based on my clinical determination;
- ☐ Person has no history of lacking compliance with treatment for a mental illness
- ☐ Person has not within the preceding 36 months been involuntarily admitted to a Baker Act receiving or treatment facility, or received mental health services in a forensic correctional facility or engaged in one or more acts of serious violent behavior toward self or other, or attempts at serious bodily harm to self/others;
- ☐ Person has not been found to be unlikely to voluntarily participate in recommended treatment and has not either refused voluntary placement or been found to be unable to determine whether placement is necessary;
- ☐ Person hasn't been found, based on his/her treatment history and current behavior, to need involuntary outpatient placement 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;
- ☐ There has been no finding that it is likely the person will benefit from involuntary outpatient placement; **or**
- ☐ There are available less restrictive treatment alternatives offering an opportunity for improvement of his/her condition.

Observations upon which this determination was made are: _____

A face-to-face examination was conducted at _____ am pm on _____ Date

by: _____

Signature of ☐ Psychiatrist ☐ Clinical Psychologist ☐ Emergency Department Physician

License Number _____

Typed or Printed Name of Examiner _____

Date _____

_____ am pm
Time

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT

IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____

CASE NO.: _____

**Notice to Court
Request for Continuance of Involuntary Placement Hearing**

_____, a person awaiting a hearing on:

☐-Involuntary Inpatient Placement, pursuant to 394.467, FS, or

☐-Involuntary Outpatient Placement, pursuant to 394.4655, FS

at _____ Receiving or Treatment Facility has requested a
continuance of his/her hearing for a period of _____ (not to exceed a period of four weeks).

Any independent expert examination, if requested, will be completed and results provided to the undersigned attorney of record during the period of this continuance.

Signature of Counsel

Date

____ am pm
Time

Typed or Printed Name of Counsel

cc: ☐ Person ☐ Facility Administrator ☐ State Attorney ☐ Guardian ☐ Representative

See s. 394.467(5), Florida Statutes
CF-MH 3113, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

IN RE: _____ CASE NO.: _____

**Order Requiring Involuntary Assessment and Stabilization
for Substance Abuse and for Baker Act Discharge of Person**

THIS MATTER came to be heard pursuant to s. 394.467, F.S., on the issue of whether the above-named person should be ordered to involuntary inpatient placement or involuntary outpatient placement, and the court having considered testimony and evidence and having heard the argument of counsel, has concluded as follows:

1. The above-named person does not meet the criteria for involuntary inpatient placement in a treatment facility or involuntary outpatient placement, pursuant to the provisions of Chapter 394, Florida Statutes.
2. There is a good faith reason to believe that the above-named person is substance abuse impaired, and, because of such impairment, has lost the power of self-control with respect to substance use, and
☐ has inflicted, or threatened or attempted to inflict, or unless admitted to involuntary treatment for substance abuse is likely to inflict physical harm on himself or herself or another.
☐ is in need of substance abuse services, and, by reason of substance abuse impairment, has such impaired judgment that said person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto.
3. The above-named person should be admitted to a hospital or to a licensed detoxification facility or addictions receiving facility for involuntary assessment and, if necessary, stabilization, pursuant to s. 394.467(6) and s. 397.6811, Florida Statutes.
4. The admission ordered herein below is the least restrictive appropriate alternative for the assessment and stabilization of the above-named person who may be substance abuse impaired.

Whereupon, it is

ORDERED

- ☐ That the above-named person shall be discharged this date from any involuntary status for a mental illness pursuant to Chapter 394, Florida Statutes.
- ☐ That the above-named person shall be admitted for a period not to exceed 5 days to _____ for substance abuse involuntary assessment and, if necessary, stabilization.
- ☐ _____ shall take the above-named person into custody and deliver said person to the licensed service provider specified above, or, if none is specified, to the nearest appropriate licensed service provider for involuntary assessment.
- ☐ The Public Defender is discharged, and _____ is appointed counsel for all matters pursuant to s. 397, F.S.

DONE AND ORDERED in _____ County, Florida, this _____ day of _____, _____.

Printed Name of Circuit Court Judge

Signature of Circuit Court Judge

See s. 394.467(6)(c), Florida Statutes
CF-MH 3114, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

IN THE CIRCUIT COURT, _____ JUDICIAL CIRCUIT,
IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____

Case No.: _____

**ORDER REQUIRING EVALUATION FOR
INVOLUNTARY OUTPATIENT PLACEMENT**

THIS MATTER came to be heard on _____, pursuant to s. 394.467, F.S., on petition for involuntary inpatient placement of the above-named person and the court being advised in the premises, finds as follows:

1. The above-named person does not meet the criteria for involuntary inpatient placement in a mental health treatment or receiving facility.
2. The above-named person is 18 years of age or older, has a mental illness, and has a history of lack of compliance with treatment for mental illness.
3. The above-named person is unlikely to survive safely in the community without supervision; this finding is supported by testimony of _____ as to his/her clinical determination.
4. The above-named person has:
☐ A. At least twice within the preceding 36 months been involuntarily admitted to a receiving or treatment facility as defined in s.394.455, or received mental health services in a forensic or correctional facility, or
☐ B. Engaged in or attempted to engage in one or more acts of serious violent behavior toward self or others within the preceding 36 months.
5. The above-named person is, as a result of mental illness, unlikely to voluntarily participate in recommended treatment and has either refused voluntary placement for recommended treatment after sufficient and conscientious explanation and disclosure of the purpose of placement, or is unable to determine whether placement is necessary.
6. In view of the 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 the person or others, or a substantial harm to the person's well-being through neglect or refusal to care for self as set forth in s. 394.463(1);
7. It is likely that the person will benefit from involuntary outpatient placement. All available less restrictive alternatives that would offer an opportunity for improvement of his or her condition are either inappropriate or unavailable.

Whereupon, IT IS ORDERED

1. That the above-named person be discharged this date from any involuntary inpatient placement and treatment for mental illness.
2. That the above-named person shall be evaluated by _____ located at _____ for involuntary outpatient placement within _____ days of the date of this hearing.

DONE AND ORDERED in Chambers at _____ County, Florida, this ____ day of _____, 20____.

Printed Name of Circuit Court Judge

Signature of Circuit Court Judge

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

**Findings and Recommended Order Restoring Person's Competence
to Consent to Treatment and Discharging the Guardian Advocate**

A hearing was held on _____, to consider the continued involuntary placement of
_____, a person placed at _____
facility. This person was previously found incompetent to consent to treatment and _____
was appointed as guardian advocate.

Testimony and evidence was considered at this hearing regarding the person's competence, including:

On the basis of this evidence, it is recommended that the Court restore this person's competence to consent to treatment and that the guardian advocate previously appointed be discharged.

Signature of Administrative Law Judge Date _____ Time _____ am pm

Typed or Printed Name of Administrative Law Judge

It is hereby ordered, that _____ be restored to competence to consent
to treatment and that _____, guardian advocate be discharged.

ORDERED this _____ day of _____.

Printed Name of Circuit Court Judge

Signature of Circuit Court Judge

This form must be completed, attached to each of the forms listed below and sent by the receiving/treatment facility or service provider within one working day of the person's arrival at the facility/provider or upon the facility/provider's receipt of a court order for involuntary inpatient placement or involuntary outpatient placement to:

Questions about form completion and receipt may be addressed to bareporting@fmhi.usf.edu or by calling 813-974-9665. Additional information about form completion can be found at <http://bakeract.fmhi.usf.edu>.

- ☐ Ex-Parte Order for Involuntary Examination
- ☐ Report of Law Enforcement Officer Initiating Involuntary Examination
- ☐ Certificate of Professional Initiating Involuntary Examination
- ☐ Involuntary Inpatient Placement Order
- ☐ Involuntary Outpatient Placement Order
- ☐ Continued Involuntary Outpatient Placement Order

Gender	Race	Hispanic Origin?	Immediately prior to this exam and/or placement, was the person in:		
<input type="checkbox"/> Female	<input type="checkbox"/> Caucasian/White	<input type="checkbox"/> Yes	Yes	No	Answer for Adults ONLY (18 and over)
<input type="checkbox"/> Male	<input type="checkbox"/> African-American/Black	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	A nursing home?
	<input type="checkbox"/> Asian		<input type="checkbox"/>	<input type="checkbox"/>	An assisted living facility?
	<input type="checkbox"/> Other		<input type="checkbox"/>	<input type="checkbox"/>	Jail (i.e., sent for examination from jail)?
			Yes	No	Answer for Children Only (under 18)
			<input type="checkbox"/>	<input type="checkbox"/>	Department of Juvenile Justice Custody?
			<input type="checkbox"/>	<input type="checkbox"/>	DCF custody (such as shelter or foster care)?
			<input type="checkbox"/>	<input type="checkbox"/>	School?

By Authority of s. 394.463, Florida Statutes
CF-MH 3118, Sept 06 (obsoletes previous editions) (Mandatory Form but name/address/phone number/FMHI number for provider may be preprinted.)

**Notification of a Facility's Non-Compliance
(Pursuant to Chapter 400, F.S.)**

TO: Agency for Health Care Administration
Consumer Assistance Unit
2727 Mahan Drive, Building 3
Tallahassee, FL 32308

FROM: _____
Name of Receiving Facility

Address of Receiving Facility

Please be advised that _____ was received by
Name of Person
_____ on _____. The above-named person
Name of This Receiving Facility Date
was transported from _____ located at _____
Sending Facility Sending Facility's Address
by _____ for one of the following:
Method and Title of Transporter

- ☐ Involuntary examination without the required ex parte order, professional certificate, or report of a law enforcement officer pursuant to s.394.463 (2)(b), F.S. **OR**
- ☐ Voluntary admission without the required assessment of the person's ability to give express and informed consent to treatment pursuant to s.394.4625 (1)(b), F.S.

You may contact me at this telephone number with any questions regarding the above: _____.

Signature of Person Completing this Form Date

Printed Name of Person Completing this Form Title

This notification shall be made by certified mail no later than the first working day after the admission of the person to the receiving facility. A copy shall be placed in the person's clinical record.

See s. 394.463(2)(b) 400.102(1) Florida Statutes
CF-MH 3119, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Certification of Guardian Advocate Training Completion

Guardian Advocate Self-Test (Completion Required as a part of the training, before certification)

1. Briefly, what are the eight recommended steps to prepare for decision-making as a Guardian Advocate? (See Chapter 2 of Manual)
 - a. _____
 - b. _____
 - c. _____
 - d. _____
 - e. _____
 - f. _____
 - g. _____
 - h. _____
2. Briefly, what does “Express and Informed Consent” mean? (See Chapter 4 of Manual) _____

3. Briefly, what role does “Substitute Judgment” play in the Guardian Advocate decision making process? (See Chapter 4 of Manual)

4. List the three types of consent that may be authorized by the court? (See Chapter 1 of Manual)
 - a. _____
 - b. _____
 - c. _____
5. List the types of consent authorized on your order of appointment as a Guardian Advocate. (See the court order appointing you as Guardian Advocate)
 - a. _____
 - b. _____
 - c. _____

Certification

This is to certify that I _____, guardian
Name of guardian advocate
advocate appointed to represent _____ on _____
Name of Person Date of Appointment
by the circuit court completed the training course required by the court on _____.
Date training completed

The completion of training occurred prior to my providing any consent to the person’s treatment.

Printed Name of Guardian Advocate Signature of Guardian Advocate Date

Printed Name of Facility Witness Signature of Facility Witness Date

**Notification to Court of Person's Competence to Consent
to Treatment and Discharge of Guardian Advocate**

_____, a guardian advocate appointed by the court on
Name of guardian advocate

_____ for _____ who was:
Date of appointment Name of person

☐ Court ordered for involuntary inpatient placement located at _____
Name of receiving or treatment facility

OR

☐ Court ordered for involuntary outpatient placement with services provided by: _____
Name of service provider

Has been discharged from his or her duties on _____, 20____ due to the person's regaining competence
to consent to his or her own treatment.

Printed Name of Facility Administrator/Service Provider or Designee

Signature of Facility Administrator/Service Provider or Designee

Date

Certification of Person's Incompetence to Consent to Treatment and Notification of Health Care Surrogate/Proxy

I have personally examined _____, a person at _____
Printed Name of Person Name of Facility

I have determined that the above-named person is incompetent to consent to treatment because his or her judgment is so affected by a mental illness that he/she lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.

A Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate will be filed with the court within the time period required by law. Until the guardian advocate is appointed by the court, a health care surrogate or proxy ☐ will ☐ will not be asked to make treatment decisions for the above-named person.

If a health care surrogate or proxy is to be used, complete the following:

☐ The person has executed an advance directive naming a surrogate to make health care decisions on his or her behalf upon the person's incapacity. (Specify: _____)

☐ The person has not executed an advance directive or designated a surrogate or the surrogate named above is now unable or unwilling to serve, but the following individual, in the following order of priority, (Specify: _____) will be asked to serve as a health care proxy:

- ☐ Judicially appointed guardian authorized to consent to medical treatment;
- ☐ Person's spouse;
- ☐ Adult child of the person;
- ☐ Parent of the person;
- ☐ Adult relative of the person who has exhibited special care and concern for the person; or
- ☐ Close friend of the person who has exhibited special care and concern for the person, who has presented an affidavit to the facility that he or she is willing to assume the proxy role and has maintained such regular contact with the person so as to be familiar with the person's activities, health, and religious or moral beliefs.
- ☐ Licensed clinical social worker selected by the provider's bioethics committee or through an arrangement with the bioethics committee of another provider and not employed by the provider. Documentation of efforts to locate proxies from prior classes must be recorded in the person's record.

Signature of Physician

License Number

Typed or Printed Name of Physician

Date of Exam

____ am pm
Time of Exam

CONTINUED OVER

Notification to Health Care Surrogate or Proxy (Page 2)

You, _____, have been designated as the Health Care Surrogate or Proxy for _____, a person being served in _____ facility. Until the court considers the facility's Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate for the above-named person, you have been named as the person authorized to make treatment decisions for the person. Prior to making any treatment decisions for the person, you will:

1. Be provided the same information required by statute to be provided to a guardian advocate; and
2. Meet and talk with the person and person's physician in person if at all possible, by telephone if not.

As a health care surrogate or proxy, you have the authority to provide informed consent only for health care decisions for the person which you believe the person would have made under the circumstances if he or she were capable of making such decisions. You may access appropriate clinical records, apply for public benefits, and authorize the release of information and clinical records to appropriate persons to ensure the continuity of the person's health care, and may authorize the transfer of the person to or from a health care facility. You do not have the authority to consent to abortion, sterilization, electroshock therapy, psychosurgery, experimental treatments, and can not have the person admitted to a psychiatric facility on a voluntary basis or provide consent to treatment for a person on voluntary status.

Printed Name of the Administrator or Designee

Signature of Administrator or Designee

Date

This form shall be provided to the health care surrogate or proxy, with a copy provided to the person and representative. A copy shall be retained in the person's clinical record.

Affidavit of Health Care Proxy

I, _____, am willing to serve as a health care proxy for
_____. I certify that I am one of the following:

- ☐ Judicially appointed guardian authorized to consent to medical treatment (Appointed by the _____ Court on the following date _____. A copy of the court order and letters of guardianship have been provided to the facility).
- ☐ Person's spouse;
- ☐ Adult child of the person;
- ☐ Parent of the person;
- ☐ Adult relative of the person who has exhibited special care and concern for the person (Specify the degree of relationship _____)
- ☐ Close friend of the person who has exhibited special care and concern for the person, who has presented an affidavit to the facility that he or she is willing to assume the proxy role and has maintained such regular contact with the person so as to be familiar with the person's activities, health, and religious or moral beliefs.
- ☐ Licensed clinical social worker selected by the provider's bioethics committee or through an arrangement with the bioethics committee of another provider and not employed by the provider. Documentation of efforts to locate proxies from prior classes must be recorded in the person's record.

To my knowledge, the person has not executed an advance directive designating another person as his or her health care surrogate, or if one was previously designated, the surrogate named by the person is not able or willing at this time to serve as the health care surrogate. If a previously designated health care surrogate is unable or unwilling to serve, please describe the circumstances: _____

Signature of Health Care Proxy

Date

Printed Name of Health Care Proxy

Signature of Witness:

Personal Safety Plan

☐ You can document on this form suggested calming strategies IN ADVANCE of a crisis. You can list things that are helpful when you are under stress or are upset. You can also identify things that make you angry. Staff and individuals receiving services can enter into a “*partnership of safety*” using this form as a guide to assist in your treatment plan. The information is intended only to be helpful; it will not be used for any purpose other than to help staff understand how to best work with you to maintain your safety or to collect data to establish trends. This is a tool that you can add to at any time. Information should always be available from staff members for updates or discussion. Please feel free to ask questions.

1. Calming Strategies:

It is helpful for us to be aware of things that help you feel better when you’re having a hard time. Please indicate (5) activities that have worked for you, or that you believe would be the most helpful. If there are other things that work well for you that we didn’t list, please add them in the box marked “Other”. We may not be able to offer all of these alternatives, but we would like to work together with you to determine how we can best help you while you’re here.

<input type="checkbox"/> Listen to music	<input type="checkbox"/> Exercise
<input type="checkbox"/> Read a book	<input type="checkbox"/> Pace in the halls
<input type="checkbox"/> Wrapping in a blanket	<input type="checkbox"/> Have a hug with my consent
<input type="checkbox"/> Write in a journal	<input type="checkbox"/> Drink a beverage
<input type="checkbox"/> Watch TV	<input type="checkbox"/> Dark room (dimmed lights)
<input type="checkbox"/> Talk to staff	<input type="checkbox"/> Medication
<input type="checkbox"/> Talk with peers on the unit	<input type="checkbox"/> Read religious or spiritual material
<input type="checkbox"/> Call a friend or family member	<input type="checkbox"/> Write a letter
<input type="checkbox"/> Voluntary time in the quiet room/comfort room	<input type="checkbox"/> Hug a stuffed animal
<input type="checkbox"/> Take a shower	<input type="checkbox"/> Do artwork (painting, drawing)
<input type="checkbox"/> Go for a walk with staff	<input type="checkbox"/> Other? (Please list below)

2. What are some of the things that make you angry, very upset or cause you to go into crisis? What are your “triggers”?

<input type="checkbox"/> Being touched	<input type="checkbox"/> Called names or made fun of
<input type="checkbox"/> Security in uniform	<input type="checkbox"/> Being forced to do something
<input type="checkbox"/> Yelling	<input type="checkbox"/> Physical force
<input type="checkbox"/> Loud Noise	<input type="checkbox"/> Being isolated
<input type="checkbox"/> Contact with person who is upsetting	<input type="checkbox"/> Some else lying about my behavior
<input type="checkbox"/> Being restrained	<input type="checkbox"/> Being threatened

3. Signals of Distress:

Please describe your warning signals, for example, what you know about yourself, and what other people may notice when you begin to lose control. Check those things that most describe you when you’re getting upset. This information will be helpful so that together we can create new ways of coping with anger and stress:

<input type="checkbox"/> Sweating	<input type="checkbox"/> Clenching teeth
<input type="checkbox"/> Crying	<input type="checkbox"/> Not taking care of self
<input type="checkbox"/> Breathing hard	<input type="checkbox"/> Running
<input type="checkbox"/> Yelling	<input type="checkbox"/> Clenching fists
<input type="checkbox"/> Hurting others:	<input type="checkbox"/> Swearing
<input type="checkbox"/> Throwing Objects	<input type="checkbox"/> Not eating
<input type="checkbox"/> Pacing	<input type="checkbox"/> Being rude
<input type="checkbox"/> Injuring self: (Please be specific)	<input type="checkbox"/> Other? (Please list below)

CONTINUED OVER

Personal Safety Plan (page 2)

4. Preferences Regarding Gender and Others:

Do you have any preferences or concerns regarding who serves you when you are upset or angry?

Women staff _____ Men staff _____ No preference _____ Language _____

Ethnicity _____ Culture _____ Of a particular religion _____

5. Preferences Regarding Physical Contact:

We would like to know about your preferences regarding physical contact. For example, you may not like to be touched at all or you may find it helpful to have a hug or be touched *appropriately* when you are upset.

Do you find it helpful to be hugged or touched appropriately when you are upset?

Yes ___ No ___ Comments: _____

6. Seclusion and Restraint:

This facility is trying to eliminate the use of seclusion and restraints, therefore, it would be helpful to know if you have ever been placed in a seclusion room or been restrained. This information will be used only for collecting data and for training purposes, not to predict any future behaviors.

Have you ever been placed in a seclusion room? Yes ___ No ___

Have you ever been restrained? Yes ___ No ___

7. In Extreme Emergencies:

In **extreme** emergencies seclusion and restraint may be used as a last resort. Is there anything you find helpful in emergency situations that could prevent them from being used?

Alternative physical spaces such as:

Comfort Room _____

Quiet Room _____

Other such as exercise _____

Medication by mouth _____

Emergency injection _____

Other: _____

8. Medical Conditions:

Do you have any physical conditions, disabilities, or medical problems such as asthma, high blood pressure, back problems, etc., that we should be aware of when caring for you during an emergency situation?

9. Helpful Medications:

We may be required to give medications if other measures do not help you to calm down. In this case, we would like to know what medications have been especially helpful to you? Please describe. _____

10. Not Helpful Medications:

Are there any medications that are not helpful? What and why? _____

CONTINUED

Personal Safety Plan (page 3)

11. Room Checks:

Room checks are done at night to make sure you are okay. In order to make room checks as non-intrusive as possible is there anything that would make room checks more comfortable for you? _____

12. Trauma History:

Do you have any issues regarding abuse such as sexual or physical abuse that you would like to talk about with staff, or with counselor? Yes___ No___

Would you like more information on these issues in classes or support groups? Yes____ No____

13. Anything Else?

Is there anything else that would make your stay easier and more comfortable? For example do you have any special issues like cultural, diet, sexual preference, appearance, etc. that you think could contribute to misunderstandings or cause problems for you? Please describe:

[illegible]

The Personal Safety Form Information should be presented to the treatment team and incorporated into the treatment plan for this individual. Each individual shall receive a copy. This form has been adapted from an original form created by the Massachusetts Department of Mental Health

Application for Designation as a Receiving Facility

Name of Applicant Facility: _____

Street Address: _____

City: _____, FL Zip Code: _____ - _____

Telephone Number: (____) _____

Administrator: _____

Provide complete responses to the following questions and issues, attaching additional sheets where necessary.

1. Designation requested for:

- ☐ All populations
- ☐ Adults Only – Approved Transportation Exception Plan attached
- ☐ Minors Only – Approved Transportation Exception Plan attached

2. The following are the street addresses for each location at which persons will be received or treated for involuntary examination. Each will operate 24 hours / 7 day a week emergency services and psychiatric licensed beds.

Name of Facility	Street Address	City	Zip Code

3. Psychiatric services, including any distinct programs to be provided to each of the following consumer groups, and the projected numbers of persons to be served in each group are as follows:

	Psychiatric Services	Distinct Programs	Projected Number
Minors below 10 years of age			
Minors between the ages of 10 to 17 years			
Adults			
Persons 60 or more years of age			
Other specialty groups			

CONTINUED OVER

Application For Designation as a Receiving Facility (Page 2)

4. The community need for maintaining or expanding the present level of service to meet the existing need, and why this applicant is best suited for this purpose. Included is information about the public's need for specialty services to specific age or disability groups. Evidence of such need may include certificate of need data and other information published by the Agency for Health Care Administration, the organization's or community's utilization of available or licensed psychiatric bed capacity, geographic accessibility information, input from local governmental agencies. (Attach response on separate sheet(s).)
5. The facility's compliance program, including key facility protocols which will be used to assure all involved practitioners and staff are knowledgeable of, and implement legal rights of persons served by the facilities and providers, key psychiatric care, records standards, complaint reporting, and investigation and reviews, to maintain a consistently high level of compliance with applicable Baker Act laws, ethical principles, and rights protections are as follows: (Attach response on separate sheet(s).)
6. The facility's complaint and grievance system, including any mandatory time frames is as follows. Attach pamphlet used by the facility to educate persons served by the facility and family members about this system. (Attach response on separate sheet(s).)
7. Protocols to prevent the organization, its staff, its contractors, and its privileged professionals from economic exploitation of, trafficking persons among facilities for economic purposes or similar activities prohibited by s. 817.505, F.S., and related statutes are as follows: (Attach response on separate sheet(s).)
8. Frequent, if not daily opportunity for persons to receive exercise, fresh air and sunshine, except as individually restricted and documented in the person's record and within the physical limitations of the facility are assured by the following: (Attach response on separate sheet(s).)
9. The means utilized to create a low stimulation or separate psychiatric emergency reception and triage area that minimizes individual's exposure to undue and exacerbating environmental stresses while awaiting or receiving services is as follows (general hospitals only): (Attach response on separate sheet(s).)
10. Continuing aftercare or post discharge psychiatric care services provided at the receiving facility other than referral or transfer are as follows: (Attach response on separate sheet(s).)
11. The facility's discharge planning policies provide for continuity of medication availability until post-discharge follow-up services are scheduled are as follows. (Attach response on separate sheet(s).)

CONTINUED

Application For Designation as a Receiving Facility (Page 3)

Certifications:

Submission of this application constitutes authorization by the applicant and release for the Department of Children and Families, to make inquiries and obtain information about the conduct of the applicant, its key employees and contractors, and its psychiatric services management company, to verify the representations and information provided in this application. Application for designation as a receiving facility is agreement to abide by all statutes and rules governing the Baker Act and related laws.

I certify that the above information and information on the attachments is correct:

Signed for the Facility _____ Date _____

Typed Name: _____ Title: _____

Attachments:

1. A copy of the facility's license issued pursuant to chapter 394 or 395, F.S., evidencing its eligibility to apply for designation.
2. A copy of the most recent state monitoring or licensing survey report.
3. Copy of the most recent survey report of the organization by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) or, if not JCAHO accredited, by another national accrediting body.
4. A current Certificate of Good Standing for the applicant organization issued by the Florida Secretary of State.
5. Documentation of the applicant's governing authority, authorizing the application for designation.

By Authority of s. 394.461, Florida Statutes
CF-MH 3125, Feb 05 (obsoletes previous editions) (Mandatory Form)

BAKER ACT

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

Petition for Involuntary Outpatient Placement

COMES NOW the Petitioner, _____, and alleges:

1. That Petitioner is Administrator of: _____
Name of Receiving or Treatment Facility Facility Address
2. That _____, is served in said receiving or treatment facility and has been examined at such facility
3. The person's social security number is _____ and date of birth is: _____
4. That this petition is being filed within the following time frames: (Check one below)
 - ☐ A. This person was admitted for involuntary examination and this petition is being filed within the 72-hour examination period, or if the examination period ends on a weekend or legal holiday, on the next court working day **OR**
 - ☐ B. This person was transferred to involuntary status after examination or after refusing/revoking consent to treatment or requesting discharge from the facility and this petition is filed within two court working days.
 - ☐ C. This person is currently on an order for involuntary inpatient placement, and this petition is being filed before the expiration of that order
 - ☐ D. A petition for involuntary inpatient placement has been filed and a hearing is pending.
5. That attached hereto and by reference made a part hereof, are two (2) opinions and supporting facts regarding the mental health of said person necessitating involuntary outpatient placement.
6. In addition to at least one of the two experts whose opinions are attached, the following persons may testify in support of the petition for involuntary outpatient placement:

	Guardian or Representative	Other Witness	Other Witness
Name:	_____	_____	_____
Relationship	_____	_____	_____
Address	_____	_____	_____
	_____	_____	_____
Telephone:	(____) _____	(____) _____	(____) _____

Petition for Involuntary Outpatient Placement (Page 2)

COMES NOW THE PETITIONER and further alleges that:

- ☐ 1. A Guardian Advocate is necessary to act on the person's behalf on issues related to express and informed consent to:
- ☐ Mental health treatment only, or
 - ☐ Both mental health and medical treatment decisions

And a Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate is attached;

OR

- ☐ 2. The person/respondent is competent to provide express and informed consent to his or her own treatment or the person has a guardian authorized to consent to treatment and no Guardian Advocate is requested.

Signature of Facility Administrator or Designee

Date

Time

am pm

Typed or Printed Name of Administrator or Designee

Person ☐ does or ☐ does not have a private attorney. If so, the name and address of the private attorney is:

Private Attorney Name: _____

Private Attorney Address: _____

cc: The Clerk of the Court shall provide a copy of this petition to the: (Check when applicable and initial/date/time when copy provided)

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Public Defender		am pm	
<input type="checkbox"/> Representative		am pm	
<input type="checkbox"/> State Attorney		am pm	
<input type="checkbox"/> Dept. of Children & Families		am pm	

CONTINUED / SUPPORTING OPINIONS ON PAGE 3

Petition for Involuntary Outpatient Placement (Page 3)
First Opinion Supporting the Petition

I, _____ a psychiatrist authorized to practice in the State of Florida, have personally examined _____ on _____ (within 72 hours of the signing hereof) and find from such
Name of Person Date
examination that the person meets each of the following criteria for involuntary outpatient placement. Each of the following required
criterion must be alleged and substantiated by evidence in this petition.

1. The person is 18 years of age or older, corroborated by: _____
1. The person has a mental illness, as substantiated by the following evidence: _____

2. The person is unlikely to survive safely in the community without supervision, based on a clinical determination, as substantiated by the following evidence: _____

4. The person has a history of lack of compliance with treatment for a mental illness, as substantiated by the following evidence: _____

5. The person has:
 - a. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving or treatment facility as defined in s. 394.455, or has received mental health services in a forensic or correctional facility. The 36-month period does not include any period during which the person was admitted or incarcerated, as substantiated by the following evidence: _____

 - or**
 - b. Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others, within the preceding 36 months, as substantiated by the following evidence : _____

6. The person is, as a result of a mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary, as substantiated by the following evidence: _____

7. In view of the 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 himself or herself or others, or a substantial harm to his or her well-being as set forth in the criteria for involuntary examination, as substantiated by the following evidence: _____

8. It is likely that the person will benefit from involuntary outpatient placement, as substantiated by the following evidence; _____

AND

9. All available less restrictive treatment alternatives than court-ordered involuntary outpatient placement which would offer an opportunity for improvement of said person's condition have been judged to be inappropriate, based on contact with the following programs/agencies: _____

Signature of Psychiatrist

Date

Time _____ am pm

Typed or Printed Name of Psychiatrist

License Number

CONTINUED OVER
Baker Act Forms - 123

Second Opinion Supporting the Petition (page 4)

I, _____, a ☐ psychiatrist, ☐ clinical psychologist, ☐ licensed physician *,
☐ psychiatric nurse *, authorized to provide a second opinion on this petition pursuant to Section 394.467 (2), F.S., have personally examined
 _____ on _____, (within 72 hours of signing hereof), and find

 Name of Person Date

that he/she meets the criteria for involuntary outpatient placement as stated in this petition. Observations and supporting evidence which support this opinion are: _____

[illegible]

Signature of Examiner _____ Date _____ Time _____ am pm

Typed or Printed Name of Examiner	Profession	License Number
-----------------------------------	------------	----------------

*I certify that the county in which the person is detained has less than 50,000 population and no psychiatrist or psychologist is available to provide the second opinion.

Printed Name and Signature of Administrator or Designee _____ Date _____

*** A licensed physician or psychiatric nurse may only provide such second opinion in counties of less than 50,000 population in cases where the facility administrator certifies that no psychiatrist or clinical psychologist is available to provide the second opinion (by countersigning above).**

See s. 394.4599(2)(c)3, 394.467, Florida Statutes
CF-MH 3130, Feb 05 (Recommended Form)

BAKER ACT

Designation of Service Provider for Involuntary Outpatient Placement

Pursuant to chapter 394.4655, Florida Statutes, a petition for Involuntary Outpatient Placement has been filed to require _____ to comply with a treatment plan approved by the court.

The following service provider has been identified by:

☐ _____, a representative of the Department of Children and Families, or

☐ _____, a representative of a designated receiving facility

Name of Assigned Service Provider:	
Address of Provider:	
Phone Number of Provider:	

The service provider will have primary responsibility for service provision under an order for involuntary outpatient placement. The service provider will prepare a written proposed treatment plan, in consultation with the person or the person's guardian, guardian advocate, or health care surrogate/proxy, if appointed, to be attached to the petition for involuntary outpatient placement for the court's consideration for inclusion in the involuntary outpatient placement order. The Baker Act requires that each person shall have an opportunity to assist in preparing and reviewing such a plan prior to its implementation and that the plan shall include a space for the person's comments.

For purpose of determining whether a person meets the criteria for involuntary outpatient placement or for preparing the proposed treatment plan, the clinical record may be released to the state attorney, the person's attorney, and to the appropriate mental health professionals, including the proposed service provider, in accordance with federal and state law.

The treatment plan must specify the nature and extent of the person's mental illness. The treatment plan must also address the reduction of symptoms that necessitate involuntary outpatient placement and include measurable goals and objectives for the services and treatment that will be provided to treat the person's mental illness and to assist the person in living and functioning in the community or to attempt to prevent a relapse or deterioration.

Service providers may select and provide supervision to other individuals to implement specific aspects of the treatment plan. The services in the treatment plan must be deemed to be clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker, as defined in s. 394.455, Florida Statutes, who consults with, or is employed or contracted by, the service provider.

The service provider must certify to the court in the proposed treatment plan whether sufficient services for improvement and stabilization are currently available in the local community, whether there is space available to serve this person, that funding is available to finance the care, and whether the service provider agrees to provide those services. If the service provider certifies that the services or funding required by the proposed treatment plan are not available, the petitioner may not file the petition.

A petition for Involuntary Outpatient Placement will be filed with the circuit court no later than _____. A copy of the proposed treatment plan developed by the assigned service provider, in consultation with the person, must be attached, including a certification by the service provider that the proposed services and funding are available to support the proposed treatment/service plan. The service provider shall also provide a copy of the of the proposed treatment plan to the person and the administrator of the receiving facility.

The service provider identified above shall prepare a treatment plan, consistent with the above requirements, no later than _____ to be attached to the petition for involuntary outpatient placement, unless the service provider cannot certify the availability of funded services to meet the person's needs.

Signature of ☐ DCF ☐ Receiving Facility representative

_____ Date

Printed Name of Representative

Address and Telephone Number of Representative

See s. 394.4655(2)(a), Florida Statutes
CF-MH 3140, Sept 06 (obsoletes previous edition) (Recommended Form)

**Proposed Individualized Treatment Plan for
Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement**

Pursuant to chapter 394.4655, Florida Statutes, a petition for Involuntary Outpatient Placement has been filed to require _____ to comply with a treatment plan approved by the court.

The following proposed treatment plan has been developed in consultation with the above named person (or his/her legally authorized substitute decision-maker, if appointed) for the court's consideration by the following service provider designated by ☐ the Department of Children and Families or ☐ a designated receiving facility.

Name of Assigned Service Provider: _____
Name & Credentials of Person Developing the Treatment Plan: _____
Address: _____
Phone Number: _____

The nature and extent of the person's mental illness is as follows:

The following specific services are proposed in this treatment plan, including the specific service to be provided, the organization to provide each service, the licensure or other credentials of the organization or professional to provide each service, and the frequency and duration of each service:

1. Services that will reduce symptoms that necessitate involuntary outpatient placement, including measurable goals and objectives for the services and treatment that will be provided to treat the person's mental illness:

2. Services that will reduce symptoms, including measurable goals and objectives for the services and treatment, that are provided to assist the person in living and functioning in the community.

3. Services that will reduce symptoms, including measurable goals and objectives, for the services and treatment that are provided to attempt to prevent a relapse or deterioration:

Service providers may select and provide supervision to other individuals to implement specific aspects of the treatment plan. Other individuals than those employed by the above named service provider, and their credentials, who are expected to assist in providing the services described in this proposed treatment plan are:

CONTINUED OVER

**Proposed Individualized Treatment Plan for
Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement (page 2)**

I am a ☐physician, ☐clinical psychologist, ☐psychiatric nurse, ☐mental health counselor, ☐marriage and family therapist, or ☐clinical social worker, as defined in s. 394.455, F.S. I consult with, or am employed or contracted by, the service provider and I have determined that the services, personnel, and organizations described in this proposed treatment plan are clinically appropriate.

Signature of Clinical Professional

Printed Name of Clinical Professional

Date

The service provider certifies to the court that all services described in the proposed treatment plan for person's improvement and stabilization are:

☐ Currently available in the local community

☐ There is space available to serve this person

☐ Funding is available to finance the care, and

☐ The service provider agrees to provide those services.

The nature and extent of the person's involvement in the preparation of this proposed treatment plan is as follows:

Comments about the proposed treatment plan by the person are as follows:

Signature of Preparer of Plan

Printed Name of Preparer of Plan

Date

The service provider shall also provide a copy of the proposed treatment plan to the person and the administrator of the receiving facility. For persons in state treatment facilities who are ordered to involuntary outpatient treatment, a copy of the state mental health discharge form must be sent by the treatment facility to a department representative in the county where the person will be residing, which is the county where the petition must be filed.

See s. 394.467(6)(c), Florida Statutes
CF-MH 3145, Sept 06 (obsoletes previous edition) (Recommended Form)

BAKER ACT

**Notice to Department of Children and Families of
Non-Filing of Petition for Involuntary Outpatient Placement Or Diminished Treatment Plan
Due to Non-Availability of Services or Funding**

I have evaluated _____ Social Security # _____ a person referred for:

- ☐ Involuntary Outpatient Placement
☐ Continued Involuntary Outpatient Placement

I have found that services needed by the person are:

- ☐ Unavailable in the community
☐ Unavailable due to waitlists
☐ Unfunded

As a result of this finding,

- ☐ No petition for involuntary outpatient placement or continued involuntary outplacement was filed or
☐ A petition for involuntary outpatient or continued involuntary outplacement was filed but omitted services that were unavailable or unfunded.

Please check which of the following services are needed by the person but are unavailable for any of the above reasons:

- | | |
|--|--|
| <input type="checkbox"/> Residential Treatment | <input type="checkbox"/> Vocational Program |
| <input type="checkbox"/> Psychotropic Medications | <input type="checkbox"/> Drop-In Center |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Peer Support Services |
| <input type="checkbox"/> Club House | <input type="checkbox"/> Others as specified below |
| <input type="checkbox"/> FACT or Intensive Case Management | |

The nature of the service unavailability or lack of funding is described as follows:

Signature of Service Provider Representative

Printed Name of Representative Date

Name of Service Provider

Address of Service Provider

Telephone

See s. 394.4655(2)(a)3, Florida Statutes
CF-MH 3150, Feb 05 (Recommended Form)

BAKER ACT

IN RE: _____,

Case No.: _____

**ORDER FOR INVOLUNTARY OUTPATIENT PLACEMENT
OR CONTINUED INVOLUNTARY OUTPATIENT PLACEMENT**

This matter came to be heard pursuant to s.394.4655, F.S., and on ☐ Petition for Involuntary Outpatient Placement or, ☐ Petition for Continued Involuntary Outpatient Placement, and the Court being fully advised in the premises, finds by clear and convincing evidence as follows:

1. The above-named person has been represented by counsel; said person ☐ appeared at the hearing, or ☐ presence at the hearing was waived, without objection of said person's counsel.
2. The above-named person meets the following criteria for involuntary outpatient placement pursuant to s.394.4655(1), F.S.: the person is 18 years of age or older; has a mental illness; is unlikely to survive safely in the community without supervision, based on a clinical determination; and, has a history of lack of compliance with treatment for a mental illness.
3. The above-named person has: (not applicable to **continued** involuntary outpatient placement)
☐ A. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving or treatment facility as defined in s.394.455, or has received mental health services in a forensic or correctional facility; **or**
☐ B. 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.
4. The above-named person is, as result of mental illness, unlikely to voluntarily participate in the recommended treatment plan and has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment, or is unable to determine whether placement is necessary.
5. The above-named person's treatment history and current behavior mandates the conclusion that 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 the person or others, or a substantial harm to his or her well-being through neglect or refusal to care for self as set forth in s.394.463 (1), F.S..
6. It is likely that the above-named person will benefit from involuntary outpatient placement. All available less restrictive treatment alternatives which would offer an opportunity for improvement of said person's condition are inappropriate.
7. The treatment plan which is attached hereto specifies the nature and extent of the above-named person's mental illness and specifies the outpatient treatment to be provided. The treatment plan contains a certification to the court that sufficient services for improvement and stabilization are currently available, funded, and that the service provider agrees to provide those services.
8. The services described in the treatment plan are clinically appropriate. This finding is supported by evidence presented, including the testimony of _____.
9. The Court considered testimony and evidence regarding the above-named person's competence to consent to treatment. The person is found to be ☐ competent, ☐ incompetent to consent to treatment. If found to be incompetent, a guardian advocate is appointed by separate order.
10. If the petition was referred to and heard by a Magistrate, the Magistrate's Report and Recommendation are attached, incorporated by reference, and adopted by the Court.

Whereupon, IT IS ORDERED that the above-named person be treated as an outpatient in accordance with the treatment plan attached hereto, for a period ☐ not to exceed 6 months from the date of this order, or ☐ _____, or until discharged by the administrator or transferred to voluntary status.

DONE AND ORDERED in _____ County, Florida, this _____ day of _____, 20____.

Printed Name of Circuit Court Judge

Signature of Circuit Court Judge

See s. 394.4655(6)(c), Florida Statutes
CF-MH 3155, Feb 05 (Recommended Form)

BAKER ACT

IN RE: _____ CASE NO.: _____

**Notice to Court of Modification to Treatment Plan for
Involuntary Outpatient Placement and/or
Petition Requesting Approval of Material Modifications to Plan**

This court issued an order on _____ requiring :

☐ involuntary outpatient placement **OR** ☐ continued involuntary outpatient placement for the above-named person.

Material modifications to the treatment plan previously approved by the Court

☐ For which the person or the person's guardian or guardian advocate, if appointed AGREE have been made.

☐ For which the person or the person's guardian or guardian advocate, if appointed DO NOT AGREE are being proposed for the court's consideration.

☐ A hearing is requested to review the proposed changes for which the person or the person's guardian or guardian advocate, if appointed, do not agree and the reasons for the objections to the proposed changes.

The changes or proposed changes to the currently approved treatment plan, including why the modifications are necessary and appropriate, are as follows: _____

Any objections to the changes or proposed changes to the currently approved treatment plan by the person or the person's guardian or guardian advocate, if appointed, are as follows: _____

If this petition is filed by the service provider, a copy of the complete treatment plan, including proposed changes, is attached to this filing.

Signature of Petitioner _____ Printed Name of Petitioner _____ Date _____
☐ Person ☐ Guardian ☐ Guardian Advocate ☐ Service Provider ☐ Attorney for Person

Printed Name of Petitioner _____ Printed Address and Telephone Number of Petitioner _____

ORDERED

That the proposed changes to the currently approved treatment plan are:

☐ Approved
☐ Disapproved

DONE AND ORDERED in _____ County, Florida, this _____ date of _____, 20____

Signature of Circuit Court Judge _____ Printed Name of Circuit Court Judge _____

IN RE: _____ CASE NO.: _____

Page 140

Baker Act Forms

Petition for Termination of Involuntary Outpatient Placement Order

COMES NOW the petitioner, _____ alleging that _____
No longer meets one or more of the following criteria for involuntary outpatient placement:

- ☐ The person is 18 years of age or older;
- ☐ The person has a mental illness;
- ☐ The person is unlikely to survive safely in the community without supervision, based on a clinical determination;
- ☐ The person has a history of lack of compliance with treatment for a mental illness;

The person has:

- ☐ 1. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving or treatment facility as defined in s. 394.455, or has received mental health services in a forensic or correctional facility. The 36-month period does not include any period during which the person was admitted or incarcerated; **or**
- ☐ 2. Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others, within the preceding 36 months;
- ☐ The person is, as a result of a mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary;
- ☐ In view of the 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 himself or herself or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1);
- ☐ It is likely that the person will benefit from involuntary outpatient placement; and
- ☐ All available less restrictive treatment alternatives which would offer an opportunity for improvement of said person's condition have been judged to be inappropriate based on contact with the following programs/agencies:

For each criteria checked above that the petition alleges is not currently met, substantiating evidence is provided as follows:

Wherefore, it is requested that the Court issue an order terminating its order issued on _____
requiring involuntary outpatient placement.

Signature of Petitioner

Date

Time am pm

☐ Person ☐ Guardian ☐ Guardian Advocate ☐ Service Provider ☐ Attorney for Person

Printed or Typed Name of Petitioner

Address of Petitioner

IN RE: _____ CASE NO.: _____

**Petition Requesting Authorization for
Continued Involuntary Outpatient Placement**

COMES NOW the Petitioner, _____ and alleges:

1. That Petitioner is Administrator of: _____
Name of Service Provider Address
2. That (Name of Person): _____ has been served by said service provider under an order for Involuntary Outpatient Placement entered by this Court on _____,
3. That according to the provisions of s.394.4655(7), F.S. this person may not be involuntarily placed after _____ (Date) without an order authorizing continued involuntary outpatient placement
4. That this petition is being filed within the allowed time frame
5. That the person continues to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1), F.S., as follows:
 - a.. The person is 18 years of age or older;
 - b. The person has a mental illness
 - c. The person is unlikely to survive safely in the community without supervision, based on a clinical determination, as substantiated by the following evidence: _____

 - d. The person has a history of lack of compliance with treatment for a mental illness.
 - e. The person is, as a result of a mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary, as substantiated by the following evidence: _____

Continued (Over)

f. In view of the 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 himself or herself or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1), as substantiated by the following evidence:

g. It is likely that the person will benefit from involuntary outpatient placement, as substantiated by the following evidence;

AND

h. All available less restrictive treatment alternatives than court-ordered involuntary outpatient placement which would offer an opportunity for improvement of said person's condition have been judged to be inappropriate, based on contact with the following programs/agencies:

Signature of Physician or Clinical Psychologist

Date

Time

am

pm

Typed or Printed Name of Physician or Clinical Psychologist

License Number

A description of the person’s treatment during the time he or she was involuntarily placed on an outpatient basis is attached to this petition, as is a proposed individualized plan of continued treatment, that has been developed in consultation with the person or the person’s guardian or guardian advocate, if appointed.

Wherefore, it is requested that an Order be issued authorizing this service provider to continue to treat this person on an involuntary outpatient basis until _____ or for a period not to exceed six (6) months.

Signature of Administrator or Designee

Date

Time

am

pm

Printed or Typed Name of Administrator or Designee

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

**Notice to Court of Waiver of Continued Involuntary Outpatient Placement Hearing
And Request for an Order**

_____, a person being treated under an Order for Involuntary Outpatient Placement by
_____ (service provider) and who has been found by the court to be competent to
consent to make decisions about his or her treatment, has agreed to a period of continued involuntary outpatient placement
without a court hearing.

As counsel for this person, I agree to this waiver of hearing and request the issuance of an order for continued involuntary
outpatient placement for a period of _____ (up to six months)

Signature of Person Agreeing to Waiver of Hearing

Date of Person's Signature

Signature of Counsel

Printed Name of Counsel

Date

cc: ☐ Person ☐ Service Provider ☐ State Attorney ☐ Guardian ☐ Guardian Advocate ☐ Representative

See s. 394.4655(7)(d), Florida Statutes
CF-MH 3185, Feb 05 (Recommended Form)

BAKER ACT

Florida Department of Children & Families
State Mental Health Facility Admission Form
(Submit Prior to Pre-Admission Meeting)

A. Client Identifying Information

1. Name _____
Last Maiden First M.I.
2. Discharge Address _____
3. County of Residence/Referral _____ / _____ 4. Last Living Environment _____
5. Date of Birth ____ / ____ / ____ 6. SSN _____ - _____ - _____
7. Age _____ yrs. 8. Sex ☐ M ☐ F 9. Race _____ 10. Religion _____
11. Birthplace _____ 12. USA Citizen? ☐ Yes ☐ No 13. Language _____
14. Immigration Status _____ 15. Country _____
16. Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated

B. Client Status Information

17. Legal Status (check one) ☐ Voluntary ☐ Involuntary
18. Competency Status (check one) ☐ Competent ☐ Incompetent ☐ Not Guilty by Reason by Insanity ☐ Incompetent to Proceed
19. Date Competency Hearing Held ____ / ____ / ____ 20. Hearing Site _____
21. Has legal guardian been appointed? ☐ YES ☐ NO (If yes, complete following)
Legal Guardian for ☐ client only ☐ client's property only ☐ both client and property
- Guardian's Name _____ Phone # (____) _____
- Guardian's Mailing Address _____
- Guardian Advocate's Name _____ Phone # (____) _____
- Guardian Advocate's Mailing Address _____
22. Name of Designated Representative (if any) _____ Phone # (____) _____
23. Should anyone else be contacted in an emergency? ☐ YES ☐ NO If yes, relationship to client _____
- Name _____ Phone # (____) _____
- Mailing Address _____
24. If Charges Pending Specify _____
- Criminal Statute Number _____ Name of Court _____ Case Number _____
- Judge's Name _____ Probation Officer: _____
- Probation Officer Mailing Address _____
- Probation Officer Phone # (____) _____

CONTINUED OVER

State Mental Health Facility Admission Form (Page 2)

C. Transferring or Screening Agency Identifying Information

25. Name of Agency _____
26. Agency Contact (Continuity of Care Case Manager) _____ Phone # (____) _____
27. Mailing Address _____
28. Date Case Manager Notified (mm/dd/yyyy) ____/____/____

D. Client Medical Information / History

29. Current Diagnoses (Current edition of DSM and ICD for Axis III): _____

Treating Psychiatrist: _____ Treating Physician: _____

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

(Indicate most recent GAF score & Date Given (mm/dd/yyyy) _____)

Attached Documents (Assessments, Evaluations, etc.)

Documents	Provided by Case Manager	If No or N/A Indicate Rationale	Provided by Receiving Facility	If No or N/A Indicate Rationale
30. Mental Status and Psychiatric Evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
31. Psychiatrist's Notes (Up to 90 days)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
32. Diagnostic Summary/ Clinical Impressions & Recommendations	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
33. Significant Lab and Diagnostic Reports	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
34. Psychological Evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
35. Psychosocial History (Comprehensive if available)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
36. Substance Abuse Developmental Disability Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

CONTINUED

State Mental Health Facility Admission Form (Page 3)

D. Client Medical Information / History (continued)

Attached Documents (Assessments, Evaluations, etc.) continued

Documents	Provided by Case Manager	If No or N/A Indicate Rationale	Provided by Receiving Facility	If No or N/A Indicate Rationale
37. Physical Exam and Medical History	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
38. Medication History including current prescribed medications	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
39. Appropriate Legal Documents including Court Order, Police Report and Petition for Involuntary Placement, Form 3089, 3052a, 3052b, and ex-parte order when applicable	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
40. Client Service Plan and/or Treatment Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
41. Clinician's Progress Notes (Up to past year)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
42. Functional Assessments (Most recent)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
43. Receiving Facility Admissions Summary, and, if available, Emergency Room Report			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

44. Primary Issues of Strength Checklist: Place scoring code (see key) in appropriate column to indicate extent of strength, or need in each subject area listed below, and briefly describe problem, if any.

*** Key: 0 = No Data; 1 = Minor; 2 = Moderate; 3 = Severe**

	Strength	Issue/Need	Description of Strengths, Issues, Needs (attach information, if necessary)
Health			
Mental Health			
Family			
Social			
Work			
Police, Law			
Violence			
Accidents			
Education			
Other (specify)			

CONTINUED OVER

State Mental Health Facility Admission Form (Page 4)

D. Client Medical Information / History (continued)

45. The issues/needs checked above co-occur with:

☐ Alcohol ☐ Drugs ☐ Psychiatric Disorder ☐ Developmental Disability ☐ Other (Specify) _____

46. Reason for transfer to the state facility _____

47. What steps have already been taken to explore less restrictive placement _____

48. List Previous State Hospital Admissions (attach additional sheets if necessary):

Admission Date (mm/dd/yyyy)	Facility Name	Length of Stay

49. List previous Local Hospitals, Crisis Stabilization Units, or Intensive Residential Treatment Programs serving client prior to admission (include facility/program name and mailing address):

Facility Name	Program Name	Mailing Address

E. Current Financial Information About Client

50. Monthly Income: \$_____ 51. Check one: ☐ Owns Home ☐ Rents ☐ Other _____

52. Complete the following charts as appropriate:

	Monthly Benefit	Type of Claim/ Policy Number		If Filed For	Date Filed	I.D. Number	Where Filed	Approved/Denied (Indicate why if denied)
Social Security				Medicare				
S.S.I.				Medicaid				
Veteran's Benefits				Champus				
Pensions				Medical Insurance				
Insurance/HMO				Hospitalization				
Other (Specify)				Other (Specify)				

53. List any other financial resources:

CONTINUED

State Mental Health Facility Admission Form (Page 5)

F. Recommendations and Pre-Release Plans (Items 54, 55 and 56 completed jointly by Receiving Facility & Community Case Manager)

54. List expectations of the State Facility

By Client _____

By Family _____

By Community Services _____

55. List ALL potential recommended alternatives for this client's return to the community (include the name, address, and phone number of services/programs to which the client may be referred):

Client _____

Family _____

Community Services _____

56. Describe briefly how the community staff will remain involved in the therapeutic process during this client's hospitalization (to be developed through mutual effort of Hospital and Continuity of Care Facilitator).

57. Describe briefly how the family will remain involved in the therapeutic process during this client's hospitalization (to be developed through mutual effort of Hospital and Continuity of Care Facilitator):

G. Receiving Facility's General Referral Comments

(Include statement indicating eligibility for placement in a Mental Health or Developmental Services Facility)

Signature of Person(s) Completing Form

Title

Date Signed (mm/dd/yyyy)

Signature of Person(s) Completing Form

Title

Date Signed (mm/dd/yyyy)

CONTINUED OVER

State Mental Health Facility Admission Form (Page 6)

Client Name _____		SS# _____	
Receiving Facility _____		Phone # _____	
Signature _____		Date Admission Packet Sent (mm/dd/yyyy) _____	
This side to be completed by the Receiving Facility and sent with the admission packet prior to admission		This side to be completed by the State Mental Health Facility Staff Person after receiving admission packet	
		Rating	
		Notes (Please Note Incomplete And/Or Missing information Items) (Use Back if Necessary)	
Check <input checked="" type="checkbox"/> if included in packet or Circle "NA"		Complete Info	Incomplete Info
		No Info	
1. Form 7000		3	2
A. Identifying Information <input type="checkbox"/> NA		1	
B. Status Information <input type="checkbox"/> NA		3	2
C. Tansfer/Screen Agency ID Info <input type="checkbox"/> NA		1	
D. Medical Info/History		3	2
29. Current Diagnosis <input type="checkbox"/> NA		1	
30. Psychiatric Eval/Diag Sum <input type="checkbox"/> NA		3	2
31. Psychiatric Notes <input type="checkbox"/> NA		1	
34. Psychological Evaluation <input type="checkbox"/> NA		3	2
35. Psychosocial Eval/History <input type="checkbox"/> NA		1	
37. Physical Examination <input type="checkbox"/> NA		3	2
39. Appropriate Legal Docs <input type="checkbox"/> NA		1	
40. Service Treatment Plan <input type="checkbox"/> NA		3	2
41. Clinicians' Progress Notes <input type="checkbox"/> NA		1	
42. Functional Assessment <input type="checkbox"/> NA		3	2
43. Rec Fac Admission Summary <input type="checkbox"/> NA		1	
44. Prim Issue/Strength Ck List <input type="checkbox"/> NA		3	2
45. Issues/Needs Co-occurring <input type="checkbox"/> NA		1	
46. Reason for Transfer <input type="checkbox"/> NA		3	2
47. Steps taken to explore less restrictive placement <input type="checkbox"/> NA		1	
48. Previous Psychiatric Admis <input type="checkbox"/> NA		3	2
49. Previous Other Admissions <input type="checkbox"/> NA		1	
E. Current Financial Information <input type="checkbox"/> NA		3	2
F. Recommend./Pre-Release Plan <input type="checkbox"/> NA		1	
2. Joint Review (of admission packet information) (State Mental Health Facility Staff Person Completes)			
A. Who Reviewed? State Mental Health Facility _____ Receiving Facility _____			
B. When Reviewed? Date(s) (mm/dd/yyyy) _____			
C. What incomplete/missing information items need to be resolved? (Use back if needed)			
Above Item #	Action to Resolve	Who to Resolve	Date Due (mm/dd/yyyy)
3. Satisfaction of the State Mental Health Facility Staff Person (Please Circle Appropriate Rating)		Rating	
		Strongly Agree	Agree
		Neutral	Disagree
		Strongly Disagree	
		Comments (Please Explain Low Ratings: 3 or Less) (Use Back if Necessary)	
A. Overall, I am very satisfied with the admission packet information and process.		5	4
		3	2
B. State Mental Health Facility Staff Person Signature _____		Phone # () _____	

See s. 394.4573 and s. 394.468, Florida Statutes
CF-MH 7000, Jan 98 (Recommended Form)

BAKER ACT

Department of Children & Families
State Mental Health Facility Discharge Form

Instructions: This form will be faxed to the community case manager the day of discharge and to the medical service provider in jail, if appropriate. A copy of this form with the attachments will be mailed by the next working day.

Attach copies of Need/Issue Lists, Service Plan, current status, significant lab reports, physical exam (completed in last 30 days), attach copy of latest clinical summary/competency exam completed within 30 days prior to discharge, and comprehensive social history with latest update.

TO (Agency) _____

Phone # (_____) _____ Fax # (_____) _____

Mailing Address _____

ATTN (Case Manager) _____ Phone # (_____) _____

A. Social Worker's Section: (Include all relevant demographic information)

1. Client's Name _____ Hospital Number _____

Legal Status _____ Date of Admission (mm/dd/yyyy) ____/____/____

Social Security Number _____ - _____ - _____ Date of Birth (mm/dd/yyyy) ____/____/____

County of Residence _____ County of Admission _____

Guardian or First Representative _____ Relationship _____

Address _____

Phone # (_____) _____

2. Discharged Status Including Conditional Release Plans: _____

_____ Discharge To _____

Discharge Address _____

Phone Number # (_____) _____

3. Financial Status: Type of Benefit(s) _____

Name of Payee _____ Amount of Benefits _____

Date Applied For ____/____/____ Date Accepted/Rejected ____/____/____ Appeals ____/____/____
(mm/dd/yyyy) (mm/dd/yyyy) (mm/dd/yyyy)

4. Who takes responsibility for the client upon discharge? (List name, relationship, responsibilities)

Social Worker's Signature _____ Date (mm/dd/yyyy) _____ Phone # (_____) _____

CONTINUED OVER

State Mental Health Facility Discharge Form (Page 2)

B. Psychiatrist's Section: Current Diagnoses (Current edition of DSM [Axis I, II, IV & V] and ICD [Axis III]):

AXIS I: _____ AXIS II: _____

AXIS III: _____ AXIS IV: _____

AXIS V: GAF = _____ On Admission SCI-PANSS = _____ On Admission

GAF = _____ On Discharge SCI-PANSS = _____ On Discharge

Course of Hospitalization:

1. Reason for Admission (Circumstances which brought client to hospital):

2. Assessment and Findings (Diagnostic assessments completed and findings including mental status exam):

3. Treatment and Response (Types, frequencies, and response from admission to present):

4. Homicidal/Suicidal History (Address any issues related to these behaviors):

5. Medication History for current admission, including any dosages, court ordered medications, significant labs for psychiatric management, (i.e., lithium levels, etc.), and side effects. (See also Medical Physician's section, page 3).

6. Prognosis including recommendations for follow up and early warning signs of decompensation (address delusional speech).

Psychiatrist's Signature

_____/_____/_____
Date (mm/dd/yyyy)

Phone # (_____) _____

CONTINUED

State Mental Health Facility Discharge Form (Page 3)

C. Medical Physician's Section:

(summary of current hospital course as it relates to medical issues, note special consultations, need for follow up)

Allergies _____ Diet _____

Medical Diagnoses _____

Lab and Other Studies including Pap Smear and Blood Levels appropriate for management of medical conditions.

Immunizations: ☐ PPD ☐ DT ☐ Influenza ☐ Pneumovax

Hospital Course, Special Issues/Concerns, Recommendations for Follow-up (List some descriptive items such as important salient treatment modalities, special issues/concerns, successful treatment modalities):

Medication Regime including dosages, significant labs, and side effects. (See also Psychiatrist section page 2)

Medical Physician's Signature Date (mm/dd/yyyy) Phone # (____) _____

CONTINUED OVER

State Mental Health Facility Discharge Form (Page 4)

D. Nurse's Section:

1. Adaptive Equipment: Indicate below if client has items listed or if client needs items listed.

<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Dentures (Type) _____	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Hearing Aid
<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Wheelchair	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Crutches
<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Glasses	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Contacts
<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Prosthesis _____	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Cane
<input type="checkbox"/> Has	<input type="checkbox"/> Needs	Walker			

2. Describe skin condition: _____

3. Is client at risk for choking? (check one) ☐ Yes ☐ No
Does the attached Service Implementation Plan contain information related to prevention of aspiration? (check one)
☐ Yes ☐ No

4. Is client is on Blood/Body Fluid Precautions? (check one) ☐ Yes ☐ No

5. Side Effects/Adverse Reactions: _____

6. Current Medications as ordered for separation (include date/time of last dose): _____

Number of days supply sent with client: _____

7. Medication not sent (per facility policy) _____

8. Is client capable of taking his/her own medication? (check one) ☐ Yes ☐ No
Has medication education been provided? (check one) ☐ Yes ☐ No

9. History of medication compliance while in hospital. ☐ Never ☐ Sometimes ☐ Usually ☐ Always

CONTINUED

Baker Act Forms - 151

State Mental Health Facility Discharge Form (Page 6)

E. Rehabilitation Section Instructions: Check (3) the appropriate response.

Primary Language _____ ☐ Writes ☐ Speaks ☐ Signs
 Secondary Language _____ ☐ Writes ☐ Speaks

Presently Attending Education: ☐ Yes ☐ No ☐ Reads ☐ Writes ☐ Counts ☐ Tells Time

Has completed: ☐ High School ☐ Vocational ☐ College

Interested in attending classes: ☐ High School ☐ Vocational ☐ College ☐ Graduate

Requires Therapeutic Devices: ☐ Glasses ☐ Hearing Aid

Behavioral Response Level

Language Skills ☐ Verbal ☐ Non-Verbal

Receptive Language (check one)

- ☐ Doesn't understand speech
- ☐ Understands simple conversation/instructions
- ☐ Understands complex conversation/instructions

Attention Span: ☐ 0-3 min. ☐ 4-9 min. ☐ 10+ min.

Expressive Language (check one)

- ☐ Makes no sounds
- ☐ Uses simple words
- ☐ Uses sentences
- ☐ Carries on conversation
- ☐ Other _____

Group Therapy Skills

- ☐ Likes Working in Group
- ☐ Expresses Feelings to Group
- ☐ Sets Goals for Self
- ☐ Speaks in Turn
- ☐ Responds to Feelings
- ☐ Identifies Interpersonal Barriers

Leisure Activities

- ☐ Initiates Leisure Activities
- ☐ Schedules Own Leisure Activities
- ☐ Selects Preferred Leisure Activities
- ☐ Participates in Offered Leisure Activities
- ☐ Invites Friends to Participate
- ☐ Evaluates Satisfaction

Social Skills (check all that apply)

- ☐ Expresses Feelings
- ☐ Expresses Affection Appropriately
- ☐ Initiates Conversations with Others
- ☐ Responds to Criticism (Pos/Neg)
- ☐ Converses About Family
- ☐ Compliments Others
- ☐ Offers Assistance
- ☐ Responds to Personal Statements
- ☐ Requests Assistance When Needed
- ☐ Expresses Opinions
- ☐ Asks Before Borrowing Items From Others
- ☐ Isolative
- ☐ Speaks in Normal Tone of Voice
- ☐ Boundary Issues (Personal Space)

Activity Preferences: (Mark boxes indicated by client)

- | | | | |
|---------------------------------------|--|---|----------------------------------|
| <input type="checkbox"/> Arts/Crafts | <input type="checkbox"/> Parties/Programs | <input type="checkbox"/> Religious Services | <input type="checkbox"/> Music |
| <input type="checkbox"/> Horticulture | <input type="checkbox"/> Discussion Groups | <input type="checkbox"/> Exercising | <input type="checkbox"/> Outings |
| <input type="checkbox"/> Library | <input type="checkbox"/> Recreation | <input type="checkbox"/> Reading | <input type="checkbox"/> Movies |
| <input type="checkbox"/> Plays Sports | <input type="checkbox"/> Watches Sports | <input type="checkbox"/> Other _____ | |

Past Employment (check): ☐ Sheltered Workshops ☐ Supported Employment ☐ Private Sector

Presently Employed With _____

Comments (recap client participation in Rehab. activities) _____

Rehab. Employee Signature

_____/_____/_____
Date (mm/dd/yyyy)

Phone # (____) _____

CONTINUED

State Mental Health Facility Discharge Form (Page 7)

F. Direct Care Section: Instructions: Place an "I" for independent, "E" for needs encouragement or "A" for requires assistance. In comment section, reflect on encouragement and assistance required.

Housekeeping:

- ☐ Makes Beds
- ☐ Operates Washer
- ☐ Operates Dryer
- ☐ Folds Clothes
- ☐ Keeps room neat

Eating Habits:

- ☐ Eats Breakfast, Lunch, and Dinner
- ☐ Steals Food
- ☐ Shares Food
- ☐ Uses Good Table Manners
- ☐ Follows Diet
- ☐ Rate or Speed of Eating
- ☐ Feeds Self Independently

Budgets:

- Spends \$ _____ Weekly
- Spends ☐ Moderately ☐ Excessively on Snacks and Cigarettes
- ☐ Can manage own money
 - ☐ Shops for Clothing
 - ☐ Saves Money
 - ☐ Saves for Leisure

Grooming:

- ☐ Bathes
- ☐ Dresses
- ☐ Brushes Teeth
- ☐ Washes Hair
- ☐ Shaves
- ☐ Grooms Hair
- ☐ Wears Clean Clothes
- ☐ Wears Appropriate Clothes
- ☐ Uses Deodorant

Uses Telephone:

- ☐ Local
- ☐ Long Distance
- ☐ Can Dial 911

Other:

- ☐ Removes Items from Other's Rooms
- ☐ Closes Bathroom Door
- ☐ Flushes Toilet
- ☐ Wash Hands after Using Rest Room
- ☐ Washes Hands
- ☐ Crosses Street Safely
- ☐ Hoards Things
- ☐ Dresses Appropriate to Season

Use of Tobacco Products:

- ☐ Maintains a Schedule
- ☐ Chain Smokes
- ☐ Doesn't Smoke
- ☐ Smokeless Tobacco Products

Sexual Acting Out:

- ☐ Knowledge about
- ☐ Sexually Intruding on Others
- ☐ Exposing Self
- ☐ Public Masturbation
- ☐ Urinates in Public

Independent Living Clients Only

- ☐ Use of Transit Systems
- ☐ Develop a Budget
- ☐ Knows Food Safety Rules
- ☐ Knows Safety Rules for Kitchen
- ☐ Knows how to Evacuate in a Emergency
- ☐ Knows Items to Stock for Emergencies

Comments _____

Direct Care Staff Signature _____ Date (mm/dd/yyyy) _____ Phone # (_____) _____

CONTINUED OVER

State Mental Health Facility Discharge Form (Page 8)

G. Post Hospital Aftercare Recommendations by Service Team:

1. Check (3) indicates behavior as applicable to client:

Item	Previous History	Never	Sometimes	Often	Usually	Always
Violent to Self/Others/Property						
Suicidal						
Assaultive						
At Risk of Leaving						
Medication Compliance						
Therapeutic Activity Compliance						
Cooperative						
Demonstrates Understanding of Illness						
Has Supportive Family/Other						

2. List of circumstances under which relapse is apt to occur (early warning signs to look out for).

3. List crucial intervention needed to help promote successful placement (frequency of family contact, participation in AA, Day Treatment Group Therapy).

4. Description of the degree of supervision needed by the client. ☐ None ☐ Minimal ☐ Close

Comments (describe circumstances): _____

5. Treatment Recommendations: _____

6. Client Preferences or Recommendations: _____

7. Appointment at Local Community Mental Health Agency Date ____/____/____ Time ____ am pm
(mm/dd/yyyy)

Name of Therapist _____ Appointment Confirmed By _____

8. Appointment for Medical Problems Date ____/____/____ Time ____ am pm
(mm/dd/yyyy)

Street Address _____

Physician's Name _____ Phone # (____) _____

Name of Person Responsible for Medical Treatment (including financially) _____

9. Additional Follow-up _____

_____ Date Signed ____/____/____ Phone # (____) _____
(mm/dd/yyyy)

Service Team Leader or Designee

CONTINUED

State Mental Health Facility Discharge Form (Page 9)

H. Client's Copy of Discharge Summary: (To be completed with the client and assigned unit staff. A copy of this plan shall given to the client at the time of discharge).

Date: _____ Name: _____
(mm/dd/yyyy)

Hospital #: _____ SSN: _____

Legal Status: ☐ Voluntary ☐ Involuntary ☐ Incompetent to Proceed ☐ Not Guilty by Reason of Insanity
☐ Competent ☐ Incompetent
☐ Advance Directive ☐ Health Care Surrogate
 Guardian: ☐ Person ☐ Property

This individualized discharge plan has been developed by:

Staff Person _____ Client _____ Case Manager _____

Guardian's Name: _____ (_____) _____
 Address _____ Phone _____

Address _____

Provision for Placement: {For persons returning to jail, the following information is submitted for consideration in regards to potential placement and follow-up services.}

I will reside at: _____
 Address _____
 (_____) _____
 Phone # _____ Contact Person _____

I understand the client rules are: _____

I ☐ agree ☐ do not agree to abide by the rules. (Check one)

Family: My family ☐ has ☐ has not been notified of my discharge or ☐ has not been by my request.

They will assist me through _____

 Family was provided education on _____

Community Services Recommended	Available in Community	Recommended by Team	Agreed to by Client	Comments
Intensive Case Management				
Case Management				
Medical				
Substance Abuse				
Therapy				
Sheltered Employment				
Supported Employment				
Home Help				
Independent Living Skills Training				
Day Treatment				
Religious Services				
Financial				
Legal				
Educational				
Other (Specify):				

CONTINUED OVER

State Mental Health Facility Discharge Form (Page 10)

H. Client's Copy of Discharge Summary:

Psychiatric Services: Psychiatric Services will be provided by Dr.: _____

Address: _____

Phone: (_____) _____ Contact Person: _____

My first appointment will be: Date: _____ Time: _____ am pm
(mm/dd/yyyy)

Medical Services: Provision of medical care will be provided by Dr.: _____

Address: _____

Phone: (_____) _____ Contact Person: _____

My special medical needs are: _____

Medication: My medications are for _____ dosage _____

I understand the importance of medication and agree to take it as prescribed. If I have problems, I will contact my case manager who is: _____ at (_____) _____

Financial: I will receive income of	Amount	Source
	\$ _____	_____
	\$ _____	_____

My cost of care will be \$ _____ I will receive for spending \$ _____

Transportation: Upon discharge, transportation will be provided by: _____

My daily transportation need to Dr. appointments, day treatment and recreational activities will be provided by _____.

Case Management Services: _____ will serve as my case manager.
_____ will be my link to community services. I should let him/her know what my needs or concerns are. I will meet with him/her on (mm/dd/yyyy) _____ at _____ am pm for our first community visit at _____. He/She works for: _____.

Address: _____ Phone #: (_____) _____

Provision for State Hospital Follow Up & Continuity of Care: I will be on a _____ day leave of absence to ensure my adjustment and smooth transition into community living.

_____ will follow up with _____ phone calls and/or face to face visits.
Social Worker's Name _____ Number/frequency _____

I may feel free to contact treatment team members during this transition. My treatment contacts are:

Names	Phone #'s
_____	(_____) _____
_____	(_____) _____

CONTINUED

State Mental Health Facility Discharge Form (Page 11)

Other Significant Information:

This treatment plan has been approved and agreed upon this _____ day of _____, _____
by affixed signatures:

Client

Hospital Personnel

Case Manager

Legal Guardian

Client did not agree to sign. Reason: _____

CONTINUED OVER

Client Name _____		Client ID#: _____		SS# _____		
State Mental Health Facility Staff Person _____			Phone # _____			
Signature _____			Date Discharge Packet Sent (mm/dd/yyyy) _____			
This side to be completed by the State Mental Health Facility Staff Person and sent with discharge packet prior to discharge		This side to be completed by the Community Case Manager after receiving the discharge packet				
		Rating			Notes (Please Note Incomplete and/or Missing information Items) (Use Back if Necessary)	
Check <input checked="" type="checkbox"/> if included in packet or circle "NA"	Complete Info	Incomplete Info	No Info			
1. Form 7001	3	2	1			
A. Social Worker's Section <input type="checkbox"/> NA						
B. Psychiatrist's Section <input type="checkbox"/> NA	3	2	1			
C. Medical Physician's Section <input type="checkbox"/> NA	3	2	1			
D. Nurse's Section <input type="checkbox"/> NA	3	2	1			
E. Rehabilitation Section <input type="checkbox"/> NA	3	2	1			
F. Direct Care Section <input type="checkbox"/> NA	3	2	1			
G. Post Hospital Aftercare <input type="checkbox"/> NA	3	2	1			
H. Discharge Plan <input type="checkbox"/> NA	3	2	1			
I. Attachments	3	2	1			
1. Service Plan <input type="checkbox"/> NA						
2. Court Orders <input type="checkbox"/> NA	3	2	1			
3. Clinical Summaries <input type="checkbox"/> NA	3	2	1			
4. Physical Exam <input type="checkbox"/> NA	3	2	1			
5. Psychosocial History <input type="checkbox"/> NA	3	2	1			
6. Other _____ <input type="checkbox"/> NA	3	2	1			
7. Other _____ <input type="checkbox"/> NA	3	2	1			
8. Other _____ <input type="checkbox"/> NA	3	2	1			
2. Joint Review (of admission packet information) (Community Case Manger Completes)						
A. Who Reviewed? State Mental Health Facility _____ Community Case Manager _____						
B. When Reviewed? Dates(s) (mm/dd/yyyy) _____						
C. What incomplete/missing information items need to be resolved? (Use back if needed)						
	Above Item #	Action to Resolve		Who to Resolve	Date Due (mm/dd/yyyy)	
3. Satisfaction of the Community Case Manager		Rating				Comments (Please Explain Low Ratings: 3 or Less) (Use Back if Necessary)
Please Circle Appropriate Rating		Strongly Agree	Agree	Neutral	Disagree	
A. Overall, I am very satisfied with the admission packet information and process.		5	4	3	2	1
B. Community Case Manager Signature _____ Phone # (_____) _____						

BAKER ACT

Physician to Physician Transfer Form
Must be completed at time of transfer to and from the State Hospital

Person's Name:	DOB:
Referring Facility:	Phone # ()
Referring Physician:	Phone # ()
Date of Admission to Referring Facility:	
Discharge Diagnosis	AXIS I:
AXIS II:	AXIS III:

Significant/Critical Events During Hospitalization (current status, suicide attempts/gestures, self injurious behavior, restraints, special precautions, etc.):

Significant Medical History, Treatment & Diagnosis (Allergies, recent significant laboratory findings, med/surg procedures, etc.)

Current Medications (List using additional sheet if necessary or attach current MAR)

Name of Medications	Dosage	Frequency	Lab Values	Taken Day of Transfer		
				Yes	Time Taken	No

Failed Medication Regimens: _____

Current Precautions (suicide precautions, elopement precautions, etc.): _____

Management Suggestions: _____

Signature of Physician *: _____ Date _____

Printed Name of Physician _____ Physician's approved designee may sign in the absence of the physician

Use reverse or attach additional sheets if needed

By authority of s. 394.455(29) and s. 394.461(2), Florida Statutes
CF-MH 7002, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

