BAKER ACT
BENCHGUIDE

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ACKNOWLEDGMENTS

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This benchguide was partially extracted, with permission, from the "2014 Baker Act User Reference Guide: The Florida Mental Health Act" written by Martha Lenderman under a contract between USF Florida Mental Health Institute with the Florida Department of Children and Families.

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PURPOSE

The *Baker Act Benchguide* was developed to serve as an educational resource and a user-friendly reference for Florida circuit judges who are dealing with proceedings under the Baker Act. Although far-reaching, this benchook cannot hope to be definitive; readers should always check cited legal authorities before relying on them.

DISCLAIMER

Viewpoints reflected in this publication do not represent any official policy or position of the Florida Supreme Court, the Office of the State Courts Administrator, the Florida judicial conferences, the Florida Court Education Council, or the Florida Court Education Council's Publications Committee.

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Introduction: Development and Use of *Baker Act Benchguide*

This benchguide is intended to help the courts appropriately carry out their responsibilities related to the Baker Act, including:

- To enter orders on ex parte petitions for involuntary examinations under the Baker Act.
- To conduct hearings on initial and continued involuntary inpatient placement and involuntary outpatient services filed by administrators of Baker Act receiving and treatment facilities.
- To respond to petitions for writs of habeas corpus filed on behalf of individuals held in Baker Act receiving or treatment facilities.
- To respond to filings by Baker Act receiving facility administrators to limit individuals' access to firearm purchase or possession of a concealed weapon permit.

This benchguide 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 chapter 394, Florida Statutes, and chapter 65E-5, Florida Administrative Code, as well as other federal and state laws, have legal authority.

The creation of administrative rules to implement and clarify the statute is governed by chapter 120, Florida Statutes. The state law prohibits the repetition of statute in administrative rules. Therefore, judges, magistrates, assistant state attorneys, assistant public defenders, and clerks dealing with the Baker Act must be familiar with and routinely reference both the statutes and the corresponding rules to ensure correct implementation of the Baker Act law.

Please note that the forms and flowcharts included in this benchbook were promulgated by DCF before the 2016 statutory amendments and do not incorporate those changes.

To the extent possible, the word "individual" or "person" is used (rather than "patient") throughout this benchguide, 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. Each chapter in this benchbook contains useful material on select complex subjects derived from

the Baker Act law, administrative rules, forms, practices, and other statutes and case law. A glossary of definitions, acronyms, and common terms is at the end of Chapter One.

This benchguide was partially extracted from the "2014 Baker Act User Reference Guide: The Florida Mental Health Act" written by Martha Lenderman under a contract between USF Florida Mental Health Institute with the Florida Department of Children and Families. The colloquy was prepared by General Magistrate Sean Cadigan of the Thirteenth Judicial Circuit, who also reviewed the document for usefulness to the judiciary.

The benchguide was otherwise prepared by Martha Lenderman. The material in this benchguide was not prepared by attorneys, and reliance on its content should not be considered as legal advice.

A separate benchguide for the Marchman Act governing substance abuse impairment is in progress and will be available through the Office of the State Courts Administrator.

Chapter One: History and Overview of Baker Act

I. History

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, the 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. In 2016, three bills were passed that revised mental health law in Florida. SB 12 was passed to improve access to court and make the process more seamless for persons in crisis with substance abuse and mental health issues. HB 439 authorizes the creation of mental health courts, expands eligibility for veteran programs and courts, and HB 769 made changes, such as reducing the period of time persons with certain nonviolent offenses may be held in forensic facilities.

It is important that the Baker Act be used only 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 to the Baker Act may include:

- Developmental Disabilities, ch. 393, Fla. Stat.
- Marchman Act (Substance Abuse Impairment), ch. 397, Fla. Stat.
- Emergency Examination and Treatment of Incapacitated Persons, § 401.445, Fla. Stat.
- Federal Emergency Medical Treatment and Active Labor Act (EMTALA)

hospital "Anti-Dumping" law, 42 U.S.C. § 1395dd.
- Hospital Access to Emergency Services and Care, § 395.1041, Fla. Stat.
- Adult Abuse, Neglect, and Exploitation, § 415.1051, Fla. Stat.
- Health Care Advance Directives, ch. 765, Fla. Stat.
- Guardianship, ch. 744, Fla. Stat.
- Expedited Judicial Intervention Concerning Medical Treatment Procedures, Fla. Prob. R. 5.900

II. Rights of Persons with Mental Illnesses

See § 394.459, Fla. Stat.; Fla. Admin. Code R. 65E-5.140. 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, requires prompt physical examination after arrival, requires treatment planning to involve the person, and requires that the least restrictive appropriate available treatment be used 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 they are removed, a witnessed inventory is required.

- **Voting in Public Elections**: Guarantees individuals 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 the person's choice upon discharge.

- **Sexual Misconduct Prohibited:** Provides that 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**: Ensures the 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 released only 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 in other very limited circumstances. Persons in

mental health facilities have the right to access their clinical records.

- **Violation of Rights**: Provides that anyone who violates or abuses any rights or privileges of persons provided in the Baker Act is liable for damages as determined by law.

III. Voluntary Admissions

A. In General

See § 394.4625, Fla. Stat.; Fla. Admin. Code R. 65E-5.270.

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.

B. Selected Definitions

See § 394.455, Fla. Stat.

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. For the purposes of this part, the term does not include developmental disabilities as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse." § 394.455(28), Fla. Stat.

- "'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(15), Fla. Stat.

- "'Incompetent to consent to treatment' means a state in which a person's judgment is so affected by a mental illness or a substance abuse impairment that he or she lacks the capacity to make a well-reasoned, willful, and

knowing decision concerning his or her medical, mental health, or substance abuse treatment." § 394.455(21), Fla. Stat.

C. Criteria for Voluntary Admissions

See § 394.459(3)(a).

Section 394.4625(1)(a), Florida Statutes, provides:

> 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. 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 can be admitted only after a hearing to verify the voluntariness of the consent.

Each person entering a facility, regardless of age, must be asked to give express and informed consent for admission and treatment. Express and informed consent for admission and treatment of a person under 18 years of age is required from the minor's guardian. See Chapter Three of this benchguide concerning who is a "guardian" of a minor.

D. Voluntary Admission — Exclusions

See § 394.4625(1), Fla. Stat.

- A minor can be admitted on a voluntary basis only 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 chapters 400 and 429, Florida Statutes, 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 be transferred to involuntary status.

E. Consent to Admission/Treatment

Before consent to admission or treatment can be given, 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 that may exist
- Clinically significant interactive effects with other medications
- Similar information on alternative medication that 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 by any person legally authorized to make health care decisions on behalf of the individual.

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.

F. Transfer to Voluntary Status

See § 394.4625(4), Fla. Stat.

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, clinical psychologist, or psychiatric nurse, 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.

G. Transfer to Involuntary Status

See § 394.4625(5), Fla. Stat.

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.

H. Discharge of Persons on Voluntary Status

See § 394.4625(2), Fla. Stat.

A facility must discharge a person on voluntary status under the following circumstances:

- The person 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.

- The person *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.

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

IV. Involuntary Examinations – § 394.463, Fla. Stat.; Fla. Admin. Code R. 65E-5.280

A. 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 (as defined in the Baker Act) and because of the mental illness

- the person either
  - has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination, OR
  - is unable to determine whether examination is necessary, AND
- without care or treatment, the person is likely to either
  - suffer from neglect or refuse to care for himself or herself, which "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
  - cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

§ 394.463(1), Fla. Stat.

B. Initiation of Involuntary Examination

See § 394.463(2), Fla. Stat.

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

- **A circuit or county court may** enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, specifying 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 an appropriate, or the nearest, facility within the designating receiving system under section 394.462, Florida Statutes, 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 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. Fla. Admin. Code R. 65E-5.260(2).

  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.

- **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 an appropriate, or the nearest, facility within the designating receiving system under section 394.462 for examination. The officer must execute a written report (form CF-MH 3052a) **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.

- **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 (form 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 an appropriate, or the nearest, facility within the designating receiving system under section 394.462 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. Op. Att'y Gen. Fla. 08-31 (2008).)

C. Definitions of Professionals

See § 394.455, Fla. Stat.

- "'Physician' means a medical practitioner licensed under chapter 458 or chapter 459 who has experience in the diagnosis and treatment of mental illness or a physician employed by a facility operated by the United States Department of Veterans Affairs or the United States Department of Defense." § 394.455(32), Fla. Stat.

- "Physician assistant" means a person licensed under chapter 458 or chapter 459 who has experience in the diagnosis and treatment of metal disorders." § 394.455(33), Fla. Stat.

- "'Psychiatrist' means a medical practitioner licensed under chapter 458 or chapter 459 for at least 3 years, inclusive of psychiatric residency." § 394.455(36), Fla. Stat.

- "'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(5), Fla. Stat.

- "'Clinical social worker' means a person licensed as a clinical social worker under s. 491.005 or s.491.006." § 394.455(7), Fla. Stat.

- "'Mental health counselor' means a person licensed as a mental health counselor under s. 491.005 or s.491.006." § 394.455(26), Fla. Stat.

- "'Marriage and family therapist' means a person licensed as a marriage and family therapist under s. 491.005 or s.491.006." § 394.455(25), Fla. Stat.

- "'Psychiatric nurse' means an advanced registered nurse certified under s. 464.012 who has a master's or doctoral degree in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has 2 years of post-master's clinical experience under the supervision of a physician." § 394.455(35), Fla. Stat.

- "'Qualified professional' means a physician or a physician assistant licensed under chapter 458 or chapter 459; a psychiatrist licensed under chapter 458 or chapter 459; a psychologist as defined in s. 490.003(7); or a psychiatric nurse as defined in s. 394.455. § 394.455(38), Fla. Stat.

D. Selected Procedures for Involuntary Examinations

See § 394.463(2), Fla. Stat.

Any receiving facility accepting a person based on a court's ex parte order, a law enforcement officer's report, or a mental health professional's certificate must send a copy of the document with the required cover sheet to the Florida Department of Children and Families (DCF) (via the Baker Act Reporting Center) on the next working day.

A person can't be removed from any long-term care program or residential placement licensed under chapter 400 (nursing homes) or chapter 429, Florida Statutes (assisted living facilities), and transported to a receiving facility for involuntary examination unless an ex parte order, a law enforcement officer's report, or a mental health 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, mental health professional certificate, or law enforcement officer's report must notify DCF of the admission by certified

mail or by email, if available, by the next working day. § 394.463(2)(b), Fla. Stat.

E. Initial Mandatory Examination

See § 394.463(2)(f), Fla. Stat.; Fla. Admin. Code R. 65E-5.2801.

A person must receive an initial mandatory examination by a physician or clinical psychologist at a facility without unnecessary delay to determine whether the criteria for involuntary services are met. Emergency treatment may be provided. This initial mandatory involuntary examination must include:

- a thorough review of any observations of the person's recent behavior;
- a review of the document initiating the involuntary examination and the transportation form;
- a brief psychiatric history; and
- a timely face-to-face examination of the person to determine if he or she meets the criteria for release.

The person can't be released by a receiving facility "without the documented approval of a psychiatrist or a clinical psychologist or, if the receiving facility is owned or operated by a hospital or health system, the release may also be approved by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist or an attending emergency department physician with experience in the diagnosis and treatment of mental illness and after completion of an involuntary examination pursuant to this subsection. A psychiatric nurse may not approve the release of a patient if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist." § 394.463(2)(f), Fla. Stat. The person must be given prompt opportunity to notify others of his or her whereabouts.

F. Release from Involuntary Examination

See § 394.463(2)(g), Fla. Stat.

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

- 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.

- The person, unless 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 medical, mental health, or substance abuse treatment.

- A **petition for involuntary placement** must be completed within 72 hours and filed with the circuit court for involuntary inpatient placement, or with the circuit or criminal county court for involuntary outpatient services, 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.

G. Notice of Discharge or Release

See §§ 394.463(3), 394.469(2), Fla. Stat.

Notice of discharge or transfer of a person must be given as provided in section 394.4599, Florida Statutes. Notice of the release must be given to the individual and his or her guardian, guardian advocate, health care surrogate or proxy, attorney, and representative, to any person who executed a certificate admitting the individual to the receiving facility, and to any court that ordered the individual's evaluation.

H. Reporting to DCF

See section 394.463(2)(a), Fla. Stat.

Any receiving facility **accepting** a person for involuntary examination must send to DCF via the BA Reporting Center a cover sheet (form CF-MH 3118) and a copy of the completed initiating form:

- ex parte petition/order;
- 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 one day, including:

- involuntary inpatient placement order;
- involuntary outpatient servicesorder; and
- continued involuntary outpatient services order

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

I. Transportation of Persons for Involuntary Examination

See § 394.462, Fla. Stat.; Fla. Admin. Code R. 65E-5.260.

Law enforcement has **no** responsibility to transport persons for **voluntary** admission. Nor 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, 42 U.S.C. § 1395dd.

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, or the **appropriate facility within the designated receiving system**, for the examination.

A law enforcement agency **may decline** to transport a person to a receiving facility **only when any of the following have occurred**:

- 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, "consign" the person to the care of the transport company.

  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.

- A law enforcement officer takes custody of a person under the Baker Act and assistance is needed for the safety of the officer or the person in custody, in which case the officer may request assistance from emergency medical

personnel.

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, Florida Statutes, 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. § 395.002(8), Fla. Stat.

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 an appropriate or the nearest designated receiving facility — not to a hospital emergency department that might be more convenient to the law enforcement officer — unless a Transportation 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.

- A mental health professional member of a 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. In such cases 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.

- A transportation plan meeting the criteria set out in section 394.462, Florida Statutes, has been approved by the Board of County Commissioners and the Secretary of the Department of Children and Families.

The appropriate facility within the designated receiving system or the nearest receiving facility must accept persons brought by law enforcement officers or EMS or private transport company authorized the county for involuntary examination. § 394.462(1)(j), Fla. Stat. This means that the law enforcement officer will never be legally obligated to further transport a person once presented to the appropriate or nearest receiving facility or a hospital.

J. Persons with Criminal Charges

See § 394.462, Fla. Stat.; Fla. Admin. Code R. 65E-5.260.

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 appropriate or 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 a felony 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 section 901.35, Florida Statutes.

K. Weapons Prohibited on Grounds of Hospital Providing Mental Health Services

See § 394.458, Fla. Stat.

Except as authorized by law or a 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.

L. Paperwork Required by the Baker Act

See §§ 394.462, 394.463, Fla. Stat.; Fla. Admin. Code R. 65E-5.280

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" (form CF-MH 3052a) 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 (form CF-MH 3052b), 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.

M. Involuntary Placement

See §§ 394.467, 394.4655, Fla. Stat.; Fla. Admin. Code R. 65E-5.290, 65E-5.285

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 the mental illness the person has refused voluntary placement or is unable to determine whether placement is necessary, and either
    - he or she is incapable of surviving alone or with the help of others and without treatment is likely to suffer from neglect that poses a real and present threat of substantial harm to his or her well-being, or

- there is a 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 all available less restrictive treatment alternatives that would offer an opportunity for improvement of the condition have been judged inappropriate.

An adult may be involuntarily ordered for involuntary **outpatient** services upon a finding of the court by clear and convincing evidence that:

(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 has refused voluntary services for treatment after sufficient and conscientious explanation and disclosure of why the services are necessary or is unable to determine for himself or herself whether services are necessary.

(g) In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient services 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).

(h) It is likely that the person will benefit from involuntary outpatient services.

(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.

§ 394.4655(2), Fla. Stat.

Within 72 hours of arrival at facility, or if the 72-hour period ends on a weekend or holiday then no later than the next working day thereafter, a petition for involuntary **inpatient** placement **must** be filed by the receiving facility administrator (or a petition for involuntary outpatient services **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. 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, a physician assistant, a social worker, or by a psychiatric nurse, each as defined in the Baker Act. The second opinion may be conducted by electronic means. The public defender will be appointed by the court to represent the person unless the person is 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. § 394.467, Fla. Stat. The filing of a petition authorizes the facility to retain the person pending completion of a hearing.

The court is required to hold the involuntary placement hearing within five 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, on an involuntary basis for a period of up to 90 days, or up to six months at a state facility:

- to be retained at/transferred to or treated **at** an appropriate receiving or treatment facility, or
- to be treated **by** an appropriate receiving or treatment facility.

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 in issue." *See, e.g.*, Fla. Stand. Jury Instr. (Civil) 405.4.

A petition for involuntary **outpatient** services can be filed only 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, and 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 services which the service provider agrees to deliver. The order shall be for a period of up to 90 days.

A person can be held at a receiving facility pending the court hearing on involuntary **outpatient** services 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** services 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.

N. Continued Involuntary Services

See § 394.4655(8), Fla. Stat.; Fla. Admin. Code R. 65E-5.285(4).

If a person continues to meet the criteria for involuntary outpatient services, the administrator is required, at least ten days 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, in the court that issued the order for involuntary outpatient services, a petition requesting authorization for continued involuntary services.

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 or she was receiving involuntary services, and an individualized plan of continued treatment.

Hearings on petitions for continued involuntary **outpatient** services are judicial and are conducted by the court. Unless the person is otherwise represented by private counsel, he or 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 90 days. The same procedure can be repeated prior to the expiration of each additional period the person is retained.

Hearings on petitions for continued involuntary **inpatient** placement are administrative rather than judicial hearings and are conducted by an administrative law judge. However, if the placement was ordered for less than six months, case law holds that the Florida Division of Administrative Hearings (DOAH) and the judiciary have concurrent jurisdiction for continued inpatient placement. *See, e.g.*, *W.M. v. State*, 992 So. 2d 383 (Fla. 5th DCA 2008) (within six-month maximum period of order for involuntary inpatient placement, circuit court has concurrent jurisdiction over commitment proceedings; after six-month period expires, all placements must be handled through administrative hearings). (In 2016 the maximum period was reduced to 90 days except for state treatment facilities, where the maximum period remains six months.)

O. Discharge of Persons on Involuntary Status

See § 394.469, Fla. Stat.; Fla. Admin. Code R. 65E-5.320.

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.

P. Transfers

See § 394.4685, Fla. Stat.; Fla. Admin. Code R. 65E-5.310.

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" or "hospital transfer" law (42 U.S.C. § 1395dd) and Florida's hospital licensing law (chapter 395, Florida Statutes). 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, the following 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 the request of the person, guardian, or guardian advocate, and upon acceptance of the person by the private facility;

- From private to public facilities upon the 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 two 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 the request of the person, guardian, or

guardian advocate, and upon acceptance of the person by the facility to which transfer is sought.

Q. Baker Act Oversight

See § 394.457, Fla. Stat.

"The Department of Children and Families (DCF) is designated the 'Mental Health Authority' of Florida. The department and the Agency for Health Care Administration (AHCA) shall exercise executive and administrative supervision over all mental health facilities, programs, and services." § 394.457(1), Fla. Stat. DCF is required to report to AHCA any violation of the rights or privileges of persons, or of any procedures provided under the Baker Act, by any facility or professional licensed or regulated by AHCA. § 394.459(9), Fla. Stat. DCF is also 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 Fort 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).

R. Immunity

See § 394.459(10), Fla. Stat.

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, unless that person commits negligence.

S. Statute and Rule Matrix — Florida Mental Health Act (Baker Act)

Florida Statute	Corresponding Fla. Admin. Code Rule
394.451 Short title	N/A
394.453 Legislative intent	N/A
394.455 Definitions	65E-5.100 Definitions
394.457 Operation and administration	65E-5.110 Delegation of Authority
	65E-5.120 Forms
394.4572 Screening of mental health personnel	N/A
394.4573 Continuity of care management system; measures of performance; reports	65E-5.130 Continuity of Care Management System
	65E-5.1301 Transfer Evaluations for Admission to State Mental Health Treatment Facilities from Receiving Facilities
	65E-5.1302 Admissions to State Treatment Facilities
	65E-5.1303 Discharge from Receiving and Treatment Facilities
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
394.458 Introduction or removal of certain articles unlawful; penalty	N/A
394.459 Rights of patients	65E-5.140 Rights of Persons.
	65E-5.150 Person's Right to Individual Dignity
	65E-5.160 Right to Treatment
	65E-5.1601 General Management of the Treatment Environment
	65E-5.1602 Individual Behavioral Management Programs
	65E-5.170 Right to Express and Informed Consent
	65E-5.1703 Emergency Treatment Orders
	65E-5.180 Right to Quality Treatment
	65E-5.1802 Maintenance of the Facility
	65E-5.190 Right to Communication and Visits
	65E-5.200 Right to Care and Custody of Personal Effects

	65E-5.210 Right to Vote in Public Elections
	65E-5.220 Right to Habeas Corpus
	65E-5.601 Operation and Administration of State Mental Health Treatment Facilities
	65E-5.602 Rights of Residents of State Mental Health Treatment Facilities
394.4593 Sexual misconduct prohibited; reporting required; penalties	N/A
394.4595 Florida statewide and local advocacy councils; access to patients and records (Defunded by 2010 Legislature)	N/A
394.4597 Persons to be notified; patient's representative	N/A
394.4598 Guardian advocate	65E-5.230 Guardian Advocate
	65E-5.2301 Health Care Surrogate or Proxy
394.4599 Notice	N/A
394.460 Rights of professionals	N/A
394.461 Designation of receiving and treatment facilities and receiving systems	65E-5.350 Eligibility Criteria and Procedures for Designation of Baker Act Receiving Facilities
	65E-5.351 Minimum Standards for Designated Receiving Facilities
	65E-5.352 Procedures for Complaints and Investigations in Receiving Facilities
	65E-5.353 Criteria and Procedures for Suspension or Withdrawal of Designation of Receiving Facilities
394.4612 Integrated adult mental health crisis stabilization and addictions receiving facilities	N/A
394.4615 Clinical records; confidentiality	65E-5.250 Clinical Records; Confidentiality
394.462 Transportation	65E-5.260 Transportation
	65E-5.2601 Transportation Exception Plan
394.4625 Voluntary admissions	65E-5.270 Voluntary Admission
394.463 Involuntary examination	65E-5.280 Involuntary Examination
	65E-5.2801 Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S
394.4655 Involuntary outpatient services	65E-5.285 Involuntary Outpatient Placement
394.467 Involuntary inpatient placement	65E-5.290 Involuntary Inpatient Placement
	65E-5.300 Continued Involuntary Inpatient Placement at Treatment Facilities
394.46715 Rulemaking authority	N/A

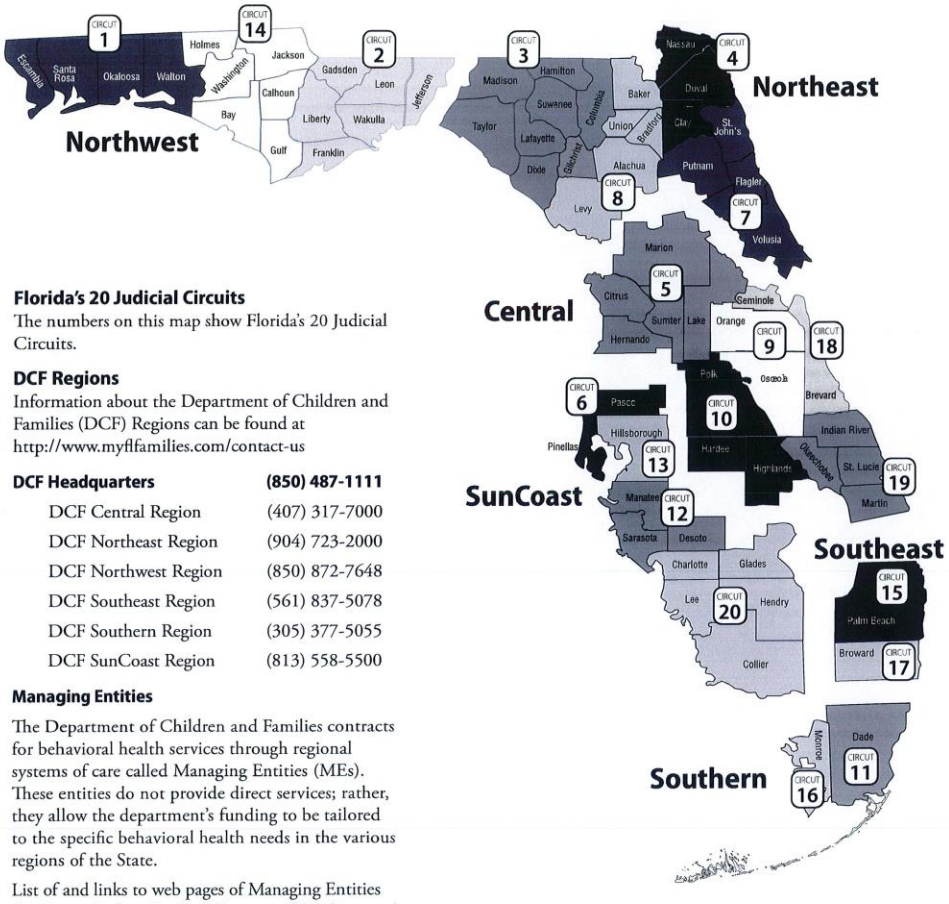
394.4672 Procedure for placement of veteran with federal agency	N/A
394.468 Admission and discharge procedures	N/A
394.4685 Transfer of patients among facilities	65E-5.310 Transfer of Persons Among Facilities
394.469 Discharge of involuntary patients	65E-5.320 Discharge of Persons on Involuntary Status
394.473 Attorney's fee; expert witness fee	N/A
394.475 Acceptance, examination, and involuntary placement of Florida residents from out-of-state mental health authorities	N/A
394.4784 Minors; access to outpatient crisis intervention services and treatment	N/A
394.4785 Children and adolescents; admission and placement in mental facilities	N/A
394.47891 Military veterans and service members court programs	N/A
	65E-5.330 Training
	65E-5.400 Baker Act Funded Services Standards

*The following sections of Part I of chapter 394, Florida Statutes (Baker Act), have been intentionally omitted from this matrix: 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."

V. Maps of Administrative Entities Regions

A. Judicial Circuits and DCF Regions

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/

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B. DCF Regions and Managing Entities

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

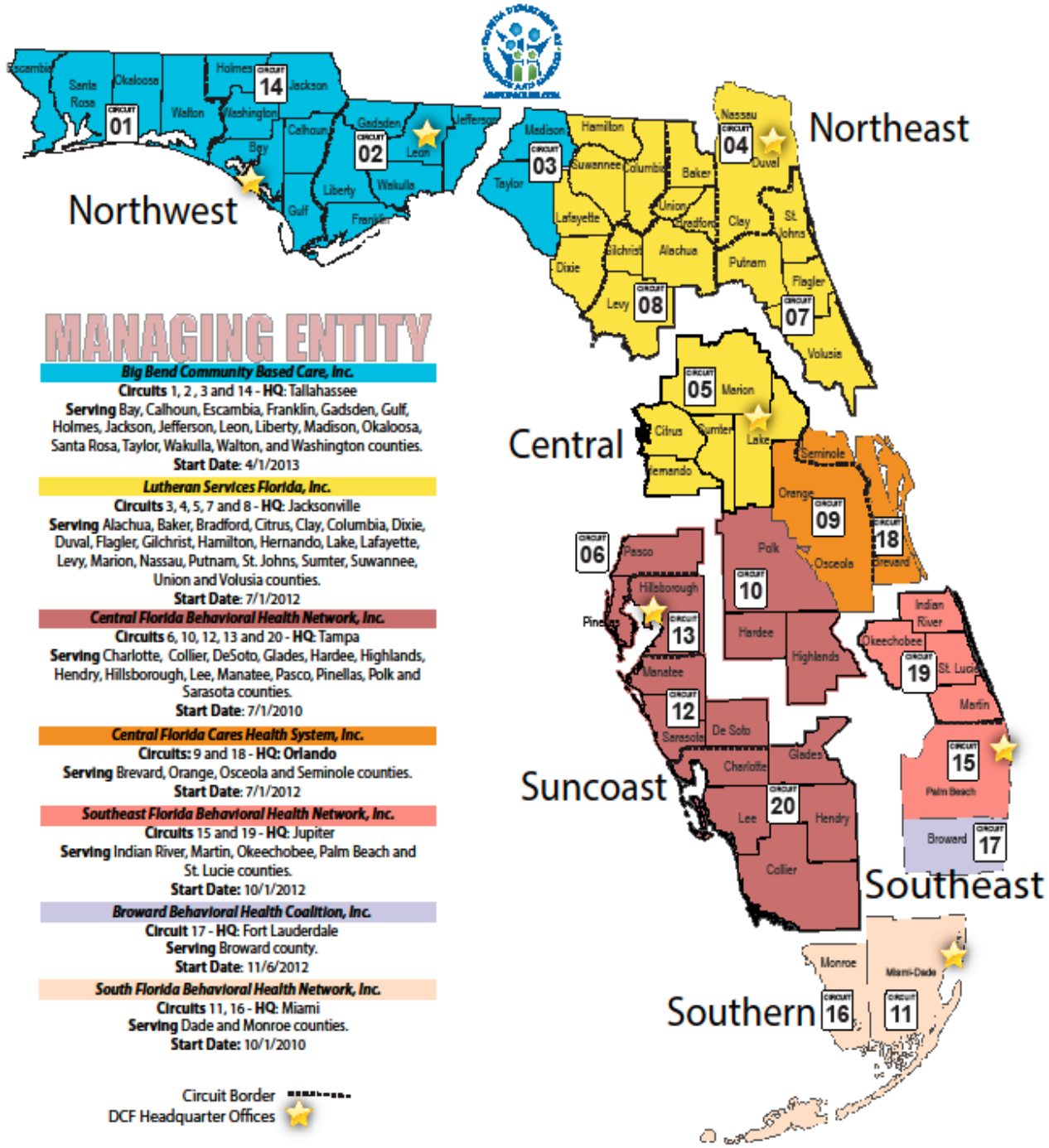
Southeast Florida Behavioral Health Network

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

C. Managing Entities



MANAGING ENTITY

Big Bend Community Based Care, Inc.
Circuits 1, 2, 3 and 14 - **HQ**: Tallahassee
Serving Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington counties.
Start Date: 4/1/2013

Lutheran Services Florida, Inc.
Circuits 3, 4, 5, 7 and 8 - **HQ**: Jacksonville
Serving Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union and Volusia counties.
Start Date: 7/1/2012

Central Florida Behavioral Health Network, Inc.
Circuits 6, 10, 12, 13 and 20 - **HQ**: Tampa
Serving Charlotte, Collier, DeSoto, Glades, Hardee, Highlands, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk and Sarasota counties.
Start Date: 7/1/2010

Central Florida Cares Health System, Inc.
Circuits: 9 and 18 - **HQ: Orlando**
Serving Brevard, Orange, Osceola and Seminole counties.
Start Date: 7/1/2012

Southeast Florida Behavioral Health Network, Inc.
Circuits 15 and 19 - **HQ**: Jupiter
Serving Indian River, Martin, Okeechobee, Palm Beach and St. Lucie counties.
Start Date: 10/1/2012

Broward Behavioral Health Coalition, Inc.
Circuit 17 - **HQ**: Fort Lauderdale
Serving Broward county.
Start Date: 11/6/2012

South Florida Behavioral Health Network, Inc.
Circuits 11, 16 - **HQ**: Miami
Serving Dade and Monroe counties.
Start Date: 10/1/2010

Circuit Border
DCF Headquarter Offices

VI. Psychiatric Diagnoses and Treatment/Medication

A. Diagnoses

The Diagnostic and Statistical Manual of Mental Disorders (DSM) -IV, produced by the American Psychiatric Association, noted five axes, or dimensions, to be considered in assessment of psychological problems:

- Axis I: Clinical Disorders
- Axis II: Personality Disorders and Developmental Disabilities
- Axis III: General Medical Conditions
- Axis IV: Psychosocial and Environmental Problems
- Axis V: Global Assessment of Functioning

However, in the DSM-5, released in 2013, the multiaxial diagnostic system was removed and replaced with a simplified documentation approach. Former Axes I, II, and III were combined into one list, with separate notations for former Axes IV and V, covering psychosocial and environmental factors and disability.

"Mental illness" is defined in the Baker Act to mean "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." § 394.455(28), Fla. Stat. Impairments of the mental or emotional processes that interfere with individuals' ability to control their actions or to perceive or understand reality are generally considered to be thought disorders or mood disorders.

Thought disorders may include, but are not limited to, schizophrenia and schizoaffective disorders:

- **Schizophrenia**: a group of mental disorders involving disturbances of thinking, mood, and behavior; may be an altered view of reality, may include delusions and hallucinations. Mood changes include strange emotional responses and inability to relate to others. Withdrawn, childlike, and bizarre behavior may be noted. Schizophrenia is a chronic disorder of both thought and mood. It interferes with the person's ability to maintain interpersonal relationships and to function in daily life. Antipsychotic medications are used to help control the distressing signs and symptoms

suffered by an individual who has schizophrenia.

- **Schizoaffective disorder**: combines major depressive episodes and manic episodes with concurrent symptoms of schizophrenia.

Mood disorders are a category of mental health problems that includes a disturbance in mood, usually deep sadness or indifference, excitement, or irritability. These include bipolar disorder (previously called manic-depressive disorder) and major depressive disorder. Mood stabilizers are primarily used to treat bipolar disorder and to stabilize mood in other conditions. Antidepressants are used to treat major depressive disorders and severe depression in other conditions.

- **Major depression**: depressed mood with diminished interest or pleasure, often with agitation, loss of concentration, insomnia or hypersomnia, fatigue, feelings of worthlessness.

- **Manic episode**: a distinct period of abnormally and persistently elevated, expansive, or irritable mood, generally with decreased need for sleep, pressured speech, flights of ideas, distractibility, excessive involvement in pleasurable activities.

- **Bipolar disorder**: cycling between depressive episodes and manic episodes.

B. Psychotherapeutic Medication

The term "psychotherapeutic medication" refers to all medications used to treat brain disorders that result in primary disturbances in mental function. Depending on the effect of the drug, treatment medications may be lumped into various groups:

- Antipsychotics
- Antidepressants
- Mood stabilizers
- Hypnotics
- Anti-anxiety medications

Properly used, psychotherapeutic medications can cause rapid and significant improvement in the way the person feels and acts. However, psychotherapeutic

medications can have negative effects. The doctor must explain the likely benefits, serious negative reactions, temporary and permanent side effects, and risk associated with each proposed psychotherapeutic medication to the person, and to any substitute decision maker when the individual is incompetent to make his or her own treatment decisions.

The practice of prescribing psychotherapeutic medications has undergone significant changes since they were first discovered in the early 1950s. From a single medication, there are now many available medications for treating the various psychiatric conditions. Any physician and any psychiatrist can prescribe psychotherapeutic medications. An advanced registered nurse practitioner (ARNP) or a physician assistant (PA) may also be able to prescribe under the supervision of a physician. There have been many powerful advances made in the pharmacological treatment of bodily illnesses and diseases, including the treatment of mental illnesses. Medication advances have helped many persons with severe mental illnesses to leave institutions and to progress toward recovery and productive lives.

C. Allergies and Side Effects

1. Generally

Allergies are the body's reaction to what it regards as "foreign" stimuli (allergen) that cause reaction. Histamine release is at the root of many unpleasant body events in such an allergic reaction. A few of these are listed below:

- Runny nose and watery eyes. This is the classic hay fever. The histamine release in the nose and eye tissues can be triggered by allergen particles in the air that come into contact with the nasal passages and eyes.

- Skin rashes. Rashes can affect a small or large percentage of the body. Poison ivy oil, for example, causes histamine to be released. In response, blood vessels dilate, fluid is released, and a rash or swelling forms.

- Gastrointestinal disturbances. Although an allergic reaction such as hives or swelling of the lips may occur after consuming something, GI symptoms usually are not allergic reactions. Medication reactions can be widespread and systemic. GI symptoms are usually a side effect, a result of the action of serotonin change in the gut or in the brain (nausea).

- Breathing difficulties. This is the most serious reaction. The histamine

release causes inflammation of the airways, which creates difficulty in breathing. The inflammation can be severe enough to totally close the airways. At this point the allergic reaction is truly life threatening.

It is possible to have any or all of these reactions to a medication. It is important to clarify the difference between these allergic reactions and side effects. Most symptoms that a person may describe as allergic reactions are often known side effects. Most individuals are relieved to know the reaction is not a rare, deadly, allergic response and that it is expected and treatable. An informed, reassured person tolerates known side effects better and is more compliant. Depending on the medication, a side effect may occur only a certain percentage of time (e.g., 5% vs. 20% is an important distinction).

If a medication appears to have caused an intolerable side effect, the doctor must decide whether it is a side effect or an allergic reaction. A history of an allergic reaction might eliminate a whole class of medications for possible use in the individual. However, a serious side effect may eliminate only the specific offending drug from consideration.

2. Antipsychotic Medications

There are older antipsychotic medications and newer classes of antipsychotic medications; the latter are referred to as "atypicals." Common side effects of antipsychotics include:

- Drowsiness and slowing, or activation and restlessness. The medication might prevent a person from being totally alert. These side effects do not always happen, and they usually lessen with time.

- Weight gain.

- Alteration in body temperature. The neuroleptic drugs can upset the temperature-regulating center in the brain. A person who is taking a neuroleptic may lose the ability to sweat, even to the point of heat stroke. Some people, especially the elderly, are more at risk for hypothermia, or lowered body temperature.

- Abnormal involuntary movements. The person feels a compelling need to be in constant movement. The person cannot sit still and may pace, squirm, shuffle in place, tap the feet, drum the fingers, and more. The affected person may talk about an "antsy" feeling of restless. These might be diagnosed as:

  - Akathesia.
  - Parkinsonism. This may include body tremors, slowed movements, and postural changes. These go away when the medication is changed or the dosage is reduced.
  - Rigidity.
  - Dystonias (a state of abnormal tonicity or prolonged tonic contractions). Dystonia can be frightening and very painful. Every muscle in a leg, for instance, may suddenly knot into hard cramps. Dystonia may also cause a person's tongue to stick out or make the eyes move rapidly. The person is helpless to stop the muscle actions.

- Blurred vision. This is generally a temporary side effect. Follow-up is recommended. For people with narrow angle glaucoma, caution is recommended.
- Dry mouth or drooling. These conditions are uncomfortable but manageable. Many medications used for relieving mental illness have these side effects.
- Changes in blood pressure; for example, orthostatic hypotension, a neuroleptic side effect, felt as being dizzy or faint when standing up. Falling in a faint is rare. Normally, when someone stands or gets out of bed in the morning, a reflex vasoconstriction occurs to maintain blood pressure. Neuroleptics may slow this reflex for a person.
- Constipation. This condition is uncomfortable but manageable. Many medications used for relieving mental illness have this side effect.
- Urinary retention or hesitancy. The person may become quite uncomfortable with a full bladder.
- Sexual dysfunction. This side effect is the most frequent reason given for no longer taking helpful medication. The doctor may try to eliminate the effect by lowering the dose or changing medications.
- Sensitivity to sunlight. Thorazine is known to cause this, but it can also happen with other antipsychotics. Some persons become much more sensitive to the sun. Persons with this side effect may feel the skin burning before the severe sunburn can be seen.

Some adverse reactions possible from antipsychotics include:

- **Tardive dyskinesia (TD):** a movement disorder where there are uncontrolled facial movements and sometimes jerking or twisting movements of other body parts. This condition may develop after several years of taking antipsychotic medications. It occurs mostly in older adults. The risk of developing TD is about 5% per year for people taking "conventional" antipsychotics; e.g., four years of use would entail an approximately 20% risk. For the "atypical" antipsychotics, the risk is estimated to be 0.5% total, not per year. TD can be treated but not cured.

- **Neuroleptic Malignant Syndrome (NMS):** a rare but very serious side effect. Signs to watch for are muscle stiffness that occurs over one to three days, a high fever, and confusion. If these symptoms occur, medical help must be sought immediately.

3. Medications for Mood Disorders

For depression: Antidepressants are used in the treatment of depression, as well as other psychiatric disorders. There are four major classes of antidepressants: selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs), and newer antidepressant medications. Possible side effects are as follows:

- **Selective serotonin reuptake inhibitors (SSRIs)**, such as Prozac, Zoloft, Paxil, Celexa, Lexapro, and others. Side effects of SSRIs may include anxiety or nervousness, nausea and diarrhea, headache, insomnia, rash, slight weight loss, and decrease in sexual ability or desire.

- **Tricyclic antidepressants (TCAs)**, such as Pamelor, Nopramin, Tofranil, Elavil, and Anafranil, are older medications and are not used as much unless in low doses for sleep or pain control, because of the potential for death. At full doses, a person needs only a week's worth of medication to die by an intentional overdose. Also, because of interactions with some medications, a person can develop cardiac arrhythmias. TCAs may have side effects including:

    - Sedation or activation/insomnia (because of possible activation, there can be a temporary feeling of more anxiousness).

    - Weight gain or weight loss.

- Excessive sweating.
- Seizures – fairly rare; mostly the TCAs or bupropion.
- Headache.
- Blurred vision, worsening of narrow-angle glaucoma.
- Dry mouth.
- Cardiovascular effects, which may include hypertension or hypotension depending on the medication. Increased heart rate is possible, but it is usually benign.
- Gastrointestinal issues: nausea; diarrhea or constipation; decreased or increased appetite.
- Urinary retention.
- Sexual dysfunction, including decreased desire or arousal.

- **Monoamine Oxidase Inhibitors (MAOIs)**, such as Parnate, Nardil, and others, may cause side effects that include:
  - Dizziness, rapid heartbeat, loss of sexual interest, and food interaction.
  - Orthostatic hypotension.
  - Dangerous interaction with food/drink/other medications. MAOIs react with certain foods and alcoholic beverages, and some medications, to produce a severe reaction which often does not appear for several hours after taking the medication. This may include a dangerous rise in blood pressure, as well as headache, nausea, vomiting, rapid heartbeat, possible confusion, psychotic symptoms, seizures, stroke, and coma. Dietary restrictions may be necessary. Foods that may be fatal include ripened cheeses, fermented sausages, soy sauce, anchovies, pickled herring, broad beans, and red wine. Hypertensive crisis (heart rate increases and blood vessels constrict, producing a dramatically high blood pressure) can occur when MAOIs are taken with certain foods or drugs. This can be life threatening and is the major reason why MAOIs are not used more often. The person must be alert to these drug and food interactions. MAOI treatment should be re-evaluated as an option if the person is unable to follow the necessary diet.

- **Newer antidepressant medications**, such as Effexor, Cymbalta, Wellbutrin, Serzone, and Desyrel, are now in common use.

For bipolar disorder: Mood stabilizers — such as lithium, some anticonvulsant medications, and some antipsychotic medications — are used primarily to treat bipolar disorders and to stabilize mood in other conditions. Side effects of lithium may include:

- Nausea, stomach cramps, diarrhea, mild hand tremor, muscle weakness, dry mouth, thirst, frequent urination, trouble concentrating, acne, and lethargy. These are common but usually disappear after the person's body becomes accustomed to the lithium dosage.

- Hand tremors. Simultaneous treatment with some types of antidepressants can worsen this tremor. Heavy tremors may indicate lithium toxicity.

- Renal toxicity. Lithium can reduce the kidney's ability to concentrate urine in some people. It is important to monitor kidney function.

- Thyroid effects. Lithium therapy can induce hypothyroidism, causing weight gain, fatigue, low energy, and slowed mental function, which may be mistaken as being lithium side effects. Thyroid function testing and monitoring for this complication and thyroid supplementation can be added to the medication regimen.

- Cardiac effects. Many cardiac dysfunctions are possible during lithium intoxication. The main issue is to avoid toxicity. While a baseline ECG may be done, it is not usually done, because the cardiac effects occur during toxic high levels. Even a person with a normal baseline ECG can run into trouble with toxicity. These cardiac effects can be life threatening. If pre-existing cardiac disease is present, a consultation with a cardiologist is usually recommended.

- Lithium toxicity. Lithium can produce serious toxic reactions when there is too little fluid in the blood, called dehydration. "Water pills," caffeine, and alcohol deplete blood fluids. Other factors that can reduce the body's fluids and increase lithium levels are exercise with excessive sweating, fever, flu, diarrhea, vomiting, decrease in water intake, and slimming diets. A low sodium diet will increase lithium levels because the kidneys need salt to function well. During lithium therapy, the body must have enough salt and 10-12 glasses of water every day to prevent the buildup of lithium to toxic

levels. Most diuretics and NSAIDS (ibuprofen or Motrin and naproxen or Aleve, for example) have an effect on the kidneys to retain more lithium, creating toxic levels. Symptoms of lithium toxicity may include diarrhea, vomiting, nausea, slurred speech, convulsions, confusion, drowsiness, and severe trembling. The higher the level of lithium in the blood, the worse these symptoms become. The doctor should be notified immediately if these symptoms appear.

Medications can change lithium levels. Tetracycline increases lithium blood levels; many asthma aids and certain headache remedies can lower them.

4. Anti-Anxiety Medications

Benzodiazepines are widely used to treat anxiety symptoms and sleep problems in adults, and research shows some support for their use in children and youth. These medicines are subject to potential nonmedical misuse. They can contribute to excessive sedation and intoxication, especially when combined with alcohol. Side effects may include dizziness, light-headedness, drowsiness, clumsiness, unsteadiness, amnesia, forgetfulness, and slurred speech. Tolerance can occur and the initial sedation may go away. But persons in safety-sensitive positions cannot take these medications because there can still be slowed reaction times and memory can be diminished. The memory impairment can be subtle or it can be obvious. The elderly are especially prone to all the side effects and have an increased incidence of falls and memory impairment.

C. Importance of Medication Compliance

All medications have the potential of producing dramatic significant benefits for an individual. If the person does not take the medication, for whatever reason, its benefit will not be felt. Noncompliance with medication (i.e., failing to regularly follow the prescribed medication schedule necessary for the effectiveness of the medication) is the major reason for re-admissions to crisis stabilization units (CSUs) and hospitals. A person's decompensation (returning to the previous unmedicated state of illness) carries a high cost to the person in the form of psychological pain, frustration, and worst case, death. It is also costly to society in the form of increased health care expense.

Side effects are a major reason for medication noncompliance. Improved medication compliance occurs when the person is stable and feels fine while taking medications. The danger occurs when the person has been discharged from the hospital and feels that he/she is "healed" and no longer sees the need for taking the

medication.

Chronic illnesses like hypertension and diabetes, for example, require persons to take medication for the rest of their lives. Mental illness is also an illness that may require life-long medications. Fortunately, in modem society there is no longer any stigma in taking medications for chronic illnesses like diabetes. However, too many people feel differently about medications taken to treat mental illnesses. This stigma, sometimes expressed even by family members, may discourage the person from taking the needed medication. For persons needing such medications, the failure to sustain medication compliance is likely to cause repeated cycles of hospitalization with an accompanying lowering of mental abilities.

D. Electroconvulsive Therapy (ECT)

Electroconvulsive therapy (formerly known as electroshock therapy), whereby seizures are electrically induced to provide relief from psychiatric illnesses, has become a standard psychiatric treatment. The following is taken from the Mayo Clinic Electroconvulsive therapy (ECT) webpage.

ECT is used to treat:

- **Severe depression,** particularly when accompanied by detachment from reality (psychosis), a desire to commit suicide, or refusal to eat.
- **Treatment-resistant depression,** a severe depression that doesn't improve with medications or other treatments.
- **Severe mania,** a state of intense euphoria, agitation or hyperactivity that occurs as part of bipolar disorder. Other signs of mania include impaired decision making, impulsive or risky behavior, substance abuse, and psychosis.
- **Catatonia,** characterized by lack of movement, fast or strange movements, lack of speech, and other symptoms. It's associated with schizophrenia and some other psychiatric disorders. In some cases, catatonia is caused by a medical illness.
- **Agitation and aggression in people with dementia,** which can be difficult to treat and negatively affect quality of life.

ECT may be a good treatment option when medications aren't tolerated or other forms of therapy haven't worked. In some cases ECT is used:

- During pregnancy, when medications can't be taken because they might harm the developing fetus
- In older adults who can't tolerate drug side effects
- In people who prefer ECT treatments over taking medications
- When ECT has been successful in the past

Although ECT is generally safe, risks and side effects may include:

- **Confusion**. Immediately after an ECT treatment, you may experience a period of confusion that can last from a few minutes to several hours. You may not know where you are or why you're there. You may be able to return to normal activities right away, or you may need to rest for several hours after treatment. Rarely, confusion may last several days or longer. Confusion is generally more noticeable in older adults.
- **Memory loss.** ECT can affect memory in several ways. You may have trouble remembering events that occurred before treatment began, a condition known as retrograde amnesia. It may be hard to remember things in the weeks or months leading up to treatment, although some people do have problems with memories from previous years as well. You may also have trouble recalling events that occurred during the weeks of your treatment. And some people have trouble with memory of events that occur even after ECT has stopped. These memory problems usually improve within a couple of months.
- **Physical side effects**. On the days you have an ECT treatment, you may experience nausea, vomiting, headache, jaw pain, muscle ache or muscle spasms. These generally can be treated with medications.
- **Medical complications**. As with any type of medical procedure, especially one that involves anesthesia, there are risks of medical complications. During ECT, heart rate and blood pressure increase, and in rare cases, that can lead to serious heart problems. If you have heart problems, ECT may be more risky.

VII. Adult Mental Health System of Services and Support

The following is taken from the DCF webpages.

The kinds and amounts of publicly funded mental health services

available in an area are limited by the amount of funding available in that area. The following list shows the kinds of services that can be provided to people who meet the adult mental health priority population criteria.

Florida's service array can be put into the three broad categories: treatment, rehabilitation, and support services. However, many of the services identified in any one of the three categories could also be identified in one or more of the others. Assertive Community Treatment and Comprehensive Community Service Teams are two examples of services falling into more than one broad category.

- Treatment
- Rehabilitation
- Support

TREATMENT

Treatment is a systematic approach to relieving the primary symptoms and life results of mental illnesses. Treatment is intended to lessen and remove the symptoms of mental illnesses, prevent later reoccurrence or worsening of symptoms, and help individuals cope with symptoms when medications and other treatments are only partially successful. Treatment typically contains four elements:

- Medications;
- Individual therapy
- Crisis intervention; and when necessary
- Psychiatric hospitalization.

Florida considers the following services as treatment options:

Florida Assertive Community Treatment (FACT)
Florida Assertive Community Treatment Team (FACT) services are available on a statewide basis and are modeled after the original Programs of Assertive Community Treatment (PACT) in Madison, Wisconsin. There are 31 FACT teams across the state. Each team is staffed with a program psychiatrist, peer specialist, and team leader, with a total staffing of 12.3 Full Time Equivalents (FTEs). Each team has an independent advisory committee to assist the team develop resources in its community. FACT is unique in Florida - at present it

is the only service available that offers a housing, medication, and flexible funding subsidy to enrolled individuals. Each team is mandated to serve no more than 100 individuals. FACT guidelines have recently been revised so that enhancement funds can be used for an expanded variety of services and supports. FACT is not a self-directed program, and participants do not receive fixed budget amounts for discretionary use. Clinical services are provided entirely within the FACT Team - that's what makes it unique. However, an expansion of acceptable uses for enhancement funds will provide participants greater opportunities for articulating and achieving their individualized recovery goals.

Assessment
These services assess, evaluate, and provide assistance to individuals and families to determine level of care, motivation, and the need for services and supports. Assessment also assists individuals and families in identifying their strengths.

Integrated Treatment for Individuals with Co-occurring Disorders
Florida understands that many adults in our priority populations have both a mental illness and substance use disorder. A good assessment and treatment for both at the same time is required so that people can get better. Making sure contracted providers in the public mental health and substance abuse systems can do a thorough assessment and provide or arrange for needed treatment is a current priority for the state.

Crisis Support / Emergency
These are outpatient services generally available twenty-four hours per day, seven days per week, or some other specific time period, to intervene in a crisis or provide emergency care.

Crisis Stabilization Unit (CSU)
This is an emergency care intervention, available twenty-four hours per day, seven days per week. People can go to a CSU, or be brought there by police, friends or relatives. They are assessed and may be admitted voluntarily or against their wishes until the mental health emergency is over.

Health Services (see also Medical Services, which follows later in this section)

Florida's publicly-funded community mental health system does not directly purchase other types of health services. However, as part of the assessment process, case managers pursue needed health care (e.g., medical services other than psychiatric; dental care; eye care / glasses) by using resources available in the community. These efforts could include referrals to local physicians who accept Medicaid, county public health units, or physicians who provide free service time. The issues are varied and can range from routine vaccinations to treatment for diabetes or other life-threatening illnesses.

In-Home And On-Site Services
These are therapeutic services and supports rendered in non-mental health provider settings, such as in nursing homes, assisted living facilities (ALFs), residences, schools, detention centers, commitment settings, foster homes, and other community settings.

Inpatient Services
Inpatient services are services provided in hospitals licensed under Chapter 395, F.S., as general hospitals and psychiatric specialty hospitals. They are designed to provide intensive treatment to persons exhibiting violent behaviors, suicidal behaviors and other severe disturbances due to substance abuse or mental illness.

Intervention - Individual or Group
These services focus on reducing risk factors generally associated with the progression of substance abuse and mental health problems. Intervention is accomplished through early identification of persons at risk, performing basic individual assessments, and providing supportive services that emphasize short-term counseling and referral. These services are targeted toward individuals and families.

Medical and Dental Services
Medical services provide primary medical care, therapy, and medication administration. This includes a psychiatric mental status assessment, and the administration of psychiatric medications. For adults, medical services are usually provided on a regular schedule with arrangements for non-scheduled visits during times of increased stress or crisis.

Case managers also make an assessment of the need for medical and dental services (see also Health Services in this section, above), and

referrals are made to physicians or dentists in the community who accept Medicaid. People who do not have Medicaid are referred to whatever medical or dental services are available locally. These resources may include Regional Workforce Board One-Stop Centers and public health departments, medical societies, individual physicians, and hospitals. The Department pays for medical and dental care for individuals living in state mental health residential treatment facilities.

Outpatient-Individual and Group
This cost center provides a therapeutic environment that is designed to improve the functioning or prevent further deterioration of persons with mental health and/or substance abuse problems. Outpatient services are usually provided on a regularly scheduled basis by appointment, with arrangements made for non-scheduled visits during times of increased stress or crisis.

Residential Level 1
These are licensed services that provide structured, live-in, non-hospital settings with 24-hour supervision daily. There is a nurse on duty in these facilities at all times. For adult mental health, these services include two different kinds of programs: group homes and short-term residential treatment services. Group homes are for residents who may require longer lengths of stay. These facilities offer nursing supervision provided by, at a minimum, licensed practical nurses, 24 hours a day, seven days per week.

Residential Level 2
These are licensed, structured rehabilitation-oriented group facilities that have 24-hour a day, seven days per week supervision. Level 2 facilities are for persons who have significant deficits in independent living skills and need extensive support and supervision.

Short-term Residential Treatment (SRT)
These individualized, acute, and immediately sub-acute care services provide intensive mental health residential and rehabilitative services 24 hours a day, seven days per week. These services must meet the needs of individuals who are experiencing an acute or immediately sub-acute crisis and who, in the absence of a suitable alternative, would require hospitalization. SRT services provide intensive residential treatment for individuals in need of acute care for up to 120

days.

REHABILITATION

Rehabilitation is the process of helping individuals minimize the effects of mental illnesses on major role skills and develop greater competencies in employment, activities of daily living, social performance. They promote recovery.

Florida considers the following services as rehabilitation options:

Aftercare services
These services include but are not limited to relapse prevention, and are a vital part of recovery in every service level. Aftercare activities include customer participation in daily activity functions that were adversely affected by mental illness and/or substance abuse impairments. New directional goals such as vocational education or rebuilding relationships are often priorities. Relapse prevention education is essential in assisting the customer's recognition of triggers and warning signs of regression. Aftercare services help families and pro-social support systems reinforce a healthy living environment.

Comprehensive Community Service Team - Individual or Group
Comprehensive Community Service Team (CCST) services render assistance in identifying goals and making choices to promote resiliency and facilitate recovery for adults and children with mental illnesses. The services take place in either an outpatient or community setting. For individuals with mental health problems, recovery is the personal process of overcoming the negative impact of psychiatric illness despite its continued presence. CCST services are intended to restore the individual's function and participation in the community. The services are designed to assist and guide individuals in reconnecting with society and rebuilding skills in identified roles in their environment. The focus is on the individuals' strengths and resources as well as their readiness and phase of recovery. A team approach of services will be used to guide and support the adults and children served with development of a recovery plan focusing on the areas of individual and family living, learning, working, and socialization activities. Any therapy is brief and oriented toward skill building. Services provided include Assessment, Case Management, Intensive Case Management, Supported Housing, Aftercare, Supported Employment, Outreach, Outpatient, In-home/On-site,

Intervention, Information and Referral, Prevention, Prevention/Intervention and other transition and non-traditional support services as negotiated by the Department and the provider.

Day-night Services
These services provide a structured schedule of non-residential services for three (when Medicaid funded) or four or more consecutive hours per day. This may include delivery of services during evening hours. Activities for children and adult mental health programs are designed to assist individuals to attain the skills and behaviors needed to function successfully in the living, learning, work, and social environments of their community. Generally, a person receives three or more services a week. Activities for substance abuse programs emphasize rehabilitation, treatment, and education services, using multidisciplinary teams to provide integrated programs of academic, therapeutic, and family services.

Educational Services
Educational activities are provided in a variety of service settings. These include providing educational assessments; day treatment; case management; drop-in, self-help centers; and the Florida Assertive Community Treatment Team (FACT) program's specific educational service entitled Education, Support and Consultation to Family, and Other Major Supports. With the exception of the FACT-specific service for education, most educational services may be provided on-site of providers, with instructors funded through local school boards.

Florida Self-Directed Care
Florida Self-Directed Care is available in two parts of the state - the Jacksonville area and Southwest Florida. People eligible for public mental health services are given a budget and can choose the services and supports they want to buy, and from whom they will buy them. Their purchases have to be linked to a personal recovery plan, and some of the services have to be clinical. This program has served as a national model for similar efforts in other states.

Supportive Housing
Supported housing/living services are designed to help people with substance abuse or psychiatric disabilities find and keep living arrangements of their choice. They also provide services and supports to ensure continued successful living in the community. The goal of Supportive Housing is to

ensure that everyone has the opportunity to live as independently as possible.

Supportive Employment
Supported Employment programs help people get or get back to productive employment. These services are community-based and take place in an integrated work setting, which provides regular contact with non-disabled co-workers or the public. A job coach provides long-term ongoing support as needed to give an individual every opportunity to maintain employment.

Mental Health Clubhouse
Clubhouses are structured, community-based interventions where members can strengthen and/or regain interpersonal skills, get psycho-social therapy toward rehabilitation, develop the environmental supports necessary to thrive in the community, meet employment and other life goals, and recover from the bad effects of a mental illness. Services are typically provided in a community-based program with trained staff and members working as teams to address the person's life goals and to perform the tasks necessary for the operations of the program. Clubhouses use a holistic approach focusing on a person's strengths and abilities while challenging that individual to pursue chosen life goals. Florida is invested in the International Center for Clubhouse Development (ICCD) model. Though there are other programs promoting employment across the system, Florida strongly encourages the ICCD approach and certification.

Residential Level 3
These are licensed facilities, structured to provide 24-hour a day, seven days per week supervised residential alternatives to persons who have developed a moderate functional capacity for independent living. For adults with serious mental illnesses, these are supervised apartments.

SUPPORT

Support is practical, hands-on assistance to help people handle the necessities of daily living and assist them in their recovery process.

Florida considers the following services as support options:

Case Management

Case managers help people identify their needs, plan their services, link them to the service system, coordinate the various system components, monitor service delivery, and evaluate the effect of the services received.

Intensive Case Management
Same as above. Intensive case management is typically offered to persons who are being discharged from a state mental health treatment facility or crisis stabilization unit and in need of more support. They may also have more needs for things like rental or regular transportation assistance to help them live in the community.

Day Care Services
Day care services provide a structured schedule of activities for four hours or more consecutive hours per day for children of persons who are participating in a substance abuse or mental health day-night service or residential service.

Drop-In / Self-Help Centers
These centers are intended to provide a range of opportunities for persons with serious and persistent mental illnesses to independently develop, operate, and participate in social, recreational, and networking activities. Many are operated by consumers of mental health services.

Incidental Expenses
These may include the cost of medications that can't be paid for any other way, as well as things like clothing, medical care, educational needs, housing subsidies, or one-time expenses like the cost of turning on utilities for a new place to live.

Information and Referral
Provides information about resources in the community and agencies/organizations that offer assistance; links people who need assistance with people who can provide it.

Prevention
Prevention services involve strategies that avoid or put off the development of substance abuse and mental health problems. They include increasing public awareness through information, education, and alternative-focused activities.

Residential Level 4

The facility may have less than 24 hours a day, seven days per week on-premise supervision. This is the least intensive level of residential care and is primarily a support service. For adults with serious mental illnesses, this includes satellite apartments, satellite group homes, and therapeutic foster homes.

Respite Services
Respite service is an organized program designed to sustain the family or other primary care-giver by providing time-limited, temporary relief from the ongoing responsibility of care giving.

Room and Board with Supervision Levels 1-3
This pays room and board costs for people living in Medicaid-funded residential programs. Medicaid pays for the clinical services, and the SAMH program pays for the rest.

VIII. Children's Mental Health System of Services and Support

The following is taken from the DCF webpages.

> The [DCF] Children's Mental Health Program is a coordinated network of community-based services and supports that is youth-guided and family-driven to produce individualized, evidence-based, culturally and linguistically competent outcomes that improve the lives of children and their families.
>
> This program provides funding for in-home and community based outpatient services, crisis services and residential treatment (including psychiatric residential treatment facilities, Therapeutic Foster Care, and Therapeutic Group Homes provided through joint Medicaid and Mental Health Program contracts with behavioral health managed entities and providers).
>
> The program also provides coordination and management of the Juvenile Incompetent to Proceed (JITP) program. The system requires that services are individualized, culturally competent, integrated, and coordinated. The aim is to provide a smooth transition from children's mental health to the adult mental health system for continued age-appropriate services and supports. These services are designed to build resilience and to prevent the severity, duration and disabling aspects of children's mental and emotional disorders.

Services in the Children's Mental Health Program

Service Planning and Coordination - Multi-disciplinary planning teams, often called Family Service Planning Teams are family-focused and community-based, and serve as a focus for identifying supports and service planning for the family.

Residential Treatment – In some cases, residential treatment may be necessary for some children. . . . Section 394.4781, Florida Statutes, authorizes the Department to pay a portion of the costs associated with residential care for children who have been diagnosed with severe emotional disturbance, who are recommended to need a residential level of mental health treatment by a Florida licensed psychologist or psychiatrist, and who are not eligible for public or private insurance.

The Department has very limited state General Revenue funds to purchase residential mental health treatment for children who qualify and is required to review applications monthly to approve or disapprove each application in accordance with:

- The severity of the problems of the child
- The financial means of the family
- The availability of the needed residential care
- Available funds

Each DCF region has a procedure for reviewing applications for residential mental health treatment and determining whether placement in such a setting is the least restrictive, most beneficial treatment alternative for the child. Many children, even those with severe conditions, can be more effectively served in the community with a specially designed program of "wraparound" services for the child and family.

The goal of mental health treatment is to assist the child to live successfully in their community and with their families. Therefore, the placement of a child into residential mental health treatment should be made only after careful consideration is given to less restrictive treatment alternatives. Regions use a staffing process involving the child and parents or other caregivers and a multiagency group of professionals to consider the strengths and needs of the child and

family and developed a service plan to enable the child either to remain at home or to return home from the treatment setting as soon as possible. Only if the needed services cannot be provided in a less restrictive environment is placement in a residential mental health treatment program considered.

If residential treatment is approved by the [DCF] regional office, it must then be determined if funding is available to place the child. All available sources of funds are explored, including insurance (public and private) and cost-sharing with the family, the local school district, and other programs involved with the child, such as child welfare and juvenile justice.

Family Inclusion - Florida's Children's Mental Health program is fully committed to the value of family involvement. We strongly believe that families must be included in all decisions regarding the planning and provision of mental health services for their children. It is the responsibility of all who work within the system of care to make every effort to assure families have a strong voice and are actively involved in the decisions being made that impact their child and family.

Additionally, we are equally committed to including families in policy-making. Since families have personal experience with the service delivery system, they provide a reality base for policymakers, a fresh perspective on how the system of care is serving their children, and ideas for improving services. . . .

Medicaid Eligibility

Medicaid - Children may be eligible for Medicaid. Medicaid-covered services can be provided only to Medicaid-eligible children, only by Medicaid-enrolled providers. . . .

Juvenile Incompetent to Proceed Program

JITP - Florida's Juvenile Incompetent to Proceed (JITP) Program provides competency restoration services to juveniles who have been charged with a felony prior to their 18th birthday and do not have the ability to participate in legal proceedings due to their mental illness, [intellectual disability], or autism.

IX. Glossary of Common Definitions, Acronyms, and Abbreviations

Acute: sudden and/or severe

Advance directive: a witnessed written document described in section 765.101(1), Florida Statutes

Adverse reaction: sudden physical or mental crisis as a reaction to a medication

Agent: medication, drug

AHCA: Agency for Health Care Administration

Akathesia: inability to sit still, urgent need for movement to relieve anxiety

Anticonvulsant: medication to prevent or lessen seizures

Assessment: "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." Fla. Admin. Code Rule 65E-5.100(2).

BA-8: order for involuntary inpatient placement – recommended (short for form CF-MH form 3008)

BA-32: petition for involuntary inpatient placement – recommended (short for form CF-MH 3032)

BA-52A: initiation form used by law enforcement for involuntary examination – mandatory (short for form CF-MH 3052a)

BA-52B: initiation form used by authorized mental health professionals for involuntary examinations – mandatory (short for form CF-MH 3052b)

Baker Act: Florida's Mental Health Act; chapter 394, part I, Florida Statutes

Behavioral Therapy: talk therapy directed at changing thinking habits (like

rational emotive therapy)

Chronic: constant condition, or always returning

Compliance: taking medication exactly as planned

Continued involuntary placement: involuntary placement that is subsequent to the original involuntary placement hearing and order

Court: unless otherwise specified, the circuit court

Crisis: a peak in an illness

Decanoate: long duration medication injected into muscle

Decompensation: returning to the previous unmedicated state of illness

Delusion: a firmly held belief, not shared by other people, and not changed by logic

Depression: mood condition of uncontrollable sadness, worry, slowed motion

Disassociate: to become separated from reality

Discharge plan: "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." Fla. Admin. Code Rule 65E-5.100(4).

Disorder: permanent medical problem (like diabetes or mania)

Dosage: how much medication is taken at a time

DSM: Diagnostic and Statistical Manual

Dysfunction: low or missing ability

Dystonia: muscle stiffness, a painful side effect

ECT: electroconvulsive therapy

ED: emergency department or emergency room

Edema: swelling due to fluid retention

Efficacy: how well a treatment works for a person

Emergency medical condition (EMC): a medical condition with acute symptoms sufficiently severe that without immediate medical attention the condition could result in serious harm to patient health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part (defined in section 395.002(8), Florida Statutes).

Emergency treatment order (ETO): "a written emergency order for psychotropic medications . . . or a written emergency order for seclusion or restraint." Fla. Admin. Code Rule 65E-5.100(5).

Episode: event; usually one in a series

EPS: extrapyramidal symptoms; a side effect of medication formulation: the combination of chemicals in a particular medication (see generic)

Examination: "the integration of the physical examination 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 nonpsychiatric medical causes such as disease, infection, injury, toxicity, or metabolic disturbances. Examination includes the identification of person-specific risk factors for treatment such as elevated blood pressure, organ dysfunction, substance abuse, or trauma." Fla. Admin. Code Rule 65E-5.100(6)."

Express and 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." § 394.455(15), Fla. Stat.

F/U: follow up

Generic: medication made by other companies; may vary in strength compared to "brand"

Hallucination: hearing, seeing, touching, smelling or tasting unreal input

Health care proxy: "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." Fla. Admin. Code Rule 65E-5.100(7).

Health care surrogate: "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." Fla. Admin. Code Rule 65E-5.100(8).

Hematological: blood tests

Hypnotic: very calming

Hypothermia: body temperature drops below normal

ICD: International Classification of Diseases

IM: intramuscular injection of a medication

Incompetent to consent to treatment: "a state in which a person's judgment is so affected by a mental illness or a substance abuse impairment that he or she person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical, mental health, or substance abuse treatment." § 394.455(21), Fla. Stat.

Interaction: one agent may change the way another one works

Involuntary examination: an examination performed under section. 394.463, Florida Statutes, to determine if an individual qualifies for involuntary inpatient treatment under section 394.467(1) or involuntary outpatient services under section 394.4655(2). § 394.455(34), Fla. Stat.

Involuntary placement: either involuntary outpatient services pursuant to section 394.4655, Florida Statutes, or involuntary inpatient treatment pursuant to section 394.467

IOP or AOT: involuntary outpatient treatment or assisted outpatient treatment, which are synonymous; the former is used in Florida.

Lethargy: feeling of great tiredness

Maintenance dosing: dosing to prevent the person from having an acute episode of the disorder

Malaise: tiredness, vague feeling of illness

Mania: mood condition of uncontrollable physical or mental activity

Marchman Act: Florida's substance abuse impairment law; chapter 397, Florida Statutes. A Baker Act & Marchman Act Comparison document is available on the DCF website.

Medication regimen: overall medications, including kinds and amounts of each drug

Mental illness: "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."
§ 394.455(28), Fla. Stat.

Monitoring: watching and recording event

Mood: emotional state

Neuroleptic: a drug designed to treat an illness by calming the brain

NMS: Neuroleptic Malignant Syndrome, a rare and dangerous physical reaction to a psychotherapeutic medication

Noncompliance: inability or refusal to take treatment as prescribed

NOS: not otherwise specified

Obsession: unshakable focus on an idea, emotion or action (like jealousy)

Obsessive compulsive disorder (OCD): brain disruption causing repetitive ritual actions to relieve feelings of anxiety

Oculogyric: eyes are constantly moving

Orthostatic hypotension: sudden drop in blood pressure

Paranoia: unbreakable, rigid belief of being persecuted

Polydipsia: drinking too much fluid, from being constantly thirsty

Polypharmacy: use of two or more medications for the same problem at the same time

PRN: pro re nata; take when needed. "[A]n individualized order for the care of an individual person which is written after the person has been seen by the practitioner. . . . A PRN order shall not be used as an emergency treatment order." Fla. Admin. Code Rule 65E-5.100(11).

Psychomotor: movements caused by brain activity, not conscious will

Psychosis: loss of contact with reality, with delusions and hallucinations

Psychotherapeutic medications: medications used to alter abnormal thinking, feelings, or behavior

Psychotherapy: method of treating mental disorders by discussion and interaction

Receiving facility: a facility designated by DCF to receive and hold individuals involuntarily under emergency conditions or for psychiatric evaluation and provide short-term treatment; does not include county jails

Rehabilitation: bringing a person back to normal skills

SAMH: substance abuse and mental health program of DCF

Schizophrenia: a group of mental disorders involving disturbances of thinking, mood and behavior; may be an altered view of reality, may include delusions and hallucinations. Mood changes include strange emotional responses and inability to relate to others. Withdrawn, childlike, and bizarre behavior may be noted.

Service provider: "a receiving facility, a facility licensed under chapter 397, a treatment facility, an entity under contract with the department to provide mental health or substance abuse services, a community mental health center or clinic, a psychologist, a clinical social worker, a marriage and family therapist, a mental health counselor, a physician, a psychiatrist, an advanced registered nurse practitioner, a psychiatric nurse, or a qualified professional as defined in s. 39.01." § 394.455(44), Fla. Stat.

Side effect: not part of the desired medical effect

Sign: visible evidence of illness, such as a fever or hearing non-existent voices

Standing order: "a broad protocol or delegation of medical authority that is

generally applicable to a group of persons, hence not individualized." Fla. Admin. Code Rule 65E-5.100(16).

Stat: emergency, act at once! (abbreviation of Latin "*statim*," meaning immediately)

Substance abuse impairment: "a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance in such a manner that a person has lost the power of self-control and has inflicted or is likely to inflict physical harm on himself, herself, or another." § 394.455(44), Fla. Stat.

Symptom: the person's description of physical or mental illness; "the person is complaining that . . . ."

Syndrome: a group of certain signs and symptoms that indicates a particular diagnosis

Tardive dyskinesia: temporary to permanent side effect of neuroleptic medications; involuntary tongue, eye, lip movement progressing to twisted body posture

Titration: in medicine, a gradual increase

Tolerance: becoming used to an unpleasant situation

Tonic: muscles are tightened up, not relaxed

Transfer evaluation: the process by which a person who is being considered for placement in a state treatment facility is evaluated for appropriateness of admission to the facility. § 394.455(46), Fla. Stat. A civil patient may 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 must receive and consider the information documented in the transfer evaluation.

Treatment facility: "a state-owned, state-operated, or state-supported hospital, center, or clinic designated by [DCF] for extended treatment and hospitalization, beyond that provided for by a receiving facility, of persons with a mental illness." § 394.455(32), Fla. Stat. It includes a private facility designated by DCF when rendering those services to a person pursuant to the Baker Act.

Triage center: "a facility that has medical, mental health, and substance abuse professionals present or on call to provide emergency screening and evaluation for

mental health or substance abuse disorders for individuals transported to the center by a law enforcement officer." § 394.455(48), Fla. Stat.

Chapter Two: Express and Informed Consent

I. Guardian Advocates and Other Substitute Decision Makers

See § 394.459(3), Fla. Stat.; Fla. Admin. Code R. 65E-5.170.

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 about 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." § 394.455(15), Fla. Stat.

A person "incompetent to consent to treatment," as defined in the Baker Act, is a person whose "judgment is so affected by a mental illness or a substance abuse impairment that he or she lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical, mental health, or substance abuse treatment." § 394.455(21), Fla. Stat.

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), 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 and 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 that may have less severe or serious side effects.
- Potential effects of stopping treatment.
- Approximate length of care.
- How treatment will be monitored.
- That notification that any consent for treatment may be revoked orally or in writing before or during the treatment period by any person legally authorized to make health care decisions on behalf of the individual.

II. Documentation of Competence to Provide Express and Informed Consent

A physician must determine whether a person being admitted to a receiving or treatment facility is competent to provide express and informed consent to 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 or refuse to provide express and informed consent for his or her own treatment.

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

or substance abuse treatment. If the person is 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 (by **Emergency Treatment Order, 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 seven-day period). *See* Fla. Admin. Code R. 65E-5.1703.

Drugs used as a restraint are medications that are used to control behavior or to restrict the person's freedom of movement and are not part of the standard treatment for the person's medical or psychiatric condition. § 394.455(41)(b), Fla. Stat. Chemical restraints are also regulated by federal conditions of participation and accrediting organizations.

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. § 394.459(3)(b), Fla. Stat. Section 458.325, Florida Statutes, 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. See Chapter One of this benchguide for more information on ECT.

III. Persons Determined Incompetent to Consent to Treatment

See § 394.4598, Fla. Stat.; Fla. Admin. Code R. 65E-5.230.

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 to consent to treatment — unable to make well-reasoned, willful, and knowing decisions about his or her medical, mental health, or substance abuse 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 statutorily required training. See the Guardian Advocate Training and Resource Manual online for extensive information about the duties of a guardian advocate. The manual can be found on the DCF website http://www.myflfamilies.com/. A specialized web-based training course for guardian advocates can be found at http://www.dcf.state.fl.us/programs/samh/mentalhealth/training/index.shtml.

IV. Persons Adjudicated Incapacitated

See § 394.4625(1)(d), Fla. Stat.

The Baker Act prohibits the voluntary admission of any person who has been adjudicated by a court as incapacitated even though the guardianship law (section 744.3725, Florida Statutes) defines specific steps the court must follow before granting a guardian the authority to do so. The First District Court of Appeal has ruled that where the Baker Act and the guardianship law conflict on least restrictive alternatives, the Baker Act prevails. *Handley v. Dennis*, 642 So. 2d 115 (Fla. 1st DCA 1994). A concurring case from the Fourth District Court of Appeal in 2012 is *Auxier v. Jerome Golden Center for Behavioral Health*, 85 So. 3d 1164 (Fla. 4th DCA 2012). A magistrate had discharged the public defender's office in a Baker Act case because the person who was the subject of the proceedings had a plenary guardian, and her rights had been transferred to her guardian and counsel for the guardian would represent her. The person was not present at the hearing on which the order was based and did not have independent counsel, and she was involuntarily committed. The public defender's office sought review of the order discharging it from representing her, and the Fourth District Court of Appeal granted it and quashed the discharge and commitment orders. It held that "the magistrate and the circuit court departed from the essential requirements of law [which] requires appointment of the public defender's office to represent the patient in involuntary civil commitment proceedings 'unless the person is otherwise represented by counsel.' The guardian's attorney represents the guardian, not the ward." The court "agree[d] with the First District's discussion of the role of the public defender in Baker Act proceedings" in *Handley v. Dennis*.

The court order adjudicating the person as incapacitated will designate who is the guardian. "Letters of guardianship shall be issued to the guardian and shall specify whether the guardianship pertains to the person, or the property, or both, of the ward. The letters must state whether the guardianship is plenary or limited, and, if limited, the letters must state the powers and duties of the guardian." § 744.345,

Fla. Stat. The guardian can only be permitted to perform those responsibilities that have been expressly removed from the ward and delegated to the guardian.

V. Persons with Health Care Surrogates/Proxies

See ch. 765, Fla. Stat.; Fla. Admin. Code R. 65E-5.230.

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 (LCSW). Significant limitations are placed on the designation of LCSWs.

If a person's capacity to make health care decisions for himself or herself 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 health care proxy is designated, the proxy should also complete an affidavit (CF-MH 123). The 2015 Legislature authorized a competent individual to designate a surrogate in an advance directive to make his/her health care decisions without the need for a determination of incapacity.

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

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

- 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.
- Authorize transfers to and from other facilities.

The 2016 Legislature added section 765.2035, Florida Statutes, permitting a natural guardian, legal custodian, or legal guardian to designate a competent adult as a health care surrogate to make health care decisions for a minor. However, a health surrogate or proxy is not permitted under the Baker Act to apply for a minor's voluntary admission to, or authorize treatment at, a Baker Act facility.

VI. Summary of Consent Issues

A person who is competent to provide express and informed consent to admission or 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 substitute decision maker.

VII. Bench Card 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 himself/herself.	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 from serving: MH professional, facility employee, creditor, person providing substantial services, or persons subject to domestic violence injunction for which patient was petitioner.	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 from serving: licensed professional, facility employee, creditor, person providing substantial services, or persons subject to domestic violence injunction for which patient was petitioner.	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 as 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.

VIII. Frequently Asked Questions

A. Competence to Consent

Who is eligible to consent or refuse consent to their own treatment?

Minors cannot make their own inpatient mental health treatment decisions; this is the responsibility of their parent or guardian. Neither can persons who have a court-appointed guardian or a health care surrogate or proxy currently making decisions for them. Only adults who are consistently able to make well-reasoned, willful, and knowing decisions about their own mental health or medical care can consent, refuse consent, or revoke consent to their own treatment.

I'm an attorney representing a hospital that isn't designated as a receiving facility. The doctor wants to admit a patient on voluntary status who has a guardian willing to consent to the admission. We are told that many other facilities permit that type of admission. A person adjudicated by a court as incapacitated wouldn't be able to provide express and informed consent. How is inpatient mental health care provided to patients who have guardians and who need treatment, but do not meet the criteria for involuntary admission?

The issue about prohibiting voluntary admission of adjudicated persons with guardians is a statutory prohibition:

- 394.4625. Voluntary admissions (emphasis added)

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

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

  (f) Within 24 hours after admission of a voluntary patient, the admitting physician shall document in the patient's clinical record that

> the patient is able to give express and informed consent for admission. If the patient is not able to give express and informed consent for admission, the facility shall either discharge the patient or transfer the patient to involuntary status pursuant to subsection (5).

The above references "facility," not "receiving facility." These are both defined in the Baker Act. A facility is defined in the Baker Act as follows:

> (16) **"Facility" means any hospital**, community facility, 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 or who have been diagnosed as having a mental illness or substance abuse impairment. The term does not include a program or an entity licensed under chapter 400 or chapter 429.

§ 394.455, Fla. Stat. (emphasis added).

While the guardianship statute (chapter 744) has a provision where a guardian can obtain extraordinary authority of the court to have his/her ward admitted voluntarily to a receiving facility, this conflicts with the provisions of the Baker Act, which is the more specific law and would take precedence.

If a person who arrives at a receiving facility for an involuntary examination is cooperative and willing to take medications, is this sufficient to document "express and informed consent"?

No. "Cooperative and willing" are helpful descriptors, but more important is competence of the person to make such decisions. This is defined in the law as being able to make well-reasoned, willful, and knowing decisions about one's medical, mental health, or substance abuse treatment. Without competence, as defined in the Baker Act, no amount of cooperation or willingness is sufficient. The standard under the Baker Act requires more than "implied consent" because the person may have taken the medications prior to admission and/or is not currently refusing the medications. "Med compliance" is a behavior, but it doesn't necessarily reflect competence.

Recently we had a question come up about a patient being able to sign legal documents brought in by the family. The patient was not deemed incompetent by our doctor, but was not here voluntarily either. Can the patient be able to sign legally binding documents while inpatient in a mental health hospital or Crisis Stabilization Unit?

It's unclear what kind of legal documents are involved. Just because a person hasn't been adjudicated incapacitated by a court doesn't mean he/she is competent for various purposes. If the patient is on voluntary or involuntary status and has been allowed to provide consent to his/her own treatment, a physician would have had to document the person's competence to provide express and informed consent on a sustained basis (not just some "window of lucidity"). This medical statement means that the person is able to make well-reasoned, willful, and knowing medical, mental health, and substance abuse treatment decisions.

If the person's clinical record has notes from nurses, social workers, or other personnel that reflect the person's judgment or insight was impaired at the time, the legitimacy of any consent would be questionable, even for treatment, not to mention other legal documents. The person could later challenge any document signed at such a time and place due to diminished capacity or perceived coercion, whether the documents are advance directives, quitclaim deeds, a will, powers of attorney, or any other legal document.

Can a person on involuntary status still be competent to consent or refuse consent to his or her own treatment?

Yes. The issue of competence to consent is considered separately from the placement issue. If the person meets the criteria for involuntary examination or involuntary placement but is capable of making well-reasoned, willful, and knowing decisions about his or her medical, mental health, or substance abuse treatment, he or she may continue to consent, withhold consent, or refuse consent to treatment. A person on involuntary status may or may not be competent to consent to his or her own treatment. If the individual who initiated the involuntary examination noted on the form that the subject person was unable to determine the exam was necessary, as opposed to refusing the exam, the person must be presumed to be incompetent to consent to treatment until determined by a physician to have such capacity.

Must we stop giving a patient psychotropic medication if the patient has been transferred to incompetent status if that person had given consent for those medications while still competent? I know we must get a guardian advocate who will then be asked to consent to psychotropic medication; we're wondering about the interim period.

If the patient had been certified by a physician while on voluntary status as competent to make well-reasoned, willful, and knowing medical and mental health decisions (required within 24 hours of all voluntary admissions) and was provided all disclosures about medications required by law and rule, that authority would be

valid only while the patient remained competent, not valid after a subsequent determination that the patient was no longer competent to consent.

Consent given by a competent adult is valid only while the person remains competent. However, if the basis for transferring the person from voluntary to involuntary status is because the person is "refusing" to stay at the facility (as opposed to being unable to determine that placement is necessary), and the doctor continues to certify the person's competence to consent or refuse consent to treatment, it is possible that the consent could still be valid. However, if the doctor has determined that the person is no longer able to provide such express and informed consent and is requesting the court to appoint a guardian advocate, earlier consents can't be honored.

It is at this point that a relative or close personal friend, if any, should be asked to serve as the person's health care proxy unless the person had previously executed an advance directive designating a different person as his/her health care surrogate. Such a proxy or surrogate could serve as an interim decision maker until the court appointed a guardian advocate, who might be the same person.

When a person is transferred from voluntary to involuntary status, the petition must be filed with the clerk of court within two working days, not 72 hours.

B. Incompetence to Consent

If a person with a mental illness refuses to consent to treatment, is that an indication of incompetence?

No. A person's refusal to consent to treatment is not, in itself, an indication of incompetence to consent. There may be many reasons why a person may decide not to consent to a particular medication or to any medication ordered by a particular physician, or to treatment ordered at a particular facility. The decision as to whether a person is competent to consent is a clinical judgment of his or her capacity to decide, not one based on whether the person does or doesn't provide such consent.

Once a patient has a petition for involuntary placement filed, but prior to the hearing, do medication orders remain emergency treatment orders or do they become regular orders once the petition is filed?

Emergency treatment orders cannot be done either before or following the filing of the BA-32 (petition for involuntary placement, form CF-MH 3032) unless the record documents imminent danger and that there are no less restrictive interventions. Only after the appointment of a guardian advocate can such

medications needed for the person's treatment be authorized/administered if the person is found by the court to be incompetent to consent. Prior to that time, short of imminent danger, only a health care surrogate/proxy can authorize medications for which the person either refuses or lacks capacity to consent.

If a person is determined by a psychiatrist NOT to have capacity to consent, is it true that he or she can't be given any psychotropic medications unless under an ETO if he or she has no one to serve as health care proxy until after a court-appointed guardian advocate has been selected?

This is correct — no psychiatric treatment can be rendered short of imminent danger without the express and informed consent of a person authorized by law to provide such consent.

Can a person be incompetent for admission and competent for treatment or be competent for admission and incompetent for treatment?

No. If a person is incompetent to provide express and informed consent, it applies to both admission and to treatment. The Baker Act definition of "express and informed consent" requires that the consent be voluntarily given in writing by a competent person. Competence requires that the person have the capacity of providing a well-reasoned, willful, and knowing decision about his or her medical, mental health, or substance abuse treatment. If the person has this capacity, he or she can choose to be voluntary (or may be involuntary) and can choose to give or withhold consent to treatment. If the person doesn't have this capacity, he or she must be held under the elevated protection of the involuntary provisions of the law and a guardian advocate must be sought.

However, if a person is competent, he or she can potentially be either voluntary or involuntary, although most people on involuntary status lack the capacity to give well-reasoned, willful, and knowing decisions about their medical, mental health, and substance abuse care (the legal definition for incompetence). In those situations, the person is incompetent to consent and must have a guardian advocate appointed.

If a person is incompetent to consent to treatment, he/she must be placed on involuntary status. Physicians and staff need to understand that no person should be allowed to consent to treatment unless he/she would also be allowed to refuse treatment. It is the capacity of the person to make the decisions — not the quality of the decisions the person makes — that controls.

Can a person who has been determined to be incapacitated/incompetent to consent to treatment refuse consent to a particular psychiatric treatment?

No. If the proposed treatment has been fully disclosed to the legally authorized substitute decision maker who has provided informed consent to the treatment, the person does not have the authority to refuse. The person does have the right to file a petition for a writ of habeas corpus so a judge can determine if the person's rights have been violated. However, if a person strongly objects to a particular form of treatment, the guardian/guardian advocate or surrogate/proxy should talk with the person to determine the reasons for the objections. If appropriate, the guardian/guardian advocate or surrogate/proxy may, based on this information, withdraw his or her consent for the proposed treatment and negotiate a revised treatment plan with the physician.

C. Disclosure

What must be disclosed to a person before authorization for treatment can be obtained?

Before giving express and informed consent for treatment, the following information must be provided and explained in plain language to the authorized decision maker:

- Reason for admission or treatment.
- Proposed treatment.
- Purpose of the treatment to be provided.
- Identification of the proposed psychotropic medication.
- Common risks, benefits, and short- and long-term side effects thereof.
- Specific dosage range for the medication.
- Frequency and method of administration.
- Any contraindications which may exist.
- Clinically significant interactive effects with other medications.
- Similar information on alternative medications that may have less severe or serious side effects.
- Alternative treatment modalities.
- Potential effects of stopping treatment.

- Approximate length of care.
- How treatment will be monitored.
- That any consent given for treatment may be revoked orally or in writing before or during the treatment period.

Does the facility have the same responsibility to a substitute decision maker as it does to a competent adult with regard to disclosure?

Yes. Prior to the administration of treatment, a qualified staff person must provide the same information to a guardian, guardian advocate, or health care surrogate/proxy as it would to a patient competent to make his/her own decisions.

D. Consent to Treatment

Does all consent need to be provided in writing, or can we accept verbal consent under certain circumstances?

While the statutory definition of express and informed consent refers to such consent being given in writing by the legally authorized decision maker, there are times when the guardian of a minor or a guardian, guardian advocate, or health care surrogate/proxy of an adult is unavailable to provide the consent in writing.

It is standard practice in medical situations when the decision maker is not present to provide the full disclosure by telephone and receive the verbal authorization for treatment by the decision maker, with two witnesses for the facility. This is followed up by a written consent. When the substitute decision maker is not physically available to provide written consent to treatment prior to administration of treatment, it may not be in the best interest of the child or adult held in a facility. In some cases, the parent may even be out of the country and it is not possible to fax or scan and email consent forms to and from the parent. If the individual presents imminent danger, an ETO can be ordered by a physician. Otherwise, treatment would have to be withheld.

I have questions about express and informed consent by non-literate persons or persons who are physically unable to write. Is this addressed in the Baker Act or by rule?

This has been handled in different ways, depending on the circumstances:

- Laws recognize an "X" if a person generally signs his/her name this way due to illiteracy. Forms may have a place for the witness to a signature to sign and date.

- Persons sometimes will give verbal authorization for treatment but won't sign the form. If the required disclosures and the authorization are witnessed by staff members, this has always been considered as an acceptable alternative. Verbal consent should be witnessed by two staff.

- The most frequent problem is when a substitute decision maker is relied on to provide consent for treatment. Guardians, guardian advocates, and health care surrogates/proxies may live at a great distance or just be unable to come to the receiving facility in a timely way to provide written consent. Again, it has always been considered acceptable to have verbal consent if such consent is witnessed by two staff who sign that they personally heard the disclosures and the consent. The facility might consider sending a form by courier, fax, or email to the substitute decision maker to sign and return, even if after the fact.

I'm a psychiatrist treating a patient admitted involuntarily for assaultive behavior. We filed a petition for placement and are awaiting a hearing next week. The patient has repeatedly said he will stop taking medications once discharged. We would like to give him a long-acting injectable medication before he is discharged. I had assumed that the court hearing would need to take place in order to establish a guardian advocate, who could then authorize the treatment. I was recently told that the court didn't need to make this determination if we could demonstrate that (1) the patient lacks decisional capacity for this treatment, and (2) there is a family member willing to serve as a proxy decision maker. Both of these criteria are met for the patient; if it is appropriate and legal, we would likely get started with the long-acting medication long before his court hearing next week. Is this appropriate?

The Baker Act recognizes a guardian advocate appointed by the court as a substitute decision maker. However, because that appointment might not occur until seven to ten days after the individual's admission, the Florida Administrative Code has "borrowed" from the state's advance directive statute (chapter 765, Florida Statutes) that governs any and all health care decision-making for an interim decision maker until a guardian advocate has been appointed pursuant to rule 65E-5.2301, Florida Administrative Code.

As soon as a physician documents that an individual cannot provide express and informed decisions for his/her own care, a health care proxy (relative or close

personal friend) can be designated by the facility to provide "substitute decision-making" — after getting full disclosure providing the decision the proxy believes the individual would have made if competent. Only if the surrogate or proxy doesn't know what the individual would have chosen if competent can a "best-interest" standard be used. This could include long-acting medications if the proxy believes the person would have consented to this type of medication or route of administration had he/she been competent. Otherwise, the only other alternative to legally authorized decision-making would be an ETO based on documentation of imminent danger. Use of long-acting medications as an ETO requires extraordinary justification. However, if it is included in the individual's treatment plan and you've obtained express and informed consent from an authorized person, such extraordinary justification wouldn't be required.

E. Initiation of Psychiatric Treatment

If a person is determined not to have the capacity to make his or her own treatment decisions and has no known family, can a facility legally administer medications until a court hearing and appointment of a guardian advocate if the person is willing to take the offered medications?

No. There is no "implied consent" for psychotropic medications. Even if a person swallows the pills or has willingly taken the medications at a point prior to the hospitalization, the law prohibits the administration of medications unless "express and informed consent" has been obtained from the person or his/her substitute decision maker. The only exception is when the physician has fully documented the nature and extent of the person's imminent dangerousness and has ordered emergency treatment — this is limited to rapid response medications since it is for chemical restraints — an issue controlled by federal regulations as well as state law/rules. Unless such an emergency exists, psychotropic medications cannot be administered unless the person or his/her substitute decision maker provides express and informed consent to the medications.

Two additional choices may be available. An expedited court hearing can be requested on the issue of adjudicating incompetence to consent to treatment and appointing a guardian advocate. A second alternative is to appoint an independent clinical social worker as proxy, as permitted in chapter 765, part IV, Florida Statutes, and rule 65E-5.2301, Florida Administrative Code. Either of these alternatives will allow you to provide medication without waiting for an emergency to occur.

Can psychiatric treatment be initiated before informed consent is obtained?

No. Unless the person is displaying uncontrolled symptoms and behaviors that are causing imminent danger, treatment cannot be initiated unless express and informed consent is first obtained from a competent adult or from a legally authorized substitute decision maker. At any time staff observes that the person isn't making such well-reasoned decisions, treatment must stop until a substitute decision maker is found or when the physician has documented imminent danger, in which case an emergency treatment order can be considered.

If a person is admitted on involuntary examination status and the box on the BA-52 form is checked indicating the person was unable to determine a voluntary examination was needed, should we presume the person is incompetent to consent to psychotropic medications or other treatment? In this case no psychotropic medications could be administered until the physician has done a competency exam unless an ETO was ordered. Correct?

Yes, this is correct. If a person is unable to determine the examination is needed, he/she is likely to be incompetent to consent to either admission or to treatment.

If an individual on involuntary status with a legal guardian arrives at our facility, do we have to wait for a documentation of incompetence by the physician in order for the legal guardian to consent? It seems like we wouldn't have to wait, because the courts have already made this determination, which is why the person has a legal guardian. Is this correct?

If you have documentation through a copy of the court order that it is either a plenary guardianship or that the right to consent to mental health care has been removed from the person and delegated to the guardian, no assessment of competence is required since the adjudication of incompetence would have already been established by the court. Once you have documentation through the court order and letters of guardianship, you would then have to get consent from the court-appointed guardian.

F. Mental Health Advance Directives

Is there a form for a psychiatric advance directive in Florida that meets the state and federal requirements? We are aware of the recommended Baker Act form to use "Affidavit of Health Care Proxy"' (form CF-MH 3123) but do not see a form that could be used for persons with mental illness to be proactive and document their wishes should they become incapacitated.

Yes. A mental health advance directive can be found in chapter 7 of this benchguide. It is based on the 20-page Bazelon Center form, but condensed and adapted to Florida laws. It is recommended, but not mandatory. Form CF-MH

3122, as well as the affidavit form (3123), can be used by the physician to certify incompetence to consent and notify the surrogate/proxy.

I am trying to get clarification of exactly what the expectations are of our facility should one of our inpatients request to complete a mental health advance directive. Can psychiatric inpatients complete a mental health advance directive?

Only a person who is considered competent may complete a valid advance directive, even one for mental health care. If the patient is competent and there are two witnesses who attest that "at the time the advance directive was signed, the person was of sound mind and under no constraint or undue influence," the patient would be eligible to complete the form. Many facilities feel that the mere presence of a person in a receiving facility may suggest lack of competence and possibly some undue influence by staff. You may want to select a health care proxy (relative or close personal friend) while the person is hospitalized if not competent to execute an advance directive, and provide the person the paperwork and assistance as part of release from the hospital. That way the document is in place should he/she be re-hospitalized at some future time.

I need information about mental health advance directives. At this time my facility asks patients being admitted if they have one and, if they do, we get a copy. Where in the statute does it discuss mental health advance directives?

Federal regulations require that any hospital inquire about a person's advance directives at the time of admission. In addition, the Florida Administrative Code governing the Baker Act (Fla. Admin. Code Ch. 65E-5). requires that each receiving facility (hospital and CSU) also make such an inquiry. The primary statute that governs advance directives in Florida is chapter 765, Florida Statutes. It includes several references to mental health issues:

- **765.101. Definitions**

  (6) "Health care decision" means:

  (a) Informed consent, refusal of consent, or withdrawal of consent to any and all health care, including life-prolonging procedures and mental health treatment, unless otherwise stated in the advance directives.

- **765.113. Restrictions on providing consent**.

  (1) . . . or voluntary admission to a mental health facility.

- **765.202. Designation of a health care surrogate**

  (5) A principal may designate a separate surrogate to consent to mental health treatment. . . .

- **765.204. Capacity of principal; procedure**

However, the Baker Act (chapter 394, part 1, Florida Statutes) also makes several references to advance directives and health care surrogates/proxies, as does the Florida Administrative Code governing the Baker Act (Fla. Admin. Code Ch. 65E-5).

G. Electroconvulsive Therapy

We are currently treating a patient with a severe psychotic disorder. We petitioned the court for extension of the patient's stay and asked for Electroconvulsive Therapy (ECT) treatments. The judge appointed a guardian advocate and also ordered the use of ECT. We want to help the patient, but do not want to violate any rights. When a second opinion is requested by the attending psychiatrist, does the consulting psychiatrist need to physically assess the patient or can that psychiatrist just review the chart?

If the court appointed a guardian advocate under the Baker Act, the guardian advocate authority to consent to ECT is governed as follows:

> **394.4598. Guardian advocate** (emphasis added)
>
> (7) 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.**

(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.

The above requires a separate hearing after the appointment of the guardian advocate (GA) to consider the need for ECT. However, if a guardian has been appointed by the court under chapter 744, Florida Statutes, the guardianship law (instead of a GA under the Baker Act), such a guardian has the authority to consent to the ward's ECT without further order of the court, unless the court has limited the powers of the guardian in some way.

With regard to the actual administration of ECT, this is primarily governed by the Florida Medical Practice Act as follows:

458.325. Electroconvulsive and psychosurgical procedures
(emphasis added)

(1) In each case of utilization of electroconvulsive or psychosurgical procedures, prior written consent shall be obtained after disclosure to the patient, if he or she is competent, **or to the patient's guardian**, if he or she is a minor or incompetent, of the purpose of the procedure, the common side effects thereof, alternative treatment modalities, and the approximate number of such procedures considered necessary and that any consent given may be revoked by the patient or the patient's guardian prior to or between treatments.

(2) Before [electro]convulsive therapy or psychosurgery may be administered, the patient's treatment record **shall be reviewed** and the proposed convulsive therapy or psychosurgery agreed to **by one other physician not directly involved with the patient**. Such agreement shall be documented in the patient's treatment record and shall be **signed by both physicians**.

The above only requires the documented review and agreement by the second physician. It isn't addressed by the Baker Act.

Can a substitute decision maker consent to electroconvulsive treatment (ECT) on behalf of the person?

A plenary guardian has the authority to make this decision on behalf of the person. A guardian advocate has this authority only if specifically provided by the court in a hearing separate from the one where the person was determined to be incompetent to consent to medical treatment. A health care surrogate or proxy has this authority only if a person specifically authorized this power in an advance directive.

H. Consent to Medical Treatment

Is medical treatment provided to a person in a receiving facility governed by the Baker Act?

No. The Baker Act is Florida's Mental Health Act and doesn't govern non-psychiatric medical care. A facility would have to follow whatever medical consent standards apply to non-psychiatric settings for aspirin, blood pressure medications, etc.

Is there a statute or rule (other than the Baker Act) that requires informed consent for general medical treatment, such as administration of non-psychotropic drugs?

The Florida Medical Consent Law is set forth at section 766.103, Florida Statutes.

Does a Baker Act receiving facility have the right to take blood or urine samples from an individual during the involuntary examination period without consent?

As Florida's Mental Health Act, the Baker Act doesn't address medical consent issues. Only if the physician had determined the individual has an emergency medical condition requiring such diagnostic and laboratory testing could the procedures be done without a competent patient's consent or that of a legally authorized decision maker.

Does the doctor's finding of incompetent to consent for treatment under the Baker Act relate to only psychiatric treatment or also to medications for medical conditions? We frequently have individuals admitted who are on routine diabetic medication, heart medication, or medication for COPD or

other chronic conditions. To stop these medications can be life threatening, and it may take us two or three days to find a health care surrogate or proxy. Thus, for the welfare of the patient we have allowed the patient to sign consent for non-psychotropic medications. Please clarify.

The Baker Act is merely the state's mental health law and doesn't affect medical treatment. The Baker Act is silent on this issue. For medical treatment, a provider would follow whatever laws govern informed consent for medical care — it seems to be much less stringent than for mental health. More to the point is that denial of antihypertensive medications, insulin, and the entire range of other medications for non-psychiatric conditions would probably represent medical neglect on the part of a provider. Most receiving facilities will attempt to get a proxy to provide consent, but if no proxy is available they will administer these drugs anyway. Given that the patient was taking the medications prior to admission, an implied consent might be acceptable where it is not sufficient for psychotropic medications.

We have a patient committed by the court to our unit on an order for involuntary placement for up to 30 days. He was originally deemed competent and the court did not appoint a guardian advocate. Just recently we found out that he has a malignant melanoma that needs immediate surgery, but he is refusing to have it done at this hospital due to his fixed paranoia about this hospital. What legal procedures do we need to go through to get this man his needed surgery? The psychiatrist now feels the man is incompetent. Do we need to go back to court to get a guardian advocate appointed? Can a guardian advocate sign the papers for a patient to get surgery or do we need to do something else?

You have several alternatives.

- If the doctor believes the man lacks competence, this can be documented in the chart and a health care proxy can be designated from the list found in chapter 765, part IV. The proxy can immediately exercise substitute judgment, consenting to treatment that he/she believes the person would have consented to if competent to do so.

- You can file a petition (CF-MH 3106) for Adjudication of Incompetence to Consent to treatment and Appointment of a Guardian Advocate with the circuit court. The boxes for medical and for mental health treatment should be checked. While surgery isn't one of the procedures requiring a specialized separate hearing before consent for extraordinary procedures can be authorized, it might be wise to be sure the judge is aware of the circumstances. It's possible the court will provide an expedited hearing.

- You can file a petition for Expedited Judicial Intervention for Medical Treatment (rule 5.900, Florida Probate Rules) with the circuit court.

I. Guardian Advocates and Other Substitute Decision Makers

1. In General

Who can authorize the admission of a person who lacks the capacity to make his or her own treatment decisions?

A person who is incompetent to consent to treatment is incompetent to consent to admission and must be admitted on involuntary status so his or her rights can be protected — this would be by a law enforcement officer, circuit court judge, or authorized mental health professional. If a person lacks the capacity to make his or her own treatment decisions, only a guardian, guardian advocate, or health care surrogate/proxy has the authority to make treatment decisions. These substitute decision makers cannot have a person admitted on a voluntary basis, but once the person is admitted on an involuntary basis, they can begin making treatment decisions.

How can a substitute decision maker document his or her authority to make decisions on behalf of another person prior to being allowed to consent to treatment?

A guardian must provide a copy of the court order appointing him or her as a person's guardian and letters of guardianship to document the limits of the authority of the guardian. A guardian advocate must provide a copy of the court order appointing him or her that designates whether the guardian advocate has only the authority to make mental health decisions or also has the authority to make medical decisions. A health care surrogate must provide a copy of an advance directive completed when the person was competent to determine what decisions he or she would want to have made on his or her behalf. (See later questions about each one of these types of decision makers.)

If a person refuses care that his or her guardian, guardian advocate, or health care surrogate has authorized, does the physician have to issue an order for emergency treatment in order to administer the medication?

No. If the person has been determined to lack the capacity to provide express and informed consent and a legally authorized substitute decision maker has provided consent for a specific treatment after full disclosure, the person's consent to the treatment is invalid and is not needed. This doesn't mean that the facility shouldn't attempt to communicate the person's objections to the specified treatment to the

guardian/guardian advocate to determine if the substitute decision maker wishes to alter his or her consent.

2. Court-Appointed Guardians (Ch. 744, Fla. Stat.)

Does section 744.3215(4)(a), Florida Statutes, allow a guardian to seek commitment of a ward for mental health treatment using the extraordinary authority procedures of section 744.3725, without using Baker Act involuntary examination and placement procedures?

No. The Baker Act is the more specific law, which would prevail over the more general guardianship law when in conflict on this issue. Further, the First District Court of Appeal ruled in *Handley v. Dennis*, 642 So. 2d 115 (Fla. 1st DCA 1994) that the rights of the patient under the Baker Act supersede rights of the guardian under the guardianship law when in conflict. Florida's guardianship law has traditionally provided for the extraordinary authority cited above, for a guardian who has received the specific authority of the circuit court to commit the ward to a facility, institution, or licensed service provider without formal placement proceeding, pursuant to chapter 393, chapter 394, or chapter 397, as follows:

> **744.3215. Rights of persons determined incapacitated**
>
> (4) Without first obtaining specific authority from the court, as described in s. 744.3725, a guardian may not:
>
> (a) Commit the ward to a facility, institution, or licensed service provider without formal placement proceeding, pursuant to chapter 393, chapter 394, or chapter 397.

The court in *Handley v. Dennis* stated that

> the Court has concluded that if there is a conflict in these laws, both the duty of the guardian and the power of the circuit court in the guardianship proceeding must give way to the ward's right under the Baker Act to be released to a less restrictive environment. . . .
>
> [T]he court has concluded that § 744.2025 Fla.Stat. (1991) and all other provisions of the guardianship law regarding the residence of the ward, are inapplicable to Baker Act patients. . . .
>
> In summary, the court concludes that a liberty interest asserted on behalf of an involuntary mental patient in a Baker Act hearing is

> superior to any conflicting right that could be asserted on behalf of the patient under the guardianship laws.

642 So. 2d at 117–118. The Baker Act requires that any person who has been adjudicated incapacitated be held under the involuntary procedures established under chapter 394, Part I.

Our patient's mother is her court-appointed guardian of person, and the guardian is now terminally ill in late stages of Alzheimer's disease. The patient has an adult sibling; should we petition the court to have the sister appointed her guardian advocate?

Yes. You can request a guardian advocate when a natural or court-appointed guardian is no longer able to serve for an interim period until the court can appoint a successor guardian. In the meantime, an adult sibling can serve as a health care proxy providing interim decision-making for an individual on involuntary status pending appointment as a guardian advocate.

Our MD is confused as to how a patient's mother, who is the legal guardian but who also has a "No Contact" order with her son due to his violence toward her, can be his advocate for the involuntary placement hearing. We've been told that a separate guardian advocate could not be appointed when there's a legal guardian. His mother does have an attorney who'll be representing her at the hearing that she will not attend.

It is correct that a guardian advocate is generally not needed when a person has a legal guardian. There are a few exceptions, such as when the guardianship is limited (e.g, for property only) or when the guardian is not available or not willing to serve. In such cases the court will appoint a guardian advocate. It is essential that you have a copy of the guardianship order as well as the letters of guardianship in your files. These documents will verify whether the mother is a plenary guardian or a limited guardian.

In *Handley v. Dennis*, 642 So. 2d at 117, regarding when the rights of a guardian under chapter 744, Florida Statutes, conflict with the rights of an individual under chapter 394, the First District Court of Appeal concluded that "if there is a conflict in these laws, both the duty of the guardian and the power of the circuit court in the guardianship proceeding must give way to the ward's right under the Baker Act to be released to a less restrictive environment" and that all "provisions of the guardianship law regarding the residence of the ward, are inapplicable to Baker Act patients." This is the same appellate case that defines the role of the public defender or private attorney representing a client in a Baker Act matter to serve "as

an independent advocate for the patient, not as a neutral party charged with the responsibility of determining the best interests of the patient or the needs of society." *Id.*

If the guardian indeed has the authority provided in the court order to make treatment decisions for the ward, she can do this without conversing with her son. However, for a guardian advocate's authority to make treatment decisions on behalf of the individual, he/she must have spoken with the patient and the doctor in person if possible, and, if not, by phone, before providing consent.

If there is a legal order prohibiting communication between the guardian and ward, you may have another issue. If the patient violates the order, it could potentially result in criminal charges for violating the order.

Since the attorney for the mother will be attending the hearing in her place, he/she might be interested in the summary of a Sixth Circuit case (not appealed) when an attorney other than the assistant state attorney wants to question witnesses, In *In re [V.S.]*, No. 95-577-IN 003 (Fla. 6th Cir. Ct. Feb. 13, 1995), with regard to the participation of the attorney for a receiving facility in a Baker Act involuntary placement hearing, the court held that

> the facility has every right to employ legal counsel to represent their legal interests in any proceeding where the facility's legal rights, liabilities or corporate interests are implicated.
>
> Since future actions of the facility, either in providing ordered treatment, or arranging for discharge of the patient, are predicated on the outcome of the hearing, the facility is entitled to have counsel present during the adjudicatory process. Counsel for the facility, although present at the hearing, may not interpose evidentiary objections or participate in questioning witnesses. This is the assigned role of the state attorney. While the facility may be a party in interest for the purpose of placing the controversy before the court, they do not have a legally protectable interest in the outcome of an adjudication of the need for involuntary mental health treatment. The statute permits the facility administrator to throw out the first ball, but the constitutional rights of the patient require that the state attorney pitch the game.

If the assistant state attorney is prosecuting the Baker Act petition, he/she probably won't need any assistance to argue retention of the patient in the facility. You may wish to discuss this issue with the patient's attorney to see if some restriction on

communication should be placed to avoid legal harm to his/her client.

A guardian appointed by an out-of-state court has her ward in our facility. Does the guardian need to have the court in Florida re-establish the guardianship in this state?

There is no reason that the current guardian has to re-create the existing guardianship in Florida that was previously established in another state. Florida's guardianship law recognizes "foreign" guardians and gives full faith and credit to such orders. However, the order must be filed with the local circuit's clerk of court, and once filed with the clerk, the laws of Florida apply.

> **744.306. Foreign guardians.**
>
> (1) When the residence of a ward of a foreign guardian is moved to this state, the guardian shall, within 60 days after such change of residence, file the authenticated order of her or his appointment with the clerk of the court in the county where the ward resides. Such order shall be recognized and given full faith and credit in the courts of this state. The guardian and the ward are subject to this chapter.

If a person who has a plenary guardian (with full guardianship over the person and property) is ordered to involuntary outpatient services, does the court still have to seek the guardian's authority to determine housing and treatment, or does the IOP takes precedence?

There is no legal reason why an IOP court order would need to include housing or treatment because the circuit court has already authorized the plenary guardian to make such decisions. It may be that the guardian believes that the additional IOP court order will assist in getting the ward to comply, considering that a judge has specifically ordered it rather than just authorizing the guardian to make the decisions.

If a person already has a court-appointed guardian, does the guardian need to complete the guardian advocate test and submit the results to the court?

No. A guardian is not responsible for taking the guardian advocate course. If a person has a guardian appointed by the court, no guardian advocate is needed. However, it is essential that the receiving facility obtain a copy of the court order to ensure the guardian is actually the individual appointed by the court, as well as the letters of guardianship that specify whether the guardianship is a plenary one (all rights) or a limited one where only certain rights have been removed from the person and assigned to the guardian. The guardianship, if limited, must specify that

the guardian has the power to make medical and mental health decisions for the person.

Can a court-appointed guardian consent for outpatient electroconvulsive treatment on a patient who has been found incompetent without court approval, or is the court-appointed guardian and attending physician required to submit a petition to the court requesting the authorization for ECT?

A plenary guardian appointed by the court under chapter 744 can consent. A guardian advocate cannot consent to ECT on behalf of the patient without the express approval of the court provided in a second hearing. § 394.4598, Fla. Stat.

Baker Act form CF-MH 3108, titled "Petition Requesting Court Approval for Guardian Advocate to Consent to Extraordinary Treatment," has been developed for use in this situation.

3. Guardian Advocates

Who is authorized to serve as a guardian advocate?

Section 394.4598(6), Florida Statutes (emphasis added), provides:

> 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.

The Legislature was clear that the preferred candidate to be appointed as a

guardian advocate was to be a family member or friend of the patient. Only when no such family member or friend is willing and able to serve may the court appoint an "adult training and willing to serve" who isn't a relative or friend. To skip over any person in the order of listing in the law, the court must document good cause in the record.

In 2016, a new subsection (2) was added to section 394.4598, Florida Statutes, to prohibit the following persons from being appointed as a patient's guardian advocate:

(a) A professional providing clinical services to the patient under this part.

(b) The licensed professional who initiated the involuntary examination of the patient, if the examination was initiated by professional certificate.

(c) An employee, an administrator, or a board member of the facility providing the examination of the patient.

(d) An employee, an administrator, or a board member of a treatment facility providing treatment of the patient.

(e) A person providing any substantial professional services, excluding public and professional guardians, to the patient, including clinical services.

(f) A creditor of the patient.

(g) A person subject to an injunction for protection against domestic violence under s. 741.30, whether the order of injunction is temporary or final, and for which the patient was the petitioner.

(h) A person subject to an injunction for protection against repeat violence, stalking, sexual violence, or dating violence under s. 784.046, whether the order of injunction is temporary or final, and for which the patient was the petitioner.

Regardless of which person on the list of eligible persons is appointed as guardian advocate, he/she is required to undergo the training required by law. The law makes no exception. However, the court is authorized to waive some or all of the training requirements for guardian advocates or impose additional requirements. The court must make its decision on a case-by-case basis and consider the experience and education of the guardian advocate, the duties assigned, and the needs of the patient.

What is the court's obligation regarding guardian advocate training according to Florida Statutes?

Section 394.4598, Florida Statutes (emphasis added), provides:

> (4) In lieu of the training required of guardians appointed pursuant to chapter 744, a guardian advocate must, at a minimum, participate in a 4-hour training course approved by the court before exercising his or her authority. At a minimum, this training course must include information about patient rights, psychotropic medications, the diagnosis of mental illness, the ethics of medical decision-making, and duties of guardian advocates.
>
> (5) The required training course and the information to be supplied to prospective guardian advocates before their appointment must be **developed by the department, approved by the chief judge of the circuit court**, and taught by a court-approved organization, which may include, but is not limited to, a community college, a guardianship organization, and a local bar association, or The Florida Bar. **The court may 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.**

In 1996–1997 the chief judges in each of the 20 circuits approved a self-instructional manual for guardian advocates developed by DCF that incorporated the four hours of training in content required by the law. In addition, online training is available at http://www.dcf.state.fl.us/programs/samh/mentalhealth/training/index.shtml.While the law seems to imply that instructor-led courses would be the norm similar to those designed for plenary guardians who are authorized to make many decisions even before training is completed, this wasn't practical for guardian advocates for whom there generally isn't time to attend a course prior to having to make decisions.

When does the training occur for newly appointed guardian advocates — before or after their appointment?

The law says that facilities must provide the prospective guardian advocate with information about the duties and responsibilities of GAs, including information about the ethics of medical decision-making prior to the appointment. However, the four-hour training course for GAs must be completed before the GA is authorized to provide treatment decisions on behalf of the individual. The training

can be provided prior to appointment or after, as long as you've documented that the training was complete and the GA passed the test. Of course, the GA must speak with the individual and the physician before providing consent to treatment — this must be done in person if possible; if not, by telephone.

Once a person has completed the guardian advocacy training for a patient, does he/she ever have to take it again in the future for the same patient if the patient ever returns to the Baker Act facility in the future, whether it is weeks, months, or years later?

No. The proposed guardian advocate doesn't need to undergo the four-hour training course a second time if successful completion of the course is documented in your records, unless the court requires additional training. There is a recommended Baker Act form CF-MH 3120 that can be used as a "Certification of Guardian Advocate Training Completion."

The previous director of our unit has been serving as a volunteer guardian advocate for persons found to be incompetent to provide express and informed consent. Is there any problem with this role?

The Baker Act prohibits certain people from serving as a guardian advocate, as follows:

> **394.4598. Guardian advocate** (emphasis added)
>
> (1) . . . . 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.

Since the previous director is a licensed mental health counselor, he/she is "a professional referred to in this part." Some people believe this to mean a professional currently serving in a clinical role for the person, but the law doesn't state this. Further, the law distinguishes the "professional" from those who are employed by a facility providing direct services to the patient. Your hospital attorney and the court need to determine if the previous director or any other licensed professional can serve in this capacity.

Your unit's previous director shouldn't serve as a health care proxy (interim decision maker) for anyone in your hospital. The list of people who can be

considered under chapter 765, Florida Statutes, is limited to family or a close personal friend. The only other alternative is an LCSW under very limited circumstances.

There are strong similarities between the list of eligible persons who can serve as substitute decision makers under the Baker Act and under the advance directive law. However, the lists are not identical. The advance directive statute limits a proxy to a guardian, family, a close personal friend, or an independent LCSW. § 765.401, Fla. Stat. The Baker Act places preference on a health care surrogate named by the patient, in an advance directive prepared when the patient was competent, followed by family, a friend, or an adult trained and willing to serve.

In summary, no "adult trained and willing to serve" specified in the Baker Act to serve as a guardian advocate can serve as a health care proxy. Neither can an LCSW serve as a guardian advocate under the Baker Act. Otherwise, a health care surrogate properly selected from the descending order listed in the advance directive law will generally be eligible to be appointed as the patient's guardian advocate under the Baker Act.

Can a hospital train its own staff to serve as guardian advocates?

No. Section 394.4598(1), Florida Statutes, states that a professional referred to in the Baker Act, an employee of the facility providing direct services to the person, a DCF employee, a facility administrator, or a member of the Florida local advocacy council cannot be appointed as a guardian advocate.

A staff member of a receiving facility would have a direct conflict of interest in consenting or refusing consent to services recommended for a person in that receiving facility. Further, no physician, psychologist, social worker, psychiatric nurse, licensed mental health counselor, or licensed marriage and family therapist could serve in this role for a person served in another receiving facility due to the statutory prohibition.

What is the process for, and where would we send, a family member to receive the training to become a guardian advocate? I currently have a patient in the hospital and his health care surrogates are requesting this.

The Guardian Advocate Training Manual is available through the DCF website.

A web-based guardian advocate training course is available at http://www.dcf.state.fl.us/programs/samh/mentalhealth/training/index.shtml.

Who would complete the certification to verify the guardian advocate

training?

A staff member could administer the "test" and sign the certification. This should be placed in the patient's clinical record with other legal forms.

Does the Baker Act prohibit an out-of-state family member guardian advocate from being appointed?

No. Nothing precludes an out-of-state family member from serving. However, there will be logistical problems. If the court doesn't waive the four-hour training course, the GA would be required to take the course. The Guardian Advocate Training Manual is located on the DCF website and it is intended as a self-instructional manual. The GA must speak with the individual and the physician prior to providing consent for treatment — in person if possible, or by telephone if not. Disclosure of all required information about treatment and the authorization for treatment would probably have to be done by telephone — the facility would want to have two witnesses participating on the call to document what was said by both parties. Consent forms could be faxed or scanned and emailed to supplement the verbal authorization received on the call.

Can a guardian advocate consent to laboratory tests or medical procedures?

No. Unless the court has specifically authorized the guardian advocate to consent to medical treatment, authority is limited to decision-making about mental health treatment only.

Is a separate second court hearing required to authorize the guardian advocate to consent for blood draw? If the client is refusing and restraints are required to obtain the sample, do we have to go to court for approval?

It shouldn't be necessary to have a second court hearing for the guardian advocate to get specific authorization to consent for blood draws or to have the person restrained for such a blood draw if the guardian advocate has been specifically authorized by the court to consent to medical treatment in addition to psychiatric treatment. Even prior to the GA appointment, the person may meet the criteria to serve as the person's health care proxy. If so, the proxy could provide such consent if he/she believed the person would have consented to the procedure if competent to do so. A second hearing is required only in specific circumstances, including: abortion, sterilization, electroconvulsive treatment, psychosurgery, and experimental treatments.

An attending psychiatrist at our receiving facility wants to file a petition for a guardian advocate to get court authority to consent for involuntary

sterilization of the GA's sister. The patient is expected to deliver within the next several days by C-section and the doctor recommends a tubal be done at the same time. The patient is incompetent to consent. This current pregnancy is a second one — the patient is entirely unable to raise her children — the sister has custody of the first one and will likely have custody of the second one when born. Can this be done?

Sterilization is one of the extraordinary procedures that must have a separate petition filed by the guardian advocate. It is doubtful the court would approve a non-reversible procedure like this. There is too much historical abuse of sterilization and experimental studies done on persons with mental illness for this to be uncontroversial. The public defender may strongly oppose it unless convinced that this is what his/her client wants. You should have a "Plan B" if the court doesn't approve. These are reversible methods that might be more acceptable if sterilization is not approved. The GA would already have authority to consent to such an alternative plan. You need to alert the attorney representing your receiving facility or risk management, since this petition might get significant visibility.

Can a guardian advocate charge a client for services?

There isn't any prohibition for such a practice if the client is competent to contract for this service. Given that a GA is appointed only when the person is adjudicated incompetent to consent, this would be very questionable. Section 394.4598(1), Florida Statutes, requires that a GA meet the qualifications of a guardian contained in part IV of chapter 744 and specifically prohibits certain people from serving:

Individuals will be appointed to be a guardian advocate in this order: the health care surrogate named by the person; a relative; or a friend. Only if none of these people are available and willing to serve can an adult trained and willing to serve as guardian advocate for the person be named by the court. § 394.4598(6), Fla. Stat.

Can a petition for involuntary placement reflect that a person is competent to consent to treatment? If yes, is the section of the petition regarding guardian advocacy left incomplete? Does the person then need a proxy?

A person may "refuse" placement instead of being "unable to determine" that placement is necessary. If refusing placement, it is possible that the person retains competency to consent or refuse consent to his/her own treatment. This is the very circumstance that the second question on page 2 of the involuntary placement petition is intended to cover. If the person is competent to consent/refuse to consent or a court-appointed guardian for mental health decision-making is already

appointed, #2 would be checked and the other questions on the petition would not be answered. If the person is competent to make his/her own treatment decisions, a proxy would be inappropriate.

If a guardian advocate is ordered for a patient who is subsequently transferred to a state hospital, are we responsible for obtaining a different guardian advocate?

A guardian advocate is appointed by the originating court to serve until the person's order expires, or until he/she transfers to voluntary status (must be competent to make well-reasoned, willful, and knowing decisions about medical, mental health, or substance abuse treatment) or is discharged from a facility (no longer meeting involuntary placement criteria). The guardian advocate, generally a family member, isn't appointed just for the time in a single facility. The GA is appointed to serve the person, wherever he/she is, not to serve a facility. If the appointment was intended to apply only when the patient is at your facility, the court should be notified of this so a different GA could be selected if possible. The state mental health facility might not accept the person if no GA would be available to make treatment decisions on behalf of the person and there may not be access to a GA to serve.

If a guardian advocate is unexpectedly no longer able or willing to serve, a procedure is laid out in rule 65E-5.230, Florida Administrative Code, as follows:

> (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.

Are guardian advocates immune from liability for treatment decisions they make for patients?

You may need to consult with your attorney, but it doesn't appear that the law offers any immunity. If the GA appointed by the court is volunteering under the

supervision of a public or nonprofit organization, the volunteer is covered under Florida's Volunteer Protection Act (section 768.1355, Florida Statutes).

A corporation that provides guardian advocate services to patients of our hospital often does not have anyone show up for the hearings, despite notice given. The GA calls the next day and speaks to the client by phone. We then have to find a way for the GA to talk to the psychiatrist. This all must be done prior to the GA consenting for the medications. Any suggestions?

There is no legal requirement for the guardian advocate to actually attend the hearing, and it is even questionable whether the GA would have the right to do so until after the appointment took place, due to the confidentiality of the information discussed. However, given that the person may have had medications delayed from the time of admission until the time of the hearing (7-10 days), any further delay seems unreasonable. If it is the corporation named in the order, it should be easy enough to arrange for another agent of the corporation to come promptly to the hospital after appointment.

Section 394.4598(3), Florida Statutes, provides: "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**" (emphasis added). A pattern of delay should cause your hospital to consider finding an alternative service, especially since the hearing date is predictably the same each week.

4. Health Care Surrogates/Proxies

What kind of liability does a health care surrogate/proxy have for his or her decision-making on behalf of a person found incompetent to consent to treatment?

The advance directive law provides the following immunity for surrogates/proxies, as well as for providers in providing care under the statute:

> **765.109. Immunity from liability; weight of proof; presumption**
>
> (1) A health care facility, provider, or other person who acts under the direction of a health care facility or provider is not subject to criminal prosecution or civil liability, and will not be deemed to have engaged in unprofessional conduct, as a result of carrying out a health care decision made in accordance with the provisions of this chapter. The surrogate or proxy who makes a health care decision on a patient's behalf, pursuant to this chapter, is not subject to criminal

prosecution or civil liability for such action.

(2) The provisions of this section shall apply unless it is shown by a preponderance of the evidence that the person authorizing or effectuating a health care decision did not, in good faith, comply with the provisions of this chapter.

Our local CSU has asked me to serve as a proxy now that I'm no longer working there, but I'm wondering about liability as an LCSW. I do not have my own liability insurance. Do you have any thoughts on this?

The advance directive statute regarding health care proxies provides:

765.401. The proxy

(1) If an incapacitated or developmentally disabled patient has not executed an advance directive, or designated a surrogate to execute an advance directive, or the designated or alternate surrogate is no longer available to make health care decisions, health care decisions may be made for the patient by any of the following individuals, in the following order of priority, if no individual in a prior class is reasonably available, willing, or competent to act:

(a) The judicially appointed guardian of the patient or the guardian advocate of the person having a developmental disability as defined in s. 393.063, who has been authorized to consent to medical treatment, if such guardian has previously been appointed; however, this paragraph shall not be construed to require such appointment before a treatment decision can be made under this subsection;

(b) The patient's spouse;

(c) An 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;

(d) A parent of the patient;

(e) The 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;

(f) 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

(g) A close friend of the patient.

(h) 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. The proxy will be notified that, upon request, the provider shall make available a second physician, not involved in the patient's care to assist the proxy in evaluating treatment. Decisions to withhold or withdraw life-prolonging procedures will be reviewed by the facility's bioethics committee. Documentation of efforts to locate proxies from prior classes must be recorded in the patient record.

(2) Any health care decision made under this part must be based on the 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 patient would have chosen, the 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.

What's most important is that you not be asked to serve if there is any guardian, family member, or friend who is willing and able to serve. The receiving facility should have already made a diligent effort to obtain such family or friend to serve before even contacting you. If you are asked to serve, it must be after referral by an ethics committee — most medical hospitals have such a committee if the CSU does not. Most ethics committees have an expedited procedure, and there wouldn't have to be a delay for some scheduled meeting. Use of Baker Act forms CF-MH 3122 (Certification of Person's Incompetence to Consent to Treatment and Notification of Health Care Surrogate/Proxy) and CF-MH 3123 (Affidavit of Health Care Proxy) may help in ensuring compliance with the law and rules.

If you agree to serve as a proxy, your exclusive obligation is to the patient, not the convenience of the receiving facility. The decision is whether to consent and, if so, what the individual would have consented to if competent (substitute judgment standard). Only when this isn't known can a "best interest" standard be used in decision-making.

The Baker Act rules permit use of a surrogate or proxy only on an interim basis — a petition for involuntary placement and appointment of a guardian advocate must be filed within two court working days of the certification of incapacity by the physician. You must also be provided the same information that is required by law to be provided to guardian advocates and can consent to treatment for the person only after talking to the individual and to the physician — in person if possible and if not, by telephone.

If a person needs medications but refuses them and has been determined by a physician not to have capacity to make his or her own treatment decisions, can a facility staff legally call a family member or close friend to be a health care proxy without the person's consent?

Yes. A facility can contact the person highest on the list of eligible proxies to seek his or her involvement. The federal HIPAA law recognizes state statutory authority to designate persons who will "stand in the shoes of the person," such as guardians, guardian advocates, and health care surrogates and proxies. Section 765.401(1), Florida Statutes, lists individuals who, in the order of listing, can be selected by the provider to act as proxy.

The Baker Act rules indicate that when a person has not executed an advance directive, health care decisions may be made by an eligible proxy during the interim period between the time the person is determined by the physician to be incompetent to consent to treatment and the time a guardian advocate is appointed by a court. Would there be any conflict with HIPAA allowing a proxy to make decisions, since the person did not have an advance directive?

No. HIPAA defers to the state laws in recognizing individuals who are authorized to "stand in the shoes of the person" for decision-making purposes in each state. This includes guardians, guardian advocates, and health care surrogates/proxies in Florida.

Can health care surrogates and proxies give consent to mental health treatment?

Yes. Florida's advance directive law is clear that it applies to any and all health care decisions — this includes mental health decisions as well. The following provisions help to reinforce this issue:

> **765.101. Definitions** (emphasis added)
>
> (10) "Incapacity" or "incompetent" means the patient is physically or **mentally** unable to communicate a willful and knowing health care

decision. For the purposes of making an anatomical gift, the term also includes a patient who is deceased.

765.205. Responsibility of the surrogate (emphasis added)

(1) The surrogate, in accordance with the principal's instructions, unless such authority has been expressly limited by the principal, shall:

(a) Have authority to act for the principal and to make **all health care decisions** for the principal during the principal's incapacity.

765.202. Designation of a health care surrogate (emphasis added)

(5) A principal may designate a **separate surrogate to consent to mental health treatment** in the event that the principal is determined by a court to be incompetent to consent to mental health treatment and a guardian advocate is appointed as provided under s. 394.4598. However, unless the document designating the health care surrogate expressly states otherwise, the court shall assume that the health care surrogate authorized to make health care decisions under this chapter is also the principal's choice to make decisions regarding mental health treatment.

765.204. Capacity of principal; procedure (emphasis added)

(1) A principal is presumed to be capable of making health care decisions for herself or himself unless she or he is determined to be incapacitated. Incapacity **may not be inferred from the person's voluntary or involuntary hospitalization for mental illness** or from her or his intellectual disability.

The Florida Administrative Code governing the Baker Act also has extensive provisions governing the use of health care surrogates and proxies as interim decision makers until a guardian advocate is appointed by the court.

Can a health care surrogate or proxy make treatment decisions for a person in a Baker Act facility?

Yes, but only for a person who is on involuntary status and for whom a petition is to be filed with the court in a timely way requesting the appointment of a guardian advocate.

If an involuntary placement petition is completed on the weekend and there is

a proxy, can we still medicate the patient before filing on the next business day?

Yes, as long as the petition has been completed within the 72 hours permitted by law and that point in time falls on a weekend or legal holiday and you file the petition with the court on the next court working day. You can continue to seek authorization for treatment from the health care proxy until the court acts on your request for appointment of a guardian advocate.

Once a physician documents that a patient is incompetent and has no healthcare surrogate or legal guardian, can we as a facility appoint a healthcare proxy? Our local magistrate recently denied us permission to use a proxy. Our interpretation was that we didn't need the court's permission. We recognize that the proxy is time limited. Isn't the point of a proxy to avoid ETOs or, worse yet, a lack of treatment until the court hearing?

Rule 65E-5.2301, Florida Administrative Code, governing the use of a health care surrogate or proxy, was added to the rules in 1998 to provide for an interim decision maker 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. The court has no role in issues relating to health care surrogates or proxies unless a complaint is made and the court is responsible for investigating the complaint. As long as a receiving or treatment facility submits a petition for involuntary placement and appointment of a guardian advocate within two court working days of the determination by a physician of an individual's incompetence to consent to treatment, the court shouldn't have a concern.

5. Powers of Attorney

Does a power of attorney for health care override a Baker Act?

No. A person with a POA or a health care surrogate/proxy can consent only to treatment, not to admission. Adults with a substitute decision maker must remain on involuntary status because of their incapacity.

Can a power of attorney give consent to the admission or treatment of a person in a Baker Act facility?

A durable power of attorney is insufficient to authorize the admission of a person on a voluntary basis or to consent to treatment for a person, regardless of his or her legal status. However, if the POA is in the form of an advance directive for health care, the surrogate named in the advance directive can make treatment decisions but not the decision to admit the person to a facility. Such admission must be on an

involuntary basis.

IX. Selected Model Baker Act Forms for Informed Consent and Use of Substitute Decision Makers

Please note that these recommended forms were promulgated by DCF before the 2016 statutory amendments and do not incorporate those changes.

A. Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA

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: _____

_____

_____

_____

_____

_____

_____ _____ _____ am pm
Signature of Psychiatrist Date Time

_____ _____
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.

_____ _____ _____ am pm
Signature of Administrator or Designee Date Time

_____
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
☐ Person		am pm	
☐ Representative		am pm	
☐ Current Guardian Advocate		am pm	
☐ Prospective Guardian Advocate		am pm	
☐ Person's Attorney		am pm	

See s. 394.4598(1), (2), (3), (4), (5), (6), Florida Statutes
CF-MH 3106, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

B. Order Appointing Guardian Advocate

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. ☐ 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. ☐ 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

See s. 394.455(15), 394.4598(1), (2), (3), (4), (6), (7), Florida Statutes
CF-MH 3107, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

C. Petition Requesting Court Approval for Guardian Advocate to Consent to Extraordinary Treatment

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.

_____ _____ _____ am pm
Signature of: ☐ Psychiatrist ☐ Physician Date Time

_____ _____
Typed or Printed Name of Psychiatrist or Physician License Number

_____ _____ _____ am pm
Guardian Advocate's Signature Date Time

_____
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
☐ Person		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	
☐ Person's Attorney		am pm	
☐ Facility Administrator		am pm	

See s. 394.4598(6), Florida Statutes
CF-MH 3108, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

D. Order Authorizing Guardian Advocate to Consent to Extraordinary Treatment

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT

IN AND FOR _____ COUNTY, FLORIDA

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
☐ Person		am pm	
☐ Guardian Advocate		am pm	
☐ Person's Attorney		am pm	
☐ Facility Administrator		am pm	

See s. 394.4598(6), Florida Statutes
CF-MH 3109, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

E. Authorization for Electroconvulsive Treatment

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.

_____ _____ _____ _____ am pm
Signature of Physician | Printed Name of Physician | Date | Time

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.

_____ _____ _____ _____ am pm
Signature of Second Physician | Printed Name of Second Physician | Date | Time

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.

_____ _____ _____ am pm
Signature of Competent Adult | Date | Time

_____ _____ _____ am pm
Signature, * as appropriate, of: | Date | Time
☐ Guardian, ☐ Guardian Advocate,
☐ Parent of a Minor, ☐ Health Care Surrogate

_____ _____ _____ am pm
Signature of Witness | Date | Time

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.**

See s. 394.459(3)(b), 458.325, Florida Statutes
CF-MH 3057, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

F. Notification to Court of Person's Competence to Consent to Treatment and Discharge of Guardian Advocate

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

See s. 394.4598(6), Florida Statutes
CF-MH 3121, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

G. Findings and Recommended Order Restoring Person's Competence to Consent to Treatment and Discharging the Guardian Advocate

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.

_____ _____ _____ am pm

Signature of Administrative Law Judge | Date | Time

_____

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

See s. 394.467(7)(f), Florida Statutes

CF-MH 3116, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Chapter Three: Admission and Treatment for Minors

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

I. Cautionary Note

Many statutes, case law decisions, 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 DCF or the 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.

The Baker Act makes only a few distinctions between adults and minors. Where distinctions are not made, adults and minors have the same rights. Specific provisions regarding 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 ongoing basis is necessary to ensure 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.

II. Minority/Non-Age

A. Definition

"'Adult' means an individual who is 18 years of age or older or who has had the disability of nonage removed under chapter 743." § 394.455(4), Fla. Stat.

"'Minor' means an individual who is 17 years of age or younger and who has not had the disability of nonage removed pursuant to s. 743.01 or s. 743.015." § 394.455(29), Fla. Stat.

While the text of the Baker Act occasionally uses the term "minor" or "adult," in which case these definitions apply, it also uses the phrases "age 17 and under," "under 18 years of age," or "18 years of age or older" in many other citations. In such instances, the more precise age limitation would apply rather than the more generic term of "minor" or "adult."

Regarding a "minor's" access to outpatient crisis intervention and treatment (section 394.4784), such access without consent of a parent or guardian is only available to minors age 13 or older.

B. 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 widowered, 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." § 743.01, Fla. Stat.

- 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." § 743.065, Fla. Stat. However, this doesn't affect the provisions of section 390.0111, Florida Statutes, which governs termination of pregnancies.

- 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." § 743.015, Fla. Stat.

- 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." § 743.066, Fla. Stat.

C. Rights, Privileges, and Obligations of Persons 18 Years of Age or Older

Section 743.07, Florida Statutes, provides in part:

> (1) 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.
>
> (2) 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.

D. 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. The mother and father jointly are natural guardians of their biological and adopted children during minority, and they can provide consent if necessary, unless their parental rights have been terminated pursuant to chapter 39, Florida Statutes. § 744.301(1), Fla. Stat. That statute further provides:

- If one parent dies, the natural guardianship passes to the surviving parent, and the right continues even if 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, Florida Statutes, governing dissolution of marriage.)
- If the parents share parental responsibility, then both continue as natural guardians.

- "If the marriage is dissolved and neither parent is given parental responsibility for the child, neither may 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, the court can appoint a guardian for a minor without appointing an examining committee or adjudicating the child incapacitated. §§ 744.3021(1), 744.342. Fla. Stat. A guardian appointed for a minor, whether of the person or property, has the authority of a plenary guardian. § 744.3021(1), Fla. Stat. If the minor is age 14 or over, the court must consider the minor's preference as to who should be appointed guardian. § 744.312(3)(b), Fla. Stat.

"'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." § 39.01(35), Fla. Stat.

A guardian appointed by the court cannot commit the minor to a facility, institution, or licensed service provider without a formal placement proceeding pursuant to chapter 393, chapter 394, or chapter 397, unless the guardian first obtains specific authority from the court as described in section 744.3725. § 744.3215(4)(a), Fla. Stat.

The 2008 Florida Legislature extensively rewrote state laws (chapter 61, Florida Statutes) governing the dissolution of marriage (SB 2532). 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" for "parental responsibility," and changed the term "visitation" to "time-sharing." Some of these terms are as follows:

- Parenting plan. A document that governs all circumstances among the parties, including decision-making and time-sharing.

- Shared parental responsibility. Court-ordered relationship where 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 where one parent makes decisions (with or without visitation).

- Time-sharing schedule. A timetable included in a parenting plan that specifies the time the child will spend with each parent.

- Access to information. Availability of treatment records to either parent unless the court specifically revokes this right.

III. Consent for Admission to a Mental Health Facility

A. 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." § 394.4625(1), Fla. Stat.

A facility is defined in the Baker Act as "any hospital, community facility, public or private facility, or receiving or treatment facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who have been diagnosed as having a mental illness or substance abuse impairment." § 394.455(10), Fla. Stat.

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 is required from the guardian. § 394.459(3)(a), Fla. Stat. A minor 13 years of age or older is authorized to consent to outpatient crisis intervention services under section 394.4784.

B. Hospitals

Section 394.4785(2), Florida Statutes, provides:

> A person **under the age of 14** who is admitted to any hospital licensed pursuant to chapter 395, Florida Statutes, 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 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 must be reviewed by the attending physician or a designee or on-call

physician each day and documented in the case record. (emphasis added)

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

- Section 395.003(5)(a), Florida Statutes, 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."

- Section 395.003(5)(b), Florida Statutes, states: "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."

- Section 395.1041(6) , Florida Statutes, states: "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."

- Section 395.1055(5), Florida Statutes, 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."

C. Children's Crisis Stabilization Units

Minors **under the age of 14** 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. Fla. Admin. Code R. 65E-12.106(22).

IV. Consent to Psychiatric Treatment

A. Inpatient Treatment

Persons entering a facility must be asked to give express and informed consent for admission and treatment. Express and informed consent for admission and treatment of a person under 18 is required from the person's guardian, unless the minor is seeking outpatient crisis intervention services (see below). § 394.459(3)(a), Fla. Stat.

B. Residential Treatment Centers

All rights specified in section 394.459, Florida Statutes, 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. Fla. Admin. Code R. 65E-9.012.

C. Outpatient Crisis Intervention Services

The disability of non-age is removed for any minor age **13 years or older** to access services under the following circumstances, pursuant to section 394.4784, Florida Statutes (emphasis added):

> **(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 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.

V. Substance Abuse (Marchman Act) Admission and Treatment

A. In General

"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." § 397.601(4)(a), Fla. Stat. (emphasis added).

B. Criteria

A minor may be taken to a detox facility, hospital, or addictions receiving facility (ARF) for involuntary admission if there is a good-faith reason to believe the

minor is substance abuse impaired ("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"), section 397.311(18), Florida Statutes, and who, because of such condition

> (1) Has lost the power of self-control with respect to substance abuse; and:
>
> (2)(a) Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that he or she is incapable of appreciating his or her need for such services and of making a rational decision in that regard, although mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services; or
>
> (b) Without care or treatment, is likely to suffer from neglect or refuse to care for himself or herself; that such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that 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 substantial likelihood that the person has inflicted, or threatened to or attempted to inflict, or, unless admitted, is likely to inflict, physical harm on himself, herself, or another.

§ 397.675, Fla. Stat.

C. Initiation

Protective custody may be initiated through law enforcement. § 397.677, Fla. Stat. A parent or guardian may apply for a certificate for a minor's emergency admission if a professional's certificate has been obtained, see section 397.679, as well as for admission to a juvenile addiction receiving facility, section 397.6798. A parent/guardian or a licensed service provider can also petition the court for an involuntary assessment and stabilization order. § 397.6811, Fla. Stat.

D. Disposition

Release of the minor from protective custody, emergency admission, involuntary assessment, involuntary treatment, or alternative involuntary assessment, upon approval of a qualified professional in a hospital, 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 DCF or DJJ. § 397.6758, Fla. Stat.

E. 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, Fla. Stat.

F. 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.

§ 397.501(7)(e), Fla. Stat.

G. 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/her ability to pay, unless otherwise provided by law. § 397.431(2), Fla. Stat. "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." § 397.431(3), Fla. Stat.

VI. Consent for General Medical Care and Treatment

A. Power to Consent

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

§ 743.0645(1)(c), Fla. Stat. The treatment provider must maintain records that show documentation that a reasonable attempt was made to contact the person who has the power to consent to the minor's treatment. § 743.0645(2), Fla. Stat.

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 DCF or DJJ "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":

> (a) A health care surrogate designated under s. 765.2035 after September 30, 2015, or a person who possesses a power of attorney to provide medical consent for the minor. . . .
>
> (b) The stepparent.
>
> (c) The grandparent of the minor.
>
> (d) An adult brother or sister of the minor.
>
> (e) An adult aunt or uncle of the minor.

§ 743.0645(2), Fla. Stat.

"'Medical care or treatment' includes ordinary and necessary medical and dental examinations and treatment, . . . **but does not include** surgery, general anesthesia, **provision of psychotropic medications**, or other extraordinary procedures for which a separate court order, health care surrogate designation under s. 765.2035 executed after September 30, 2015, power of attorney executed after July 1, 2001, or informed consent as provided by law is required." § 743.0645(1)(b), Fla. Stat. (emphasis added).

B. Emergency Care

Section 743.064, Florida Statutes, provides as follows:

> (1) 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. These persons shall follow the general guidelines and notification provisions of this section.

(2) This section shall apply only when parental consent cannot be immediately obtained for one of the following reasons:

(a) 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.

(b) The parents, guardian, or legal custodian cannot be immediately located by telephone at their place of residence or business.

(3) 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 well-being. The hospital records shall be open for inspection by the person legally responsible for the minor.

VII. Emergency Care of Youth in DCF or DJJ Custody

Section 743.0645(3), Florida Statutes, provides:

(3) The Department of Children and Families 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.

(4) 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.

(5) 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.

VIII. Delinquent Youth

See ch. 985, Fla. Stat.

Section 985.18, Florida Statutes, titled "Medical, psychiatric, psychological, substance abuse, and educational examination and treatment," provides as follows:

(1) 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.

(2) If 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, or intellectual disability 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 chapter 393, chapter 394, or chapter 397, as applicable, must be used. . . .

(6) A physician must 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 disability services in emergency situations pursuant to chapter 393, chapter 394, or chapter 397, as 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.

(7) 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.

IX. Dependent Youth

A. Medical, Psychiatric, and Psychological Examination and Treatment of Children in DCF Custody

See ch. 39, Fla. Stat.; Fla. Admin. Code Ch. 65C-35. Rule 65C-35.007, Florida Administrative Code, provides as follows (emphasis added):

(1) 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.

(2) 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].

(3) **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.**

Section 39.407, Florida Statutes, provides in part:

(1) 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.

(2) 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 in the following manner:

(a) [From a parent or legal custodian of the child, or by court order.]

(b) If a parent or legal custodian of the child is unavailable and his or her whereabouts cannot 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 shall have the authority to consent to necessary medical treatment, including immunization, for the child. The authority of the department to consent to medical treatment in this circumstance shall be limited to the time reasonably necessary to obtain court authorization.

(c) If a parent or legal custodian of the child is available but refuses to consent to the necessary treatment, a court order shall be 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.

B. Psychotropic Medications for Children in DCF Custody

See Fla. Admin. Code Ch. 65C-35.

Section 39.407, Florida Statutes, provides:

(3)(a)1. . . . . [B]efore the department provides psychotropic medications to a child in its custody, the prescribing physician shall attempt to obtain express and informed consent . . . from the child's parent or legal guardian. The department 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 decisionmaking 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 the department seek court authorization do not apply to that medication until such time as the parent no longer consents.

2. Any time the department seeks a medical evaluation to determine the need to initiate or continue a psychotropic medication for a child, the department must provide to the evaluating physician all pertinent medical information known to the department concerning that child.

(b)1. 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.

2. If the department 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.

3. If the department is advised by a [licensed] physician . . . that the child should continue the psychotropic medication and parental authorization has not been obtained, the department shall 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.

4. Before filing the dependency petition, the department shall 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, the department 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.

(c) . . . . [T]he department 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 contraindications 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, Florida Administrative Code, adopted in 2010, governs "Psychotropic Medication for Children in Out of Home Care." Several of the many definitions in rule 65C-35.001, Florida Administrative Code, are as follows:

(1) "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.

(10) "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.

(14) "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.

(15) "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.

(18) "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:

(a) Antipsychotics;

(b) Antidepressants;

(c) Sedative Hypnotics;

(d) Lithium;

(e) Stimulants;

(f) Non-stimulant Attention Deficit Hyperactivity Disorder medications;

(g) Anti-dementia medications and cognition enhancers;

(h) Anticonvulsants and alpha-2 agonists; and

(i) 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 a prescribed psychotropic medication would more likely than not cause significant harm to the child," or
- in hospitals, crisis stabilization units, and psychiatric residential treatment programs.

§ 39.407(3)(e), Fla. Stat. 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 three business days after the medication is begun.

C. Examination, Treatment, and Placement of Children in DCF Custody

Section 39.407, Florida Statutes, provides in part as follows (emphasis added):

> (4) 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.

(5) 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).

(6) Children who are in the legal custody of the department may be **placed** by the department, 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.

X. Frequently Asked Questions

A. Minority Defined

How is a minor defined?

"'Minor' means an individual who is 17 years of age or younger and who has not had the disability of nonage removed pursuant to s. 743.01 or s. 743.015." § 394.455(29), Fla. Stat.

While the text of the Baker Act occasionally uses the term "minor" or "adult," in which case these definitions apply, it also uses the phrases "age 17 and under," "under 18 years of age," or "18 years of age or older" in many other citations. In such instances, the more precise age limitation would apply rather than the more generic term of "minor" or "adult."

Is there any difference in legal status for minors of different ages, such as above or below age 14?

There is no difference between the ages of a minor regarding inpatient care. Ages 0-17 are handled identically. The only differences referred to in the law are the status of co-location with adult patients and outpatient crisis intervention.

Who is a child's guardian?

A child's guardian is generally one or both of his or her natural or adoptive parents. After a dissolution of marriage, decisions related to the child's health care will be made by the parent or parents as set forth in the approved parenting plan. The mother of a child born out of wedlock is guardian of the child. In the absence of a parent, a guardian must be appointed by a court and can be a relative or other person interested in the welfare of the child.

B. Informed Consent and Consent to Treatment

We have a psychiatrist who is board-certified for treatment of adult, child, and adolescent patients. He has been treating a 17-year-old who is resistant to medications. The doctor wants to perform outpatient ECT, and the parents are willing to consent for the treatment. If the patient is willing to go through the procedure and the parents give consent, and the psychiatrist has all the "typical" paperwork needed for ECT, can he perform the procedure?

This issue is addressed in the Baker Act and the Medical Practice Act. These Florida Statutes provisions are as follows:

> **394.459. Rights of patients** (emphasis added)
>
> (3) Right to express and informed patient consent.—
>
> * * *
>
> (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.

Since the minor is not competent to provide consent as a result of age, the guardian has the power to make this decision. It still must be made with full disclosure of the risks, benefits, and all other factors required for consent to be "informed."

> **458.325. Electroconvulsive and psychosurgical procedures**
> (emphasis added)
>
> (1) In each case of utilization of electroconvulsive or psychosurgical procedures, prior written consent shall be obtained after disclosure to the patient, if he or she is competent, **or to the patient's guardian, if he or she is a minor** or incompetent, of the purpose of the procedure, the common side effects thereof, alternative treatment modalities, and the approximate number of such procedures considered necessary and that any consent given may be revoked by the patient or the patient's guardian prior to or between treatments.
>
> (2) Before convulsive therapy or psychosurgery may be administered, the patient's treatment record shall be reviewed and the proposed convulsive therapy or psychosurgery agreed to by one other physician not directly involved with the patient. Such agreement shall be documented in the patient's treatment record and shall be signed by both physicians.

Assuming that administering ECT to minors is an accepted psychiatric practice, there appears to be no legal barrier to a minor receiving ECT.

Does the court have authority to appoint a guardian advocate for a child when the child's guardian is refusing to consent for treatment?

A child's natural guardian has the power to consent or refuse consent to treatment on behalf of the minor, just as does a guardian (plenary or "of person") appointed by the court for an adult. In the case of an adult, a request can be filed for the court to investigate any complaints against a court-appointed guardian's decision-making. In the case of a minor whose parent's refusal to consent to medically necessary treatments might rise to the level of "medical neglect," a report to the DCF Abuse Registry should be made. There have been occasions when the natural parents/guardians of a minor have been unavailable and the child's caretaker isn't authorized to consent to psychotherapeutic medications (chapter 743, Florida Statutes) in which a guardian advocate was appointed to make such treatment decisions. This is not the case where the parents *refuse* consent.

C. Voluntary Admissions

Under what conditions can a minor be on voluntary status?

The Baker Act permits minors to be on voluntary status if they are agreeable to the admission, but only when their parent or legal guardian has applied for their admission and a judicial hearing has been conducted prior to the admission, to confirm the voluntariness of the consent. Unless parental rights have been terminated, natural or adoptive parents continue to have the right to make such decisions on behalf of their children, even if they cannot or will not do so. In the absence of a parent or legal guardian's consent, the court must make this decision.

Any reference to "voluntariness hearings" done at facilities and by facility staff was repealed from the Florida Administrative Code in 1997 because DCF was found not to have the specific statutory authority to define a hearing as an "administrative hearing" when all other references to hearings in the Baker Act are judicial in nature. Therefore, it is DCF's opinion that a judicial hearing of some type is required prior to the admission of the minor on voluntary status. There are no rules or model forms for this purpose.

A child has a right to be held on a voluntary basis if he/she meets the criteria and the correct procedures are followed — especially if the child doesn't meet the criteria for involuntary status. However, due to the onerous nature of voluntary admission of minors, especially those in DCF custody, many providers have chosen to admit all such minors on involuntary status. Assuming the minor meets the criteria for involuntary examination, it would be entirely proper to admit him/her on involuntary status. While minors may state a willingness to be in a psychiatric unit, they do not have the legal capacity to give independent consent to the admission or to treatment.

Section 394.4625(1)(a), Florida Statutes, states that "[a] person age 17 or under may be admitted only after a hearing to verify voluntariness of the consent." Please tell me what a hearing is comprised of and who must be present, and what paper must confirm that this is valid and complete. If we have a minor child and a parent or guardian in agreement with admission, can we have the Application for Voluntary Admission – Minors (CF-MH 3097) signed? Do we need the psychiatrist to determine the patient's competence, or is it sufficient for a LMHC or LCSW to make this determination? It seems that initiating a BA-52 by a professional does not make sense when the person is willing.

The model form 3097, "Application for Voluntary Admission – Minors," is an approved document in the series of Baker Act forms. It allows for the documentation of the parent/guardian's consent and the minor's assent. It is silent as to the requirement for a hearing. However, the statutory language remains in effect. DCF has proposed changes to this section of the Baker Act to allow for certain licensed professionals, such as a clinical social worker or mental health counselor, to conduct an evaluation of voluntariness. However, this bill would have to be passed by the Legislature to take effect.

We admitted a 15-year-old girl to our CSU whose parents' parental rights were terminated, and she had been in the foster care system for many years. The 72-hour period of the initial Baker Act expired yesterday, and the nurse on duty obtained a consent for voluntary admission by telephone from the child's DCF or community-based care worker. The child signed the portion of the voluntary admission form that asks if the child is willing to stay. The question arose as to whether the DCF or community-based care worker has the authority to sign the child in voluntarily, or whether a petition for involuntary placement should have been initiated prior to the expiration of the initial Baker Act. In the past we have petitioned the court for the continuation of treatment, filing with the court a petition for involuntary placement. We do know that this does not apply to treatment (medication) and are fully aware of the need for a court order to administer medication.

The law requires that the application for voluntary admission be filed by the minor's guardian. If the court had formally appointed DCF or the community-based care agency as the child's legal guardian, consent by the authorized person from that agency would be permissible. However, this isn't the usual practice. Absent a formal guardian appointed by the court, the court itself would act as the child's guardian and would be responsible for signing the voluntary application. The only other alternative would have been to file a petition for involuntary placement.

D. Involuntary Examinations

In order to initiate involuntary examination for a child or adolescent, do you need the parent's permission? This question came up after an agency director reported having heard that parents must approve before a child or adolescent can be Baker Acted.

No. There is no basis for a parent or guardian of a child to provide consent or refuse consent to his/her child's **involuntary** examination. This decision is entirely

up to a judge, law enforcement officer, or authorized mental health professional who has reason to believe the involuntary examination criteria are met. In section 394.463, Florida Statutes, governing involuntary examination, no difference between adults and minors is noted, and parental consent is not mentioned.

When a minor is brought to a receiving facility pursuant to an ex parte order for involuntary examination, does consent for the admission and treatment by the guardian specified under section 394.459(3)(a)1., Florida Statutes, still apply? If so, is this for both admission and treatment or just treatment?

The minor must be accepted by the facility and must be examined (section 394.463) by a physician, psychologist, or psychiatric nurse, as each is defined in the Baker Act, to determine if he/she meets criteria for involuntary placement (section 394.467), regardless of whether consent is obtained from the guardian. However, treatment is a different issue, since the court order is generally silent as to this issue. The minor can't be treated unless, after full disclosure, the child's legal guardian (parent or court-appointed guardian) provides consent. If a legal guardian is not available or refuses such consent, a court order for treatment would be required, short of an emergency treatment order resulting from documentation of imminent danger.

A parent of a student who was recently Baker Acted from school by the school resource officer stated that since there is Native American ancestry in the child's background, a federal order is required before he can be Baker Acted. Since the need to hospitalize him again in the future may occur, we are hoping that you can steer us in the right direction on this.

Contrary to the parent's statement, there isn't any exception in the Baker Act for persons with Native American ancestry. People of all nationalities undergo involuntary examination under the Baker Act. The Vienna Convention on Consular Relations and bilateral treaties the United States has negotiated with other countries require consulate notification and access to foreign nationals held against their will in hospitals. Only a state circuit court (in addition to certified law enforcement officers and authorized mental health professionals) has authority to initiate an ex parte order under the Baker Act — federal courts have no such authority. In fact, federal law enforcement officers can't initiate involuntary examinations, per the Florida Attorney General (Op. Att'y Gen. Fla. 99-68 (1999)) — only law enforcement officers who are certified under state law may do so. Native American reservations are subject to federal law, just like military bases and VA hospital properties. However, the Baker Act is applicable to persons of all ages who are in Florida as residents, citizens, visitors, or otherwise, on legal or

illegal bases.

Our risk managers (attorneys) indicated there is a gap in the Baker Act law. They instructed us that a child can be involuntarily examined, but cannot be involuntarily placed. Usually families sign their children in voluntarily. If it is true that you cannot treat a child on an involuntary status, what are our options?

The information you've been given is incorrect. Minors are frequently involuntarily placed by courts throughout the state, as the criteria for involuntary examination and involuntary inpatient placement refer to "a person" regardless of age. Minors cannot be ordered to involuntary **outpatient** services — this may have caused some confusion. You should also consider the issues of admission/ placement separately from the issue of treatment.

- No minor can provide **consent** for his/her own admission or treatment. However, if the child refused to **assent** (agree) to the admission, it is necessary to initiate the involuntary process — involuntary examination if necessary to conduct the examination and involuntary inpatient placement if the examination reflects that the minor meets the criteria under section 394.467, Florida Statutes.

- With regard to **voluntary** admission of a minor, a parent or guardian must actually sign the application, but a judicial hearing must be conducted **prior to** the child's admission.

With regard to a parent's demand for release of the child, you may need to consider a referral to the child abuse hotline if you believe the parent's refusal of care represents abuse or neglect, as defined in chapter 39, Florida Statutes.

Chapter Four: Involuntary Examination

I. In General

See § 394.463, Fla. Stat.; Fla. Admin. Code R. 65E-5.280.

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 ensured 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 included here:

> "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.

§ 394.455(28), Fla. Stat.

II. Criteria

Section 394.463(1), Florida Statutes (emphasis added), provides:

> 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:
>
> (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 self or others in the near future, as evidenced by recent behavior.

III. Initiation

Under section 394.463(2)(a), Florida Statutes, an involuntary examination may be initiated by the following three means:

- **A court may** enter an ex parte order (form CF-MH 3001 or other order developed by the court) stating that the person appears to meet the criteria for involuntary examination, specifying the findings on which that conclusion is based. The order must be based on sworn testimony, written or oral (form 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 the person to an appropriate, or the nearest, facility within the designating receiving system under section 394.462, Florida Statutes, 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" 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." § 394.463(2)(c), (2)(d). The officer must execute a written report titled "Transportation to Receiving Facility" (form 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. If no time limit is specified in the order, it is valid for seven days after the date it 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 must be made a part of the person's clinical record.

- **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 the person delivered, to an appropriate or 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. The report must be made a part of the person's clinical record.

- **A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker** (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, The certificate must **state the professional's observations** on which that conclusion is based. A law enforcement officer must take the person named in the certificate into custody and deliver the person to an appropriate or the nearest receiving facility for involuntary examination, and must execute a written report (CF-MH 3100) detailing the circumstances under which the person was taken into custody. The report and certificate are to be made a part of the person's clinical record.

See also Fla. Admin. Code R. 65E-5.280(1)–(3).

IV. Definitions of Mental Health Professionals

Under section 394.455, Florida Statutes, mental health professionals are defined as follows:

> (5) "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.
>
> * * *

(7) "Clinical social worker" means a person licensed as a clinical social worker under s. 491.005 or s.491.006.

* * *

(25) "Marriage and family therapist" means a person licensed as a marriage and family therapist under s. 491.005 or s.491.006."

(26) "Mental health counselor" means a person licensed as a mental health counselor under s. 491.005 or s.491.006."

* * *

(32) "Physician" means a medical practitioner licensed under chapter 458 or chapter 459 who has experience in the diagnosis and treatment of mental illness or a physician employed by a facility operated by the United States Department of Veterans Affairs or the United States Department of Defense.

(33) "Physician assistant" means a person licensed under chapter 458 or chapter 459 who has experience in the diagnosis and treatment of mental disorders.

* * *

(35) "Psychiatric nurse" means an advanced registered nurse certified under s. 464.012 who has a master's or doctoral degree in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has 2 years of post-master's clinical experience under the supervision of a physician."

(36) "Psychiatrist" means a medical practitioner licensed under chapter 458 or chapter 459 for at least 3 years, inclusive of psychiatric residency.

* * *

(38) "Qualified professional" means a physician or a physician assistant licensed under chapter 458 or chapter 459; a psychiatrist licensed under chapter 458 or chapter 459; a psychologist as defined in s. 490.003(7); or a psychiatric nurse as defined in s. 394.455.

The Florida Attorney General issued an opinion in May 2008 that **physician assistants** may, under certain conditions, initiate an involuntary examination. Op. Att'y Gen. Fla. 08-31 (2008). The opinion did not extend any other authority granted to physicians.

V. Initial Mandatory Involuntary Examination

A person must have an initial mandatory involuntary examination "by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility without unnecessary delay to determine if the criteria for involuntary services are met. Emergency treatment may be provided upon the order of a physician if the physician determines that such treatment is necessary for the safety of the person or others." § 394.463(2)(f), Fla. Stat.

This initial mandatory involuntary examination must include:

- a thorough review of any observations of the person's recent behavior;
- a review of the document initiating the involuntary examination and transportation form;
- a brief psychiatric history; and
- a timely face-to-face examination to determine whether the person meets the criteria for release.

Fla. Admin. Code R. 65E-5.2801(1).

A physical examination, which must be conducted within 24 hours of the person's arrival at the facility (section 394.459(2)(c)), 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, a clinical psychologist, or the physician in the hospital's emergency department. The release can also be approved by a psychiatric nurse (as defined in the Baker Act) performing under a protocol with a psychiatrist and as otherwise provided in section 394.463(2)(f), Florida Statutes.

VI. Release

Section 394.463(2)(g), Florida Statutes, provides:

> 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 person:
>
> 1. The patient shall be released, unless he or she is charged with a crime, in which case the patient must be returned to the custody of a law enforcement officer;
>
> 2. The patient shall be released . . . 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 voluntarily patient [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 medical, mental health, or substance abuse treatment]; or
>
> 4. A petition for involuntary placement shall be filed in the circuit court if inpatient treatment is deemed necessary or with the criminal county court, as defined in s. 394.4655(1), as applicable. If 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(4)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

If the person is converted to voluntary status in lieu of involuntary placement being sought, it may be necessary under some circumstances to file documents with the clerk of court to prohibit firearm purchase. *See* Chapter Eight of this benchguide.

VII. Notice of Discharge or Release

Notice of discharge or transfer of a person must be given as provided in section 394.4599, Florida Statutes. § 394.469(2), Fla. Stat.

Notice of release (form CF-MH 3038) must be given to the person's guardian or representative, any person who executed a certificate admitting the person to the

receiving facility, and any court that ordered the person's evaluation. § 394.463(3), Fla. Stat.

VIII. Involuntary Examination Flowchart

(DCF flowchart; 2016 legislative changes are not incorporated.)

Involuntary Examination

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

Criteria: Reason to believe person has a mental illness **and** because of the mental illness

- Person refuses ***or*** is unable to determine examination is necessary; **and**
- Likely to suffer from self-neglect ***or*** harm to self or others

Initiation by

- Law enforcement
- Circuit court
- Authorized mental health professional

Transportation to Receiving Facility

- Law enforcement takes person into custody and delivers person to nearest receiving facility for involuntary examination
- Exceptions to law enforcement transport only in accord with transportation exception plan, county-funded transport contract, or emergency medical transport

- Notices to guardian or representative
- Initiating document and cover sheet sent to BA Reporting Center within 1 working day
- Initial mandatory examination by a physician or clinical psychologist without necessary delay
- Physical examination by an authorized health practitioner within 24 hours after arrival
- Determination of adult's competence to give express and informed consent to treatment

Competent to consent — 3040a, 3040b

Incompetent to consent to treatment → Petition for adjudication of incompetence to consent and appointment of guardian advocate

Within 72 hours of examination period

- Released from receiving facility after "approval" by psychiatrist, clinical psychologist, or ER physician, with required notices sent
- Petition for involuntary inpatient/outpatient placement completed by two experts and facility administrator
  If 72 hour period ends on weekend or holiday, petition filed by next working day
- Transferred to voluntary status if all criteria are met
  If person is determined by physician to be of imminent danger, packet of forms on firearm prohibition filed within 24 hours with Clerk of Court

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IX. Frequently Asked Questions

A. Criteria and Eligibility

I'm a detective with the sheriff's office. I'm getting many calls regarding the Baker Act and people with autism who are being violent. The callers want to know if they can Baker Act if someone has autism. I explained you cannot Baker Act based on the autism label alone, but you can Baker Act if the person is a threat to himself/herself or someone else. The question then becomes: if the violence is a behavioral aspect of the developmental disability, can you still Baker Act? My position is a mental health facility would be a better choice than jail. I then suggest they explore all other alternatives that may be available. Can you please give me some guidance?

Regarding your question about initiating involuntary examination under the Baker Act, there must be a diagnosis of mental illness consistent with the definition in the law, refusal or inability to determine examination is needed, and passive or active danger. If any one of these isn't present, an initiation wouldn't be appropriate. Just being a threat to self or others (active danger) wouldn't be sufficient unless it resulted from a mental illness. Autism is a diagnosis under chapter 393, Florida Statutes, governing developmental disabilities that is excluded from the statutory definition of mental illness:

> **394.455. Definitions** (emphasis added)
>
> (28) "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 developmental disabilities as defined in chapter 393**, intoxication, or conditions manifested only by antisocial behavior or substance abuse.
>
> **393.063. Definitions**
>
> For the purposes of this chapter, the term:
>
> (3) "Autism" means a pervasive, neurologically based developmental disability of extended duration which causes severe learning, communication, and behavior disorders with age of onset during infancy or childhood. Individuals with autism exhibit

> impairment in reciprocal social interaction, impairment in verbal and nonverbal communication and imaginative ability, and a markedly restricted repertoire of activities and interests.

While a person cannot be Baker Acted for dangerous behavior resulting from autism, a judge or law enforcement officer may have reason to believe the person has a mental illness in addition to autism. In such a situation, the initiation of involuntary examination may be appropriate. Judges and law enforcement officers aren't expected to be diagnosticians; they can be wrong just like a mental health professional is sometimes wrong. They also need to be aware that the person is only going to be examined and may be released immediately or within 72 hours back to where they came from. If treated, the only treatment available is for psychiatric conditions and not for a developmental disability. Initiating an involuntary examination may alleviate an immediate danger situation but is unlikely to have any lasting benefit. You are correct that criminalization of a developmental disorder or a mental health diagnosis should be avoided whenever possible.

One of my deputies was told by the local CSU that it doesn't accept Alzheimer patients and officers can't Baker Act an Alzheimer's patient. The deputy then took the patient to the county hospital. The deputy told the social worker that the man had beaten his wife earlier in the day and then stood out in the street directing traffic. There was no medical issue with this man. Was the CSU correct?

Section 394.462(1)(k), Florida Statutes, states: "The appropriate facility within the designated receiving system pursuant to a transportation plan or an exception under subsection (4), or the nearest receiving facility if neither apply, must accept persons brought by law enforcement officers, or an emergency medical transport service or a private transport company authorized by the county, for involuntary examination pursuant to s. 394.463." This means that if the person is on Baker Act involuntary status and transport is by law enforcement or specified transport services, there is no exception to the receiving facility being required to "accept" the person from the officer. If the person is under the involuntary provisions of the Marchman Act, the facility must provide such persons "a basic screening or triage sufficient to refer the person to the appropriate services." § 394.462(l). If the facility can't manage the person's medical condition, the person has public or private insurance that will pay at another facility, or for any other reason the facility can't accept the person, it is up to the receiving facility to arrange the person's transfer to a more appropriate facility. It may be true that the facility won't "admit" a person with Alzheimer's or other medical conditions, but it must

"accept" the person and arrange for medical transport rather than having the officer put such a person back into the cruiser.

As noted above, section 394.455(28), Florida Statutes, defines the term "mental illness." This definition excludes developmental disabilities, substance abuse impairment, and antisocial behavior. It has no other exceptions for Alzheimer's or other conditions. If a person has Alzheimer's and otherwise meets the criteria for involuntary examination, the person can indeed be Baker Acted.

Is it possible to involuntarily hospitalize someone with severe anorexia, and if so, what are the criteria used and what type of professional would evaluate and sign the Baker Act forms?

A person must have a "mental illness" as defined in the Baker Act and meet the criteria for involuntary examination, including that:

> 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.

§ 394.463(1), Fla. Stat.

The involuntary examination can be initiated by a circuit court judge, a law enforcement officer, or an authorized mental health professional.

Regarding your first question about anorexia as a diagnosis, professionals usually

consider a thought or mood disorder diagnosis to be required for the Baker Act. If you as an authorized professional, based on your own evaluation of the person, believe anorexia to be such a thought or mood disorder or that the person has a thought or mood disorder in addition to the anorexia, that would suffice.

One of the criteria for commitment for involuntary examination is "The person is unable to determine for himself or herself whether examination is necessary." Is there any guidance, case law, or criteria that are used to make this determination?

Zinermon v. Burch, 494 U.S. 113, 110 S.Ct. 975, 108 L.Ed.2d 100 (1990), a U.S. Supreme Court decision, was based on the definitions and other provisions of chapter 394, part I, Florida Statutes, which include:

> **394.455. Definitions** (emphasis added)
>
> (15) "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.
>
> * * *
>
> (21) "**Incompetent to consent to treatment**" means a state in which a person's judgment is so affected by a mental illness that he or she lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical, mental health, or substance abuse treatment.
>
> **394.459. Rights of patients**
>
> **(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. . . .
>
> **394.4625 Voluntary admissions** (emphasis added)
>
> **(1) Authority to receive patients.--**
>
> (a) A facility may receive for observation, diagnosis, or treatment any person 18 years of age or older **making application by express**

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

* * *

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

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

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

The Baker Act has always required that an adult be competent to provide express and informed consent in order to be admitted or retained on voluntary status. An involuntary examination is based on, among other criteria, the person either refusing the examination or being unable to determine for himself/herself whether examination is necessary. Refusal is fairly clear. However, a finding of the inability to determine whether examination is necessary can be based on any number of situations; for example:

- The person is like Burch in the case cited above, who was willing to go

anywhere, do anything, or sign any document because he thought he was in Heaven. The U.S. Supreme Court found this to be de facto evidence of being incompetent to provide express and informed consent.

- The person repeatedly changes his/her mind.
- The person is clearly manipulating a law enforcement officer to avoid involuntary status.
- The person may have a severe impulse control problem and is articulating a desire for help, but may not be able/willing to act on the desire.

Generally "unable to determine" is someone who fits one or more of the above types of situations or is determined to be unable to make consistent "a well-reasoned, willful, and knowing decision concerning his or her medical, mental health, or substance abuse treatment." § 394.455(21), Fla. Stat.

Can an individual who is a non-resident of Florida be legally detained and court committed under the Florida Baker Act?

Yes. Any person who is present in the state of Florida is subject to the Baker Act. Such persons, if they meet the criteria for involuntary examination, can be taken into custody and legally examined under the law. If they are found to meet the criteria for involuntary placement, a petition can be filed to further detain them for treatment. It may be advisable to arrange a return of the person to his/her own state as soon as possible to ensure appropriate discharge and aftercare planning. Finally, if the person is a foreign national with citizenship in another country (even if with dual citizenship in the U.S.), there are obligations for consular notification and access.

How is "self-neglect" defined as a criteria for involuntary examination?

The Baker Act doesn't actually define self-neglect, but it does provide for the situation when the person is likely to suffer a real and present threat of substantial harm to his or her well-being that isn't avoidable by intervention from family, friends, or other services. The self-neglect must be a result of mental illness and could take the form of refusing necessary prescription medications, refusing to eat or drink, inability to sleep, placing oneself in imminently dangerous situations, or other high risk behaviors. It would not include refusal of medical intervention by a person with the capacity to make such decisions.

B. Initiation in General

Does an authorized person have a duty to initiate an involuntary examination?

Judges and mental health professionals do not have a statutory duty to initiate the examination when they have reason to believe the criteria have been met. However, they may have a responsibility under their code of ethics or under case law. On the other hand, a law enforcement officer has no discretion as to initiating an involuntary examination if he/she has reason to believe the criteria are met.

I'd like to know more about "reason to believe" the criteria are met — how much discretion an authorized person has. If a court "may" do something (discretionary) like initiate involuntary examination, what criteria is the court to use in determining whether to actually do it? Is it just a matter of general prudence? If you have the right but not the duty to do something, can you just base the decision on whim, or are there some implied criteria?

That is correct — a judge and a mental health professional may initiate if they have reason to believe the criteria are met, but have no duty to do so. A law enforcement officer has the duty to do so if he/she has reason to believe the criteria are met. If a law enforcement officer doesn't believe the criteria are met and declines to initiate, he/she may wish to document at the time, on an incident report, the reason for not initiating.

Law enforcement officers are required to initiate if they have reason to believe; judges are not required to initiate even if they have reason to believe. So a judge could find all the criteria to be met and still decline to initiate examination. The discretion offered by the "may" language comes down to whether the person with the legal authority to make the decision has reason to believe each of the criteria is met.

Some judges are more likely than others to sign orders for emergency action (domestic violence, Baker Act, Marchman Act, etc.). Other judges won't sign such an order if it will deprive a person of liberty unless it's first proven that the criteria are met. The standard is simply having "reason to believe." In *Blair v. Razilou*, 2010 WL 571980 (M.D. Fla. 2010), a federal lawsuit against the city of Naples police department, the court held that under the facts known to the police officer at the time of the Marchman Act initiation, a reasonable officer in the same circumstances **could** have believed the plaintiff met the Marchman Act criteria.

The criteria are clearly spelled out in the law. The person with the authority to initiate must rely on those criteria — nothing more or less. However, everyone has filters through which objective facts are applied against the criteria in determining whether he or she has reason to believe the criteria are met. Some examples are:

- A belief that both the clinical and functional aspects of the definition of mental illness are met.
- That the person has refused or is unable to determine the examination is needed. Refusal is objective, but the inability to determine may be quite subjective.
- That the person's self-neglect is "real, present and substantial."
- That the bodily harm is serious enough, and whether the actions on which that conclusion is based are recent enough or the harm will occur in the near enough future.

These aren't "whims" but individual belief systems. While continued training can add much more consistency for those who are authorized to initiate involuntary examinations, the subjective differences in "reasons to believe" will and should remain.

If persons with the authority to initiate an involuntary examination deviate far from their professional standards, they can face discipline from groups such as licensing boards, the Judicial Qualifications Commission, or Internal Affairs, depending on whether the initiator is a mental health professional, judge, or law enforcement officer.

Can a patient who requested voluntary status after coming in under involuntary status be transferred to a public facility under a newly created professional's certificate? My thought is that the patient's status should be changed to involuntary and a petition filed. Is this correct?

Yes. Too frequently people are transferred from involuntary to voluntary status who can't consistently make well-reasoned, willful, and knowing decisions about their medical, mental health, or substance abuse treatment — the very definition of competence to consent. Then when the person requests discharge or refuses treatment, the law requires that either the person be released within 24 hours or a petition for involuntary inpatient placement be filed within two court working days of the person's request/refusal.

A certificate of a professional is only used to have the person taken into custody and delivered to a designated receiving facility. Once at a receiving facility, the proper procedure is to release the person, convert to voluntary, or file the placement petition within 72 hours. However, when a petition for involuntary inpatient placement is filed on behalf of a person on voluntary status who requests discharge or refuses treatment, it must be filed within two working days of the request or refusal. Any transfer to another facility and re-evaluation at that facility would have to fit within the original 72-hour period during which a person's liberty can be denied for the purpose of involuntary examination.

How does a family member get his or her adult child Baker Acted when the parties reside in different states? Can the person obtain an ex parte order in Florida that would be enforced in Delaware? Could the family member have the receiving facility be a VA hospital in Delaware if the subject qualifies?

Each state has enacted its own mental health law, and each is different. The family would have to contact the Delaware authorities to determine the basis for an involuntary examination in that state. Any initiation of such action would probably have to take place in the state where the person needing the examination actually lives so his/her due process rights can be protected. It is unknown whether Delaware would permit the family to communicate with the court or others having authority to initiate such intervention by sworn testimony or whether their presence would be required — it depends on the requirements of that state's mental health law. Regarding treatment at a VA hospital, this would be permitted in Florida, but whether that would apply in Delaware is unknown.

C. Initiation by Courts

I am trying to find out the procedure for a family member to petition a judge for an ex parte order to have someone involuntarily picked up for psychiatric assessment. We have had times when we advise the family to get one but never tell them how to do it. Does it require more than one person to get it? Can a non-relative request an ex parte order for a friend or neighbor if no family is around?

The Baker Act provides the following for an ex parte order:

> A circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination and specifying the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on written or

> oral sworn testimony that includes specific facts that support the findings. 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 an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The order of the court shall be made a part of the patient's clinical record. A fee may not be charged for the filing of an order under this subsection. . . . The order shall be valid only until the person is delivered to the facility or for the period specified in the order itself, whichever comes first. 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.

§ 394.463(2)(a)1., Fla. Stat.

Any person who has first-hand knowledge of the individual's mental health status can file a petition with the probate office of the clerk of court. The law just states that it must be based on sworn testimony, but doesn't indicate how many people must file. It generally requires only one petition if the judge believes the criteria to be met. If the judge has any reservations, he/she might require a second petition. The judge is going to want to be assured that the petitioner's reason for filing isn't retaliatory in any way.

The four-page model petition form (CF-MH 3002) can be found on the DCF website, but the court in your circuit may have modified the form. There is no reason the petitioner couldn't have a copy of the form in advance to know what type of information may be required. The staff in the clerk's office is not able to provide the petitioner more than ministerial assistance. *See* § 28.215, Fla. Stat. ("The clerk of the circuit court shall provide ministerial assistance to pro se litigants. Assistance shall not include the provision of legal advice"); Op. Att'y Gen. Fla. 94-80 (1994). Once the petitioner completes the form and swears to the accuracy of the information provided, the clerk will take the form to the judge and the judge will decide whether to sign an ex parte order for examination and a pick-up order for the sheriff to execute. The whole process shouldn't take more than several hours, assuming the person can be easily found.

A judge completed a law enforcement BA form and marked out everywhere it said law enforcement officer and wrote in "Judge." If a judge wanted to Baker Act someone, what would be the appropriate form to use? Now that the law enforcement officer is at our door with the Baker Act form completed by

the judge, what would be the appropriate steps for the receiving facility to take?

A judge doesn't qualify to execute a law enforcement officer's report initiating an involuntary examination under the Baker Act. Only a certified law enforcement officer is authorized to do so — this is defined below:

> **394.455. Definitions**
>
> As used in this part, unless the context clearly requires otherwise, the term:
>
> (24) "Law enforcement officer" has the same meaning as provided in s. 943.10.
>
> **943.10. Definitions; ss. 943.085-943.255**
>
> The following words and phrases as used in ss. 943.085-943.255 are defined as follows:
>
> (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.

A judge is authorized to enter an order initiating an involuntary examination only under the following circumstances:

> **394.463. Involuntary examination**
>
> **(2) Involuntary examination.--**
>
> (a) An involuntary examination may be initiated by any one of the following means:

> 1. A circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination and specifying the findings on which that conclusion is based. The ex parte order for involuntary examination **must be based on written or oral sworn testimony** that includes specific facts that support the findings. 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 an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The order of the court shall be made a part of the patient's clinical record. A fee may not be charged for the filing of an order under this subsection. A facility accepting the patient based on this order must send a copy of the order to the department on the next working day. The order may be submitted electronically through existing data systems, if available. The order shall be valid only until the person is delivered to the facility or for the period specified in the order itself, whichever comes first. 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.

The model petition that contains the statutorily required sworn testimony is form CF-MH 3002, and the Ex Parte Order for Involuntary Examination is form CF-MH 3001. It would be good to work through your agency's attorney to get information to the judge as soon as possible so this doesn't happen again. Judges are usually grateful for the information. You may wish to inform your attorney of this event in any case.

I'm a circuit court judge. I've heard that some judges believe that a judge can enter an order in open court for an involuntary examination of a person who appears in court exhibiting symptoms of a mental illness. I believe this would be unlawful and that a petition must be filed, or that law enforcement could make the determination if called to the courtroom but that the judge could not.

You are correct. Section 394.463(2)(a)1., Florida Statutes, requires that any ex parte order "be based upon written or oral sworn testimony."

While the law permits oral testimony that could potentially be elicited in a courtroom, the Florida Administrative Code requires use of the model state form (CF-MH 3002) "or other form used by the court." Fla. Admin. Code R. 65E-5.280.

Whatever form or method is used, the information included on the petition form is considered by most courts to guide the appropriate application of the law.

Our CSU received two admissions yesterday on orders signed by a county judge, titled "Order Releasing Defendant on His Recognizance for Psychiatric Evaluation." The patients came to us from the county jail with the language "Ordered and Adjudged that the Defendant in the above-styled case is to be released on his/her own recognizance contingent upon the Detention Center personnel delivering him/her to the public receiving facility for evaluation and treatment. The Defendant shall not be released from the facility unless 24 hour advance notice has been provided to this Court in writing so that the Court may further consider his/her custodial status." Do we treat this as an ex parte order under the Baker Act and follow Baker Act procedure filing a petition for placement to hold the patient beyond 72 hours, or do we consider this court order sufficient to hold the patient and treat the patient without further action? Can the patient consent to his/her own treatment if the psychiatrist finds the individual competent to do so? If the patient is found by the psychiatrist to be incompetent to consent to treatment, should we petition the court for a guardian advocate, or is the fact that the order we received includes the word treatment sufficient to treat the patient? We had an order similar to this some time back, and the public defender had us file a BA-32 and have a guardian advocate appointed, stating that the order signed by the judge denied the patient his rights under the Baker Act.

You must either accept a judge's order or appeal it — otherwise you might be subject to contempt. This is one that you may wish to have your attorney review, perhaps with the DCF circuit legal counsel as well. Until July 1, 2016, only a circuit judge has jurisdiction to enter an ex parte order for involuntary examination under the Baker Act — not a county judge, unless the chief judge has appointed that county judge to sit circuit for a temporary period. It sounds like the judge didn't initiate the involuntary examination under the Baker Act, the civil mental health statute. Instead, it appears to be a forensic competency evaluation; this is usually done while the person is in jail, by experts appointed by the court and at the cost of the local judicial system.

It is important that the purpose of the examination/evaluation be clarified as quickly as possible because the latter evaluation probably wouldn't be possible at your facility. If it is intended to be a civil ex parte order, you must release the person back to law enforcement within 72 hours or file a BA-32 with the court for further "detention." At this point, the person will have a public defender to represent him/her in the Baker Act proceedings. The person probably already has a

public defender for the criminal matter. Again, if it is a Baker Act issue, the person can consent or refuse to consent to his/her own treatment if found by the physician to be able to make a well-reasoned, willful, and knowing decision about medical, mental health, or substance abuse treatment. Otherwise, a guardian advocate would have to be requested per the Baker Act. Your attorney and the DCF counsel should meet with the local judges about the appropriateness of certain court orders for future reference.

Can a county court judge in a first appearance hearing order a misdemeanor defendant to have an involuntary Baker Act assessment? In our county the judge has been ordering the individual to cooperate with CSU in its Baker Act assessment, not actually ordering the evaluation but rather leaving that to the discretion of the mental health professional.

No. A circuit or county judge has jurisdiction under the Baker Act to enter an ex parte order for "involuntary" examination. Such an order has to be based on sworn testimony by an individual who has personal observations of the defendant's behavior.

However, in the circumstance you describe, the defendant is being ordered to be "voluntary" under the law. This involves providing express and informed consent to the examination. Such consent cannot involve any element of force, duress, or coercion:

> **394.455. Definitions**
>
> (15) "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.

However, a judge's order prevails unless it is appealed by a party with standing to do so. In such a circumstance, the defendant's public defender or private counsel or the assistant state attorney is probably the party with such standing. It might be helpful for the attorney representing your agency to meet with the judge on the issue for future reference.

When a judge issues a pick-up order for the sheriff to take a person into custody under the Baker Act, what happens if law enforcement can't find the person within 14 days? Does the petitioner need to go back to the court and resubmit the petition, or does the sheriff keep the order indefinitely?

Section 394.463(2)(a)1., Florida Statutes, states: "The order shall be valid only until the person is delivered to the facility or for the period specified in the order itself, whichever comes first. 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." This means that the judge can make the order for a period greater or less than seven days, but if no time is specified by the judge, it expires seven days after it is signed. In the example you describe, the order was written to provide up to 14 days for law enforcement to find the person and take him/her into custody. If that occurs within 14 days, the order expires upon taking the person into custody and acceptance at the receiving facility. If the person isn't found within the 14 days, the order expires and a new order would have to be sought to take the person into custody.

I am a general magistrate handling BA hearings. Is a hearing required when an ex parte petition for involuntary examination is denied due to legal insufficiency? That is, should an order denying the request for examination provide a hearing date for a petitioner to address his or her concerns?

A hearing is not needed to deny the petition for legal insufficiency at the time of or subsequent to a denial anywhere in the state. The law and rules governing this process only require an ex parte process (without a hearing) for a court to enter an order denying a person his or her liberty for the purpose of involuntary examination. The sworn testimony in an affidavit should stand on its own as to whether the information is persuasive in convincing a judge that there's reason to believe each of the criteria is met. There is no reason why a judge couldn't conduct a hearing with a petitioner if he/she believed it was needed. Neither is there any reason why the petitioner couldn't file a subsequent amended petition providing additional information for the judge's consideration. Finally, if the patient's condition escalated after the petition was filed/denied, the petitioner could contact law enforcement in an emergency to request initiation of the examination.

D. Transport

Can a judge order an individual to be transported for involuntary examination to a facility that is not the nearest?

No. A person must be taken by law enforcement to the facility designated in the county's transportation plan or the nearest receiving facility rather than to the preferred facility. After arrival at the designated Baker Act receiving facility, the person or legal representative can request a transfer to an alternate facility. Exceptions are when law enforcement believes an emergency medical condition exists or a transportation plan has been approved by the board of county

commissioners.

E. Examination and Release

Can you explain the timeframes for involuntary examination under the Baker Act and when the petition for involuntary placement must be filed with the court?

The 72-hour clock starts when the person under the Baker Act arrives at a hospital or receiving facility for involuntary examination. This means if the person is delivered to your ER by law enforcement, that is when the clock starts ticking. It only stops if a physician documents that an emergency medical condition exists, and it starts back up again as soon as the doctor documents that the emergency medical condition has stabilized or doesn't exist. If the involuntary examination is initiated at your facility, the 72-hour period begins at the time the initiation form is signed.

The BA-32 petition for involuntary placement must be completed within the 72-hour period. It must also be filed with the court within the 72-hour period, unless that period ends on a weekend or legal holiday. No mention is made of weeknights. Therefore, if a person arrives at 5 a.m. on a Monday, you would have to file the petition before close of court on Wednesday, unless electronic filing is available, in which case it would be filed by 5 a.m. Thursday. Otherwise, the filing would exceed the 72-hour period from the point of arrival. However, if the person arrives at 5 a.m. on a Thursday, the petition must still be completed (signatures of both experts and the administrator) within 72 hours, but it doesn't need to be actually filed with the court until Monday (the next working day). See rule 2.514(a), Florida Rules of Judicial Administration, regarding computing time.

A petition for involuntary inpatient placement was recently dismissed in our county because more than 72 hours had passed between the law enforcement officer taking the patient into custody and the filing of the petition for placement. Please clarify.

The date/time the person was taken into custody is not referenced in the law/rules. In every case, the clock starts when the person arrives at the first facility (either ER or receiving facility). It is important to remember that all parts of a hospital, not just the psychiatric unit, are part of the receiving facility.

Who has to receive a notice of the person's release from a receiving facility after an involuntary examination?

Notice has to 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.

X. Selected Baker Act Forms for Involuntary Examination

Please note that these recommended forms were promulgated by DCF before the 2016 statutory amendments and do not incorporate those changes.

A. Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination

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
Print Name of Petitioner

court order for the 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,
   Date Time
   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 [intellectual disability], 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: Date of Birth:
Sex : ☐ Male ☐ Female Race: Attach a picture of the PERSON if possible. Picture attached: ☐ No ☐ Yes
Height: Weight: Hair Color: Eye Color:
Does the PERSON have access to any weapons? ☐ No ☐ Yes If yes, describe:
Is the PERSON violent now? ☐ No ☐ Yes Has the person been violent in the recent past? ☐ No ☐ Yes If Yes, Describe:
Does the PERSON have any pending criminal charges against him/her? ☐ No ☐ 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

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_____

OR

SWORN TO AND SUBSCRIBED before me

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**

B. Ex Parte Order for Involuntary Examination

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**

Chapter Five: Involuntary Inpatient Placement

I. In General

See § 394.467, Fla. Stat.; Fla. Admin. Code R. 65E-5.290

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 ensured under the involuntary provisions of the Baker Act. Involuntary inpatient placement (commitment) occurs only after an examination and court hearing.

II. Criteria

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

§ 394.467(1), Fla. Stat.

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 has 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 in issue." Fla. Stand. Jury Instr. (Civil) 405.4.

III. Initiation of Involuntary Inpatient Placement

After an examination and timely filing of a petition for involuntary inpatient placement, a person meeting that criteria may 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." § 394.467(2), Fla. Stat. The second opinion may be conducted by electronic means by which all parties maintain visual as well as audio communication. If the administrator certifies that no psychiatrist or clinical psychologist is available to provide the second opinion, it may be provided by a licensed physician with postgraduate training and experience in diagnosis and treatment of mental illness or by a psychiatric nurse.

The recommendation must be entered on a petition for an involuntary inpatient placement certificate (form CF-MH 3032), or other form approved by the court, that authorizes the facility to keep the person pending transfer to a treatment facility or completion of a hearing. *Id.*

IV. Petition for Involuntary Inpatient Placement

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 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 where the person is located. No fee can be charged for the filing of the petition for involuntary inpatient placement. § 394.467(3), Fla. Stat.

V. Appointment of Counsel

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 has other counsel. The clerk of the court must immediately notify the public defender of the 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 represents the state, rather than the petitioning facility administrator, as the real party in interest in the proceeding. § 394.467(4), Fla. Stat.

VI. Continuance of Hearing

The person is entitled, with the concurrence of the person's counsel, to at least one continuance of the hearing, for up to four weeks. § 394.467(5), Fla. Stat. This continuance may be obtained by counsel for the person 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 — not the facility administrator or other parties — has standing to make such a request. Multiple continuances should not be sought to avoid placement unless legally sufficient express and informed consent has been obtained for the person's treatment.

VII. Independent Expert Examination

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. August 24, 2005, Commission Minutes, Agenda Item II.A. "The independent expert's report is confidential and not discoverable, unless the expert is to be called as a witness for the patient at the hearing." § 394.467(6)(a)3., Fla. Stat.

VIII. Hearing on Involuntary Inpatient Placement

The circuit 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 Fifth District Court of Appeal has held that the computation of time for involuntary placement hearings excludes 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 but rather within five business days. *D.M.H. v. Pietilla*, 33 So. 3d 800 (Fla. 5th DCA 2010).

"Except for good cause documented in the court file, the hearing must be held in the county or the facility, as appropriate, where the person is located, must be as convenient to the [person] as is consistent with orderly procedure, and shall be conducted in physical settings not likely to be injurious to the [person's] condition." § 394.467(6)(a), Fla. Stat. Further:

- The court may appoint a magistrate to preside at the hearing.
- One of the two professionals who executed the petition for involuntary placement certificate must be a witness. This role cannot be delegated to others.
- At the hearing, the testimony must be given under oath, and the proceedings must be recorded. The person may refuse to testify.
- If the court finds that the person's attendance at the hearing is not consistent with his or her best interests, 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 the right to be personally present and be constructively present through counsel, the trial court must certify through proper inquiry that the waiver is knowing, intelligent, and voluntary.

The circuit court must consider testimony and evidence regarding the person's competence to consent to treatment, as defined in section 394.455(21), Florida Statutes. 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 section 394.4598, Florida Statutes. § 394.467(6)(d), Fla. Stat.

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 person must be present at the hearing to provide testimony as desired by the court.

If at any time before the hearing ends it appears to the court that the person does not meet the criteria for involuntary inpatient placement but rather meets the criteria for substance abuse involuntary assessment, protective custody, or involuntary admission pursuant to section 397.675, Florida Statutes, the court may order (Order Requiring Involuntary Assessment and Stabilization for Substance Abuse and for Baker Act Discharge of Person, CF-MH 3114 or other form

approved by the court) the person to be admitted for involuntary assessment for five days pursuant to section 397.6811, Florida Statutes. After that, all proceedings will be governed by chapter 397, Florida Statutes (Marchman Act).
§ 394.467(6)(c), Fla. Stat.

If the court concludes that the person does meet the criteria for involuntary inpatient placement, it may enter an Order for Involuntary Inpatient Placement (CF-MH 3008 or other form approved by the court) providing that, for **up to** 90 days (many courts order a shorter period of time):

- the person be transferred to a treatment facility, **or**
- if the person is at a treatment facility, the person be retained there, **or**
- the person is to be treated **at** any other appropriate receiving or treatment facility, **or** is to receive services **from** a receiving or treatment facility on an involuntary basis.

However, any order for involuntary mental health services in a treatment facility may be for up to six months. "The court may not order an individual with traumatic brain injury or dementia who lacks a co-occurring mental illness to be involuntarily placed in a state treatment facility." § 394.467(6)(b), Fla. Stat.

IX. Admission to a State Treatment Facility

Section 394.467(6)(e), Florida Statutes, provides that the administrator of the petitioning facility must give a copy of the court order and adequate documentation of a person's mental illness to the administrator of a treatment facility (state hospital) when a person is ordered for involuntary inpatient placement, whether by a civil or a criminal court. The documentation must include the following:

- Any advance directives made by the person.
- A psychiatric evaluation of the person.
- Any evaluations of the person performed by a psychiatric nurse, a clinical psychologist, marriage and family therapist, mental health counselor, or clinical social worker.
- State Mental Health Facility Admission Form (CF-MH 7000) with attachments.

- Physician to Physician Transfer (CF-MH 7002). "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 by adequate orders and documentation."

X. Release of Persons on Involuntary Status

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 Outpatient Placement (CF-MH 3033). *See* § 394.469(2), Fla. Stat.; Fla. Admin. Code R. 65E-5.320.

The administrator must:

- 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;

- 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 (this 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 medical, mental health, or substance abuse treatment); or

- place an improved person, except a person under a criminal charge, on convalescent status in the care of a community facility.

§ 394.469(1), Fla. Stat.

XI. Return of Persons

"If a [person] involuntarily held at a treatment facility leaves the facility . . . without the administrator's authorization, the administrator may authorize a search for the [person] and his or her return to the facility. The administrator may request the assistance of a law enforcement agency in this regard." § 394.467(8), Fla. Stat.

XII. Procedure for Continued Involuntary Inpatient Placement

See Fla. Admin. Code R. 65E-5.300.

Continued involuntary inpatient placement hearings are administrative hearings and are conducted by administrative law judges (ALJs) employed by DOAH, rather than circuit court judges. The hearings "must be conducted in accordance with s. 120.57(1), except that any order entered by the administrative law judge is final and subject to judicial review in accordance with s. 120.68." § 394.467(7)(a), Fla. Stat. The Fifth District Court of Appeal has held that while continued involuntary inpatient placement hearings are administrative, the circuit court retains concurrent jurisdiction during the first six months after the order is entered. After six months, only DOAH has jurisdiction. *W.M. v. State*, 992 So. 2d 383 (Fla. 5th DCA 2008). (The 2016 Legislature reduced the maximum period of an order to 90 days at a receiving facility, while retaining a maximum period of six months at a state facility.)

If the person continues to meet the criteria for involuntary inpatient placement and is being treated at a treatment facility, the administrator must, within 20 days 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). § 394.467(7)(b), Fla. Stat. "If continued involuntary inpatient placement is necessary for a [person] admitted while serving a criminal sentence, but his or her sentence is about to expire, or for a minor involuntarily placed, 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." § 394.467(7)(e), Fla. Stat. The petition 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 (850) 921-6847

The petition 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 while he or she was involuntarily placed; and
- an individualized plan of continued treatment.

Notice of the hearing must be provided as set forth in section 394.4599, Florida Statutes. § 394.467(7)(b), Fla. Stat.

Unless the person "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." § 394.467(7)(c), Fla. Stat.

If a person's attendance at the hearing is voluntarily waived, the ALJ must determine that the waiver is knowing and voluntary before waiving the person's from all or part of the hearing. Alternatively, if at the hearing the ALJ finds that attendance at the hearing is not consistent with the best interests of the person, the ALJ may waive the presence of the person from all or part of the hearing, unless the person, through counsel, objects to the waiver. The testimony in the hearing must be under oath, and the proceedings must be recorded. § 394.467(7)(b), Fla. Stat.

If the person has been previously found incompetent to consent to treatment, the ALJ 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 ALJ 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 the person has been ordered to undergo involuntary inpatient placement and has previously been found incompetent to consent to treatment, the court must consider testimony and evidence regarding the person's incompetence. If such competency is restored, the discharge of the guardian advocate is governed by section 394.4598, Florida Statutes.

If at a hearing it is shown that the person continues to meet the criteria for involuntary inpatient placement, the ALJ must order continued placement in a receiving facility for a period not to exceed 90 days. However, any order for involuntary inpatient placement in a treatment facility (state hospital) may be for up to six months via the Order for Continued Involuntary Inpatient Placement or

for Release (CF-MH 3031). The same procedure must be repeated before the expiration of each additional period the person is retained. § 394.467(7)(d), Fla. Stat.

XIII. Involuntary Inpatient Placement Flowchart
(DCF flowchart; 2016 legislative changes are not incorporated.)

Appendix J

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.

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.

Competent to consent to treatment

May consent or refuse to consent to own treatment

Incompetent to consent to treatment

Guardian advocate appointed

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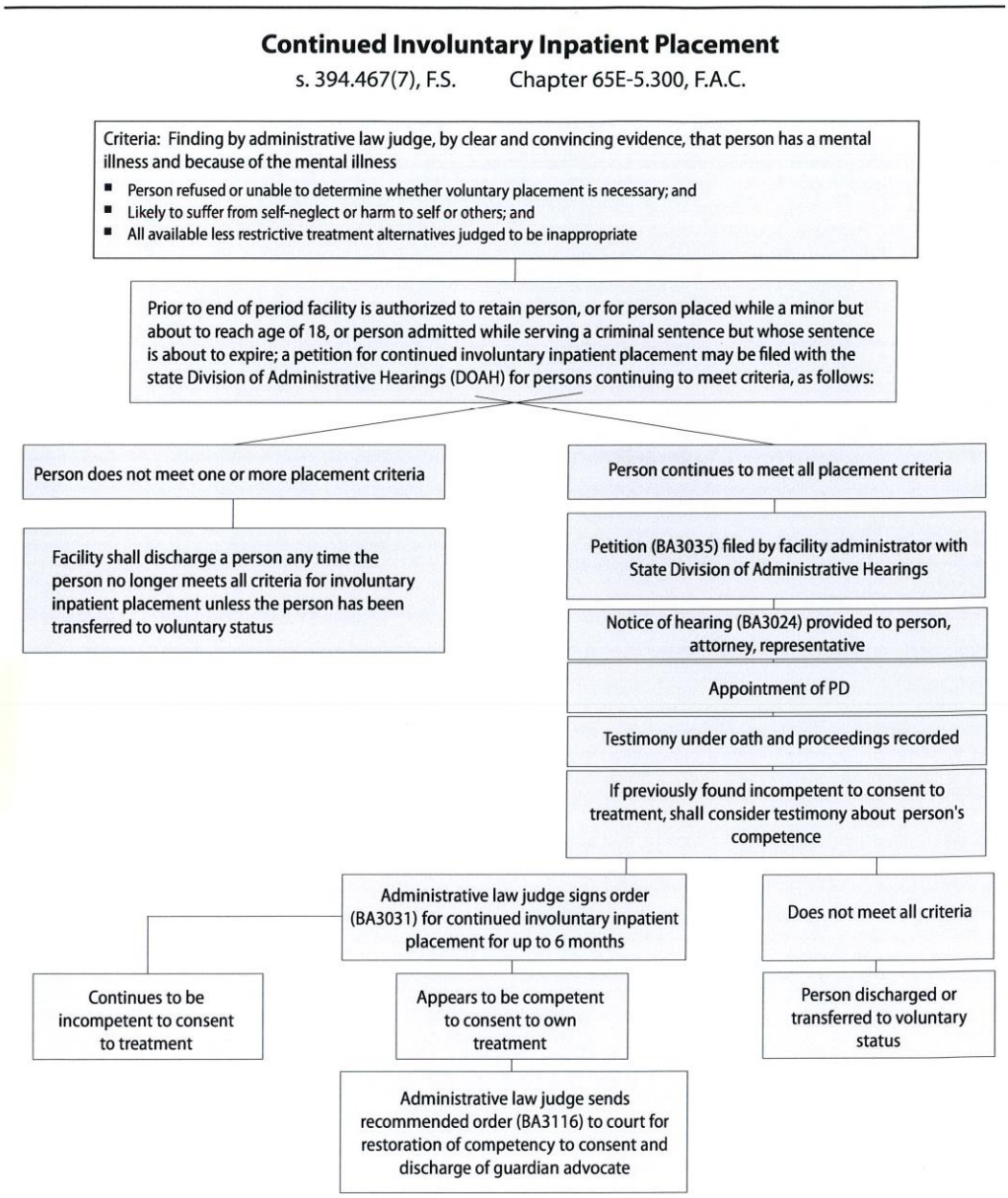
XIV. Continued Involuntary Inpatient Placement Flowchart
(DCF flowchart; 2016 legislative changes are not incorporated.)



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XV. Involuntary Inpatient Placement Hearing Colloquy

A. Introductory Remarks

When the patient is present, giving an overview of the hearing process may be beneficial:

Today we are holding a hearing on a petition for involuntary inpatient placement filed under the Baker Act. The purpose of this hearing is to determine whether clear and convincing evidence supports the criteria for such a court-ordered placement and whether the patient is competent to make his/her own treatment decisions or whether the petition should be dismissed. If an order is issued, it will state the maximum duration of the placement.

As required by law, this hearing is being recorded. The patient has the right to testify or to remain silent. However, the hearing must proceed in an orderly manner and the patient must wait for his/her turn to be heard. First, the assistant state attorney will present evidence as to why the patient should be retained in this or another Baker Act receiving or treatment facility. Then the patient's attorney will present any evidence as to the patient's wishes regarding this matter. If the state attorney cannot establish the evidence, or does not wish to proceed with the case, I will dismiss it without the need for further testimony.

All testimony taken today, including witness testimony, will also be taken under oath. The state attorney and defense counsel will be allowed the opportunity to fully respond to the testimony and evidence presented. Each party will be allowed to call any witnesses and present any evidence they may have.

If an order is entered, it may be unlawful for the patient to purchase a firearm or obtain a concealed weapons permit, pursuant to federal and Florida law.

Patient's counsel may have a moment to confer with the client, if he/she has any questions; otherwise we will proceed.

When the patient is not present, after having those who are present identify themselves for the record the court should affirmatively address the waiver of the patient's presence, if the patient's counsel did not already sufficiently cover that when introducing himself/herself:

- Is patient's counsel requesting a waiver of the patient's presence at the hearing?

- *(If* yes, *without a sufficient explanation)* Briefly state the basis for the waiver. *(If not a "knowing" waiver, the court must find that the patient's attendance at the hearing is not consistent with the best interests of the patient before allowing the attorney to waive the client's presence.)*

More about <u>WAIVING</u> the patient's presence:

The court must conduct an adequate inquiry of the facility staff or the patient's counsel.

At a minimum, the inquiry must ensure the following:

1. that patient received notice of the hearing;
2. that no one prevented the patient from attending the hearing;
3. that the patient was aware of his or her right to be present at the hearing;
4. that the patient was aware of the nature and purpose of the hearing; and
5. that the patient's mental state was such that he or she could comprehend the right being waived.

Such an inquiry is necessary even when the patient's presence is waived by his or her counsel.

Upon conclusion of the inquiry, the court must make an explicit finding on the record as to whether the patient knowingly, intelligently, and voluntarily waived his or her presence at the hearing. If a patient does not have the ability to comprehend the right he/she is waiving, the court cannot determine that the waiver was knowingly and intelligently made.

In that event the patient must attend the hearing **<u>unless</u>** 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. Where such a finding is made 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.

When the petition requests involuntary placement in a state treatment facility (e.g., state hospital), the court should acknowledge when the required transfer

evaluation has been provided to the court for consideration prior to the hearing.

A transfer evaluation completed by the state screener has been provided to the court and concurs/does not concur with the requested placement. Have the attorneys had an opportunity to review the transfer evaluation?

B. Preliminary Matters

- All witnesses please raise your right hands and be sworn.
- Does counsel for the state wish to make an opening statement? Patient's counsel?
- Counsel for the state may call its first witness.

C. Testimony and Evidence

Testimony and evidence as to involuntary placement and the related appointment of a guardian advocate (when the patient is alleged to be incompetent to make his/her own treatment decisions) can generally be heard together. If the court desires that the guardian advocate portion of the hearing occur only after the presentation of the case on the petition for involuntary placement and after the court makes a finding that the criteria have been met for such placement, then the court should notify the attorneys of that at this time.

Testimony must be given under oath and the proceeding must be recorded. One of the State's witnesses must be one of the two professionals who executed the petition for involuntary placement. After the State presents its case, counsel for the patient may make an oral motion to dismiss the petition for involuntary inpatient placement. If that motion is not granted, counsel for the patient must be given the opportunity to present its own case in defense of the petition. The defense may or may not include the testimony of the patient.

A patient cannot be required to testify. It is good practice, however, for the Court to inquire of patient's counsel if he or she intends to call the patient as a witness. It may be the case that the patient makes it clear at the hearing that he or she wants to testify, but counsel for the patient does not believe it is in the client's best interests to do so. Before allowing such a patient to testify against the advice of counsel, the attorney for the patient should be offered a brief recess to permit the attorney to meet privately with and advise the patient again in that regard. Sample hearsay issues that may arise at the involuntary placement hearing are:

Circumstances surrounding admission: The circumstances that led to the current admission are often significant to the determination as to whether the individual meets the Baker Act criteria for involuntary placement. Given the short amount of time that the state has to prepare for the hearing and the stringent statutory requirements as to when the hearings must be held, witnesses with firsthand knowledge of those circumstances, such as family members and law enforcement officers, may not always be available to testify. A testifying physician who has been qualified as an expert witness in the field of psychiatry may be able to testify about what was reported in the certificate of the law enforcement officer or the professional who initiated the involuntary examination.

- Doctor, have you considered the circumstances of the patient's admission as part of your diagnosis and treatment? (If yes, the expert may give opinion based on data reasonably relied on by experts, even if such data is not admissible in evidence. § 90.704, Fla. Stat., basis of opinion testimony by experts. Additionally, the patient statements in the report of the law enforcement officer initiating the involuntary examination or in a related police report may be admissible as evidence of the individual's then existing mental, emotional or physical condition. § 90.803(3), Fla. Stat., state of mind/then-existing mental, emotional, or physical condition hearsay exception. Further, what the patient told the doctor about these circumstances may well be admissible. § 90.803(18)(a), Fla. Stat., admissions hearsay exception (statement that is offered against a party and is the party's own statement).)

Prior admissions: This may not be the first time that the testifying physician has treated the patient. That knowledge of the patient's condition and treatment, over time, enhances the physician's current diagnosis and opinions as to the involuntary placement criteria.

- Doctor, are you aware of any prior admissions to a psychiatric hospital? *(If yes:*)

- Did these prior admissions help form a basis for your diagnosis in this case? (If relevant, the expert may give his or her opinion based on data reasonably relied on by experts, even if such data is not admissible in evidence. § 90.704, Fla. Stat., basis of opinion testimony by experts.)

Patient's Behavior: The physician should be able to testify about his or her direct observations of the patient. However, the individual's behavior during the admission that the doctor did not personally observe may be just as significant, or

even more significant, to the determination as to whether the individual meets the Baker Act criteria for involuntary placement. The physician may reasonably rely on this information that was not personally observed. Such behavior is typically documented in the patient's medical chart, at or near the time the behavior was observed by the staff member who did personally observe the behavior. The staff who documented the behavior in the patient's chart cannot always be available at the time of the hearing. Often the incidents occur in the evening and the evening staff members are not on duty at the time of the hearings. The state may be able to introduce documentation of the behavior (e.g., the record maintained for an emergency treatment order) from the patient's medical record.

- Doctor, have you had an opportunity to review the staff's notes in the record? *(If* yes*:)*
- Are you familiar with the receiving facility's record keeping procedures? *(If* yes*:)*
- I'm showing what has been pre-marked as State's Exhibit #1.
- Do you recognize this exhibit? *(If* yes*:)*
- What do you recognize it to be? (If recognized — for example, as documentation of an Emergency Treatment Order that resulted from the patient's behavior:)
- Are the entries in this document made at or near the time of the events or transactions recorded? *(If* yes*:)*
- Are the entries in this document made from information transmitted by a person with knowledge of the events or transactions recorded? *(If* yes*:)*
- Is this record kept in the course of the regularly conducted business activities of this hospital/receiving facility? *(If* yes*:)*
- Is it the regular practice of this hospital/receiving facility to make this record? *(If* yes*:)*
- Is this exhibit a fair and accurate copy of the original Emergency Treatment Order for this patient kept in the patient record at this hospital/receiving facility? *(If yes, the state may offer the exhibit into evidence. F.S. § 90.803(6), Fla. Stat., business records/records of regularly conducted business activity exception (records of the hospital/receiving facility, with*

the doctor serving as the qualified witness).)

Other witnesses:

- Are there other witnesses to be called by the state?
- Does the defense wish to call witnesses?

D. Closing Arguments

- With no further evidence to be presented, the court will now hear closing arguments.
- Counsel for the state may proceed.

[Hear argument of assistant state attorney.]

- Counsel for the patient may proceed.

[Hear argument of patient's counsel.]

E. Findings and Order of Court

1. Preliminary Contents

- There being no further evidence or argument, the Court is prepared to make findings.
- Having considered the case presented, the Court finds, by clear and convincing evidence, that

☐ The patient was admitted to this receiving facility on _____(date)_____ and the Petition was timely filed.

☐ The patient does suffer from an apparent or manifest mental illness diagnosed as _____. [***If desired/appropriate:*** In support of that finding, the Court notes the following facts in evidence _____ *(can describe the nature and extent of this illness and the relevant accompanying exhibited behavior by the patient.)*]

☐ As a result of his/her mental illness, the patient

☐ Has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement; ***or***

☐ Is unable to determine for himself/herself whether placement is necessary.

2. When Baker Act Criteria Have Been Met

and further:

☐ The patient 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/herself, and such neglect or refusal poses a real and present threat of substantial harm to the patient's well-being *[You may want to refer to some of the relevant facts/behavior that demonstrate this prong]*; **and/or**

☐ There is a substantial likelihood that in the near future the patient will inflict serious bodily harm on himself/herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm *[You may want to refer to some of the relevant facts/behavior that demonstrate this prong]*;

and

☐ All available, less-restrictive treatment alternatives that would offer an opportunity for improvement of the patient's condition, are inappropriate.

☐ As a result of these findings, the Court will enter an order that the patient be involuntarily placed in a designated mental health receiving or treatment facility as authorized by section 394.467, Florida Statutes, for a period not to exceed _____(period not to exceed 90 days, or six months if a state treatment facility)_____* from the date of the order. The recommended placement is _____(name of receiving or treatment facility)_____. *[This must be "any state treatment facility" when state placement, such as a state hospital, is being authorized]*.

If ordering less than the maximum amount that the court could order, the court should announce whether it is with or without a reservation of jurisdiction to extend or modify the court-ordered placement; for example: The Court finds that this is a short-term placement and reserves jurisdiction to extend the placement, up to a full 90-day period from the date that the Involuntary Inpatient Placement Order is entered, and to otherwise modify the Order to permit placement in a state treatment facility, upon the filing of an

appropriate petition and a hearing thereon. *[The order should ideally provide the specifics for handling extensions and modifications in your circuit. Sample language is available at the end of this Colloquy.]*

GUARDIAN ADVOCATE APPOINTMENT:

[***When required*** –

☐ A guardian advocate is necessary to act on the patient's behalf in issues relating to express and informed consent to _____(psychiatric/medical/ psychiatric or medical)_____ treatment in that the patient is incompetent to consent to treatment because the patient's judgment is so affected by his/her mental illness that the patient lacks the capacity to make a well-reasoned, willful, and knowing decision concerning treatment.

☐ The proposed guardian advocate, _____(name of individual/agency proposed to serve as guardian advocate_____, who is a _____(family member/friend/professional guardian advocate)_____, meets the qualifications of a guardian pursuant to chapter 744, Florida Statutes; **and**

- ☐ The Guardian Advocate has completed the four-hour training course; **or**
- ☐ The four hour training course shall be completed by the Guardian Advocate as required by Section 394.4598, Florida Statutes, **or**
- ☐ The training requirement is waived for the following reason(s):_____.

☐ The guardian advocate is deemed discharged upon the discharge of the patient from involuntary placement under the Baker Act or transfer of the patient to voluntary status.]

[***When not required*** –

☐ A Guardian Advocate is not required because:

- ☐ The patient is a minor and his/her parent(s) is/are available to consent to treatment **or**
- ☐ The patient has a legal guardian(s) who is/are authorized by court order to provide consent to treatment. The legal guardian is: _____.]

3. When Baker Act Criteria Have Not Been Met

and further:

☐ The patient does not meet the criteria for involuntary placement for the following reasons: _____.

☐ As a result, the Petition for the Involuntary Placement filed herein is hereby _____(denied/dismissed)_____.

[***When the patient instead meets applicable Marchman Act criteria:***

☐ The patient appears to meet the criteria for involuntary substance abuse assessment and stabilization as defined in Chapter 397, Florida Statutes. Based on the evidence presented, the Court will order that the patient be retained for up to five (5) days for assessment and stabilization under Chapter 397, Florida Statutes.]

4. Sample Provisions for Short-Term Placement With Reservation of Jurisdiction to Extend or Modify

The Court finds that this is a short-term placement and reserves jurisdiction to extend the placement up to a full six-month period from the date that this Order is entered, and to otherwise modify the Order to permit placement in a state treatment facility, upon the filing of an appropriate petition and a hearing thereon. Extensions and modifications shall be handled as follows:

(a) Extensions Only: When a facility is seeking only to extend the current placement, up to a full 90-day period (or six-month period, for a state treatment facility) from the date of this Order, it must file a Supplemental Petition for Involuntary Inpatient Placement (the regular form with "Supplemental" added to the title). The Supplemental Petition must be supported by the written statement of the patient's attending physician providing the treatment under this Involuntary Placement Order and must allege additional facts and grounds for the continued treatment that have occurred since the original petition was filed.

(b) Extensions and Modifications: When a facility is seeking to extend the current placement up to a full 90-day period (or six-month period for a state treatment facility) from the date of this Order and to have this Order modified to authorize placement in a state treatment facility, the facility must file a Supplemental Petition for Involuntary Inpatient Treatment (using

the DCF form for a Petition for Involuntary Inpatient Treatment and adding the word "Supplemental" to the title) in the above-referenced court file, noting this case number. The Supplemental Petition must be supported in the same manner as an original involuntary inpatient placement petition (a first and second opinion), but must also allege additional facts and grounds for the continued treatment which have occurred since the original petition was filed. Additionally, a Transfer Evaluation must be provided to the Court prior to the hearing on the Supplemental Petition, in accordance with applicable law.

Any Supplemental Petition filed pursuant to (a) or (b) above must be filed no later than two (2) weeks prior to the expiration of the short-term placement period ordered herein, UNLESS the placement was for 30 days or less, in which case the Supplemental Petition must be filed within a reasonable time prior to the expiration of the short-term placement order.

XVI. Frequently Asked Questions

A. Criteria and Eligibility

What is the difference between the criteria for involuntary examination and involuntary placement?

The Baker Act requires that there be "clear and convincing evidence" that the criteria are met for placement, rather than "reason to believe" by one of the specified persons authorized to initiate the examination. Further, the criteria for placement require that all less restrictive treatment alternatives that would offer an opportunity for improvement of the person's condition have been judged inappropriate. The burden of proof is by "clear and convincing evidence," defined as "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 in issue." Fla. Stand. Jury Instr. (Civil) 405.4.

Our facility received an involuntary Baker Act client from our jail with an order for Release on Own Recognizance and Direct Transport to Baker Act Facility from the mental health court judge. We did a first and a second opinion and filed a petition for involuntary placement with the court for 90 days and for appointment of her mother, who is a plenary guardian, as a guardian advocate. When we arrived in court, the state attorney told the magistrate we did not need an order to place the client; that the existing guardianship order was all that was needed. The magistrate and state

attorney decided we were in error. Who is right?

Once a person is released from the criminal justice system into the civil system for the involuntary examination or placement, the Baker Act prevails. A criminal court order to a civil facility for examination and placement wouldn't be sufficient on its own — the provisions of section 394.467, Florida Statutes, would apply. There have been two fairly recent appellate decisions issued by the Second District Court of Appeal that criminal court orders were insufficient to justify civil placement under the Baker Act: *Perkins v. State*, 84 So. 3d 336 (Fla. 2d DCA 2012); *In re Involuntary Placement of Linn*, 79 So. 3d 783 (Fla. 2d DCA 2011).

The public defender has the duty to be present and to argue for the due process rights of the individual. *Handley v. Dennis*, 642 So. 2d 115 (Fla. 1st DCA 1994), identifies the role of a public defender in a Baker Act case, as well as clearly stating that the rights of the patient under the Baker Act outweigh any rights of a guardian under the guardianship statute. The Fourth District Court of Appeal in *Auxier v. Jerome Golden Center for Behavioral Health*, 85 So. 3d 1164 (Fla. 4th DCA 2012), agreed with the First District Court of Appeal decision in *Handley*.

While the guardian has no authority to voluntarily admit the ward to a Baker Act receiving facility, she would have had the authority to consent to treatment once the ward was there on an involuntary status. There was no need to seek appointment of a guardian advocate to provide consent for treatment of an adult with a plenary guardian appointed by the court. The guardian can make treatment decisions — not admission decisions under the Baker Act.

If a psychotic patient who is not a U.S. citizen refuses medications needed for stabilization, do we follow the same process of first and second opinion, obtain a proxy, and have the court appoint a guardian advocate, or does the U.S. Citizenship and Immigration Services act as the decision maker?

Any person who is present in the state of Florida is subject to the Baker Act. Such persons, if they meet the criteria for involuntary examination, can be taken into custody and legally examined under the law. If they are found to meet the criteria for involuntary placement, a petition can be filed to further detain them for treatment. This isn't unusual in that Florida has many people visiting from other countries, both legally and illegally. If the person is a foreign national with citizenship in another country (even if with dual citizenship in the U.S.), you need to remember your obligations for consular notification and access.

Regarding medications, if certified by a physician as able to make well-reasoned,

willful, and knowing decisions about his/her treatment, the person can consent or refuse consent to treatment. If the person is not competent and is without a duly executed advance directive, a relative or close personal friend can be designated as a health care proxy until a guardian advocate is appointed by the court. Otherwise, an emergency treatment order can be used if the physician has documented imminent danger.

B. Initiation and Filing of Involuntary Inpatient Placement

We have a patient admitted on a voluntary basis and her MD changed her status to involuntary. We filed the petition for placement within two working days. Do we also have to complete a professional certificate?

No professional certificate is necessary in the circumstance you describe. The statute refers to the certificate, a law enforcement officer's report, or a court's ex parte order only as the methods to have a person taken into custody and delivered to a receiving facility. Once in a receiving facility, none of these documents are needed. You would just file the petition for involuntary placement within the two working days as you described.

A BA-32 has been filed on a veteran for private placement. Mental health providers are now seeking state placement and a court date has been scheduled. What is the process required to amend the petition for state placement in lieu of private placement?

The clerk of court can advise about the court's procedures. There isn't any restriction in the rule about filing an amended petition; however, prior to the hearing a transfer evaluation must be completed. One of the criteria for involuntary inpatient placement is that "[a]ll available less restrictive treatment alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate." § 394.467(1)(b), Fla. Stat. The Florida Legislature enacted provisions in the Baker Act requiring confirmation of the sworn statements of experts testifying in involuntary inpatient placement hearings as to the availability and appropriateness of less restrictive community alternatives. The Baker Act also specifies in section 394.461(2), Florida Statutes, which governs the designation of receiving and treatment facilities, that "[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."

I'm an assistant public defender. We have filed motions to dismiss Baker Act petitions as legally insufficient when the first and/or second opinion doesn't contain sufficient facts/observations to support the conclusion that a patient meets Baker Act criteria. While observations may support the conclusion that the patient has a mental illness, they don't support the conclusion that the patient meets the Baker Act criteria. While we have no case law on this issue, we are citing Fla. Admin. Code R. 65E-5.290(2), which states that "Each criterion alleged must be supported by evidence." We believe this refers to the petition. Since Florida courts have consistently held that a Baker Act commitment is a massive curtailment of a person's liberty interest, psychiatrists must sufficiently support their conclusion with facts/observations that a patient meets Baker Act criteria, and failure to do so warrants dismissal of the petition and release of the patient. Some facilities have tried to remedy this situation by filing addendums to the Baker Act petitions. We believe that there is no legal authority for this. Any thoughts or recommendations?

Unless the evidence elicited at the hearing reaches a "clear and convincing" level on each of the involuntary placement criteria, the court has no choice but to dismiss the petition. A definition of clear and convincing evidence provided by the Florida Supreme Court is "evidence that is precise, explicit, lacking in confusion, and of such weight that it produces in your mind a firm belief or conviction, without hesitation, about the matter in issue." Fla. Stand. Jury Instr. (Civil) 405.4.

The statutes, rules, and cases require a "clear and convincing" showing for the court to order placement. There is no indication that this also applies to the opinions in the petition, which is a separate filing with the court and for which evidence must be elicited at the hearing. While it's up to the court to make a determination as to what is sufficient, Florida appellate courts have done this many times; they have reversed court orders for placement on sufficiency of evidence.

Appellate cases have found that expert opinions and conclusions of physicians testifying at hearings aren't sufficient without testimony of witnesses to facts. This is why inclusion of a list of witnesses who will testify to facts supporting the petition for involuntary placement is essential. Often staff fail to include these fact witnesses in this section of the petition, and insufficient testimony is elicited by the state attorney at the hearing. While the psychiatrist as an expert witness will render opinions and conclusions, the facilities should also identify these fact witnesses to support the opinions of the psychiatrist.

The Supreme Court Commission on Fairness did look at this issue. In its 1999

Report and Recommendations of the Subcommittee on Case Administration, it recommended that the assistant state attorney review any such petition for sufficiency. Pages 70–71 of that report have the following content (emphasis added):

> *Issue:*
>
> *What is the appropriate role of the state attorney's office in involuntary placement proceedings?*
>
> Discussion:
>
> According to section 394.467(6)(a), Florida Statutes, "[t]he 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." It is important to remember that while the facility is the petitioner, the state is the real party of interest and must prosecute the petition.
>
> The state is the only entity with the authority to restrict a person's liberty. In an adversarial proceeding, the state attorney is required to meet a burden of proof for involuntary placement. The state attorney should gather information independently, and evaluate and confirm the information contained in the petitions. In involuntary placement proceedings, the state has the responsibility to present evidence and testimony as to the elements and requirements of the applicable statutes.
>
> As discussed previously in this report, participation by the state attorney's office is an integral part of the proceeding. In *Jones v. State*, 611 So. 2d 577 (Fla. 1st DCA 1992), the court found that "in the instant case, it appears the absence of the state was a contributing factor in the due process deficiencies attendant upon the proceeding." Thus, the role of the state attorney is critical to the process. It is incumbent upon the state attorney to vigorously investigate and prosecute the petition, just as the public defender must protect the patient's rights and represent the patient's expressed desires. **Further, if the state attorney's independent review does not show the statutory criteria are provable, then the state attorney should withdraw the petition.**
>
> * * *

Recommendation

The Subcommittee recommends that:

a. Each state attorney's office should independently evaluate and confirm the allegations set forth in the petition for involuntary placement. If the information is found to be correct, the state attorney should vigorously prosecute the petition. If the allegations are not substantiated, the state attorney should withdraw the petition.

b. Assistant state attorneys representing the state in involuntary placement proceedings must be bound to the same legal and ethical obligations of assistant state attorneys prosecuting other cases.

c. The bar should be educated as to attorneys' roles and responsibilities in handling involuntary placement proceedings.

d. The Florida Legislature should direct and fund an interdisciplinary study on whether state attorneys should be authorized to have access to clinical records, facility staff, and other pertinent information.

If the assistant state attorney believes the petition is sufficient, the court should hear it and either dismiss it if found to be insufficient or grant it if evidence raised at the time of the hearing clearly met the clear and convincing standard. It's clear that the ASA has this authority; however, it isn't as clear that the defense attorney has the same authority. If the petition is patently insufficient, the patient or his/her attorney could file a habeas petition for release from the facility.

Is it legal for the second opinion on a BA-32 to be dated and timed prior to the first opinion, or must the first opinion be documented on the petition itself to properly trigger a request for the second opinion? Being able to do the opinions "out of order" would make the physicians' lives easier.

There isn't any prohibition against a psychiatrist "ordering" an initiation for involuntary placement and completing the document later as long as he/she has personally examined the patient face-to-face prior to such an order or signing the petition form. However, it is unclear what is achieved by such an "order" — the two expert examinations and documentation of these opinions on the petition form, along with the administrator's signature and filing of the petition with the clerk of

court, must all be done within 72 hours of the patient's arrival at the facility (perhaps even earlier if the patient had waited at a medical hospital for transfer before arrival at the facility).

It is unclear why a second opinion would ever be conducted before a first opinion. The petition form elicits more extensive input from the psychiatrist conducting the first opinion, and the second opinion shouldn't differ from the first. The psychiatrist or psychologist providing the second opinion is simply concurring with the first. Either of the psychiatrists is authorized to testify at the patient's hearing. § 394.467(6)(a)3., Fla. Stat.

A petition for involuntary inpatient placement was completed this morning and the patient immediately rescinded her request for release. I haven't even completed the remaining documents necessary to file the petition with the court. The doctor authorized her to sign consent and she did. What do I now do with this petition? Just keep it in my files?

The patient appears to have been on involuntary status in order for the first and second opinions to have been completed. She had no right to request release if on involuntary status — this right applies only to persons on voluntary status. However, if she requested to transfer from involuntary to voluntary status, the following would have to be done:

- She would sign an application for voluntary admission.
- A physician or psychologist would document the completion of the initial mandatory involuntary examination as required in rule 65E-5.280(1), Florida Administrative Code.
- A physician would sign form CF-MH 3104 certifying the patient's sustained ability to make well-reasoned, willful, and knowing decisions about her medical, mental health, and substance abuse treatment. This means she has the capacity and right to consent or refuse consent to treatment.

If it had just been certified by two psychiatrists that morning that she met the criteria for involuntary inpatient placement, it takes more than just her statement that she is willing to "rescind her right to release." The psychiatrist should indicate how her condition had changed over that short a period of time. If such an improvement of condition is documented, the signed petition must remain in the person's chart as it pertains to physician documentation of meeting criteria at a point in time of her hospitalization — it cannot be kept in any other place or

destroyed just because it isn't actually filed with the court.

Can the second opinion be done by a psychiatrist who is in the same practice as the psychiatrist who does the first opinion?

Yes. There is no prohibition on two authorized professionals in the same practice from signing the two opinions required for an involuntary placement petition. As long as each professional exercises independent judgment and the opinions are in compliance with the criteria specified in the Baker Act, there isn't a problem.

Can a psychiatric ARNP do a second opinion for involuntary placement, or must it be a psychiatrist or psychologist?

Only a psychologist or second psychiatrist can provide the second opinion. The only exception is that under section 394.467(2), Florida Statutes, the receiving facility administrator may certify that no psychiatrist or psychologist is available to provide a second opinion, and may obtain a second opinion from a licensed physician with postgraduate training and experience in diagnosis and treatment of mental illness, or by a psychiatric nurse as defined in section 394.455(23), Florida Statutes. Many nurse practitioners, even those working in the psychiatric field, don't meet the specific Baker Act definition of "psychiatric nurse."

If a person on voluntary status in a CSU subsequently was adjudicated incapacitated by the court, must the CSU file a petition for involuntary placement?

Yes. The Baker Act is very specific on this issue. Section 394.4625(1)(d), Florida Statutes, states:

> 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.

If a person on an involuntary inpatient placement petition requires admission to a medical facility for emergency medical treatment, is the petition put on medical hold, or does the petition become void upon discharge of the patient from the psychiatric facility?

The only timeframe that is put on hold because of an emergency medical condition is the BA-52 involuntary **examination**. If a person is on a BA-32 involuntary placement petition or a BA-8 involuntary placement order, the Baker Act doesn't permit any variation to the statutorily prescribed time frames. However, if at any time the person no longer meets the criteria for involuntary placement, the administrator has a duty to either convert the person to voluntary (if the person is competent and willing) or release the person. If the person continues to meet the criteria for involuntary placement, he/she can't be "discharged." The person would be "transferred" instead in order that the legal status and guardian advocate (if any) are retained. The person could then be transferred back upon stabilization with all the legal issues intact. While some type of back office administrative or financial discharge would occur, to avoid having two bills for the same day of care, the clinical record should reflect a "transfer" for medical purposes rather than a "discharge."

What should be done when a person is awaiting a hearing on involuntary inpatient placement and the physician writes orders for the person to be discharged? When the family refused to take the person back, the physician cancelled the discharge order. Would the current BA-32 be nullified because of the order for discharge and another petition have to be filed?

If the physician documented that the person didn't meet criteria for involuntary inpatient or outpatient placement as a prerequisite for the discharge order, the facility couldn't go forward on an existing petition and couldn't file a new petition unless the person's condition had deteriorated after the discharge order was written. If the person is willing to apply for voluntary status and the physician has certified the person can make well-reasoned, willful, and knowing decisions about his or her medical, mental health, or substance abuse treatment, such a transfer to voluntary status can be done. If the person doesn't meet the criteria for involuntary status and is unwilling or unable to consent to voluntary status, the Baker Act requires that the person be discharged. In that case, your discharge planners should investigate alternate discharge plans other than the family.

Once a petition for involuntary placement has been filed by a receiving facility, can that facility withdraw the petition when it transfers a patient to another psychiatric facility and then immediately Baker Act the patient to cover the legal status during transport to another treatment facility? The patient is not returning to the original sending facility. We have one physician provide all of our expert testimony in court. We don't want to risk having an acutely ill patient discharged because of a coordination problem that may occur with inviting a physician from another facility to testify at a hearing at

our facility. In addition, we don't want to assume liability for another facility's 32 petition if it is out of compliance with the Baker Act law.

It would not be appropriate to withdraw the petition, once filed with the court, and start over with a new BA-52. This would result in the person being held longer than permitted under the law for involuntary examination. Such a deprivation of liberty would likely be frowned upon by the defense attorney once the person went to court. The practice around the state is that the transfer should occur prior to filing the petition or after the court hearing has taken place. That ensures that the person's due process rights are observed.

A receiving facility only has the power to discharge or release a person when a psychiatrist, psychologist, ER physician, or psychiatric nurse (as defined in the Baker Act) has determined the person doesn't meet the criteria for involuntary inpatient placement or involuntary outpatient services. Other than that, only a transfer between receiving facilities is permissible as provided in section 394.4685, Florida Statutes. A "transfer" maintains the legal status of the person.

The only alternative is if one of the two experts who signed the petition is willing to attend the hearing at the second facility to provide the legally required testimony. The attending psychiatrist at the second facility could provide supplemental testimony to that provided by one of the two signing experts as to the person's condition since arrival at the second facility. It is actually the duty of the assistant state attorney, as the real party in interest, to determine the legal sufficiency of each petition. If not sufficient, the petition should be withdrawn by the state attorney.

A magistrate for this judicial circuit called and said that the hospital has had a number of late-filed petitions recently, resulting in dismissals. The hospital has then refiled the petitions, resulting in persons being detained beyond the period permitted by law. What should be done?

The only recourse is for the patients to file petitions for writs of habeas corpus. However, the public defender could call the hospital administrator and the hospital's attorney to advise them of this. It is possible that the hospital administration doesn't even know a problem exists and will ensure that it gets fixed immediately. If immediate corrective action doesn't take place, a report to DCF and AHCA should be made.

C. Public Defender and State Attorney

What are the roles of the public defender and state attorney who conduct the Baker Act hearings?

The Baker Act involuntary inpatient placement statute, section 394.467, Florida Statutes, provides as follows:

> **(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 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.
>
> * * *
>
> **(6) Hearing on involuntary inpatient placement.--**
>
> (a)1. . . . . 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.

The Supreme Court Commission on Fairness, in its 1999 report, indicated that the state attorney and public defender have the same obligation to their Baker Act clients as they do in any other form of legal representation.

The court in *Handley v. Dennis*, 642 So. 2d 115, 116–117 (Fla. 1st DCA 1994), said the following about the role of the public defender:

> [T]he duty of the Public Defender is a legal and professional duty that is owed to the patient as a client. The Public Defender serves as an independent advocate for the patient, not as a neutral party charged with the responsibility of determining the best interests of the patient or the needs of society. . . . If the patient wishes to be released or transferred and if there is a basis for that request, the Public Defender has a duty to advocate the cause of the patient.

There are a number of appellate cases that relate to the notification and participation of the state attorney in Baker Act hearings. One Sixth Circuit court order (not appealed) defined the role of the state attorney. In *In re [V.S.]*, No. 95-577-IN 003 (Fla. 6th Cir. Ct. Feb. 13, 1995), the court held that

> the facility has every right to employ legal counsel to represent their legal interests in any proceeding where the facility's legal rights, liabilities or corporate interests are implicated.
>
> Since future actions of the facility, either in providing ordered treatment, or arranging for discharge of the patient, are predicated on the outcome of the hearing, the facility is entitled to have counsel present during the adjudicatory process. Counsel for the facility, although present at the hearing, may not interpose evidentiary objections or participate in questioning witnesses. This is the assigned role of the state attorney. While the facility may be a party in interest for the purpose of placing the controversy before the court, they do not have a legally protectable interest in the outcome of an adjudication of the need for involuntary mental health treatment. The statute permits the facility administrator to throw out the first ball, but the constitutional rights of the patient require that the state attorney pitch the game.

In preparing for a Baker Act hearing, would the PD be correct in asserting/ demanding that he/she has the right to interview a Florida Assertive Community Treatment (FACT) team leader prior to the hearing who serves the client who has a court hearing for involuntary placement? I had understood that the FACT team leader would actually be a witness for the state attorney, and if the PD wanted to interview, he or she would have to do a deposition or just question the team leader during the hearing. Other than the CSU record, would the PD have a right to review the FACT record (different provider) and require that the FACT team bring it to the PD's office? Would this only be able to happen via court order? This particular PD does not allow anyone in the hearing room except the person who is testifying (and of course the magistrate and client) and has also been known to question team leaders for over an hour, and in some instances the hearings have run all day. What responsibility does the state attorney's office have in sending an informed SA to these hearings to represent the interests of the state and be able to challenge certain unfair practices of the PD?

The Baker Act is very explicit about the public defender's right to access the

patient, medical records, and any witnesses in defending a client in Baker Act proceedings. In terms of the receiving facility's record, the confidentiality section of the law states:

> **394.4615. Clinical records; confidentiality**
>
> (2) The clinical record shall be released when:
>
> * * *
>
> (b) The patient is represented by counsel and the records are needed by the patient's counsel for adequate representation.

Section 394.455(6), Florida Statutes, defines "clinical record" as "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 facility staff** which pertains to the patient's hospitalization or treatment" (emphasis added).

It is unlikely that this definition would include medical records of the client other than those at the receiving facility. However, the patient always has the right to authorize release of his/her records at any facility unless adjudicated incapacitated and a guardian has been appointed by the court. In such cases, if the guardian didn't release the records, a good cause hearing could be conducted by the court in order to provide the records or any part of the records to the public defender in preparation for hearing. There isn't a requirement that you take these FACT records off site for the convenience of the public defender unless ordered to do so by the court.

In the involuntary inpatient placement provisions, the law extends beyond the public defender just accessing the records to accessing his/her client and any witnesses in the proceedings:

> **394.467. Involuntary inpatient placement** (emphasis added)
>
> **(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 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.

As of the end of the 2016 legislative session, the assistant state attorney as the "real party in interest" doesn't have the same access to the records and to the witnesses in preparation for the Baker Act hearing and usually has to wait until the hearing to access these resources. It is the responsibility of the petitioning facility to list the names of all potential witnesses for the state in the petition form.

It would be very rare for a witness to require a subpoena to provide testimony for the state or for the defense in a Baker Act hearing. The exclusionary rule is usually invoked to prevent a witness from hearing the testimony of any other witness.

Due to the liberty interests of the patient, the courts would uphold whatever length of time was needed for the state attorney to elicit material and relevant testimony to support continued detention as well as for the defense attorney to challenge that testimony through cross-examination as well as presenting any defense witnesses. These hearings are intended to be adversarial in the best sense of the term — not a clinical staff meeting to determine the best interests of the patient. There is a plethora of appellate cases in which dozens of orders for involuntary inpatient placement were reversed on procedural or evidentiary grounds. The magistrate and circuit court judge would surely prefer to minimize the number of appeals and reversals.

The role of the public defender in a Baker Act hearing was defined by the First District Court of Appeal in *Handley v. Dennis*, 642 So. 2d 115, 116–117 (Fla. 1st DCA 1994). The court stated:

- The duty of the public defender is a legal and professional duty that is owed to the patient as a client.
- "The public defender serves as an independent advocate for the patient, not as a neutral party charged with the responsibility of determining the best interests of the patient or the needs of society."
- If the patient wants to be released or transferred and there is a basis for the request, the public defender has a duty to advocate the cause of the patient.

The Florida Supreme Court Commission on Fairness, in its 1999 report, concluded that the duty of the state attorney and the public defender was the same in a Baker Act proceeding as in any other representation. Failure to uphold this legal and ethical duty by the attorneys could subject them to disciplinary action by The

Florida Bar.

It is beneficial for assistant state attorneys to be as well trained in Baker Act matters, and remain in the role long enough to provide equal representation to the state, as public defenders do for their clients. See p. 69 of the 1999 report.

What is the role of the state attorney in an involuntary placement hearing?

The state attorney's role is to represent the state, rather than the petitioning facility, as the real party in interest in the proceeding. The Florida Supreme Court Commission on Fairness stated that each state attorney should place a high priority on involuntary placement proceedings and properly prepare the cases on behalf of the state:

> Each state attorney's office should independently evaluate and confirm the allegations set forth in the petition for involuntary placement. If the information is found to be correct, the state attorney should vigorously prosecute the petition. If the allegations are not substantiated, the state attorney should withdraw the petition.
>
> . . . . Assistant state attorneys representing the state in involuntary placement proceedings must be bound to the same legal and ethical obligations of assistant state attorneys prosecuting other cases.

Florida Supreme Court Commission on Fairness 1999 report, p. 69. The Commission further stated the state attorney's office must be represented at and actively participate in every hearing. "If a representative of the state attorney's office is not present at the hearing, the court should halt the proceeding while the state attorney is summoned." See p. 68 of the 1999 report.

Can you explain more about the role of assistant state attorneys in preparing and presenting Baker Act cases at involuntary placement hearings?

An excellent document titled "Preparation & Presentation of Baker Act Hearings by Assistant State Attorneys" has been prepared by Mari S. Blumstein, Assistant State Attorney, Office of the State Attorney, Seventeenth Judicial Circuit, 201 SE Sixth Street, Ft. Lauderdale, FL 33301, (954) 831-7633.

Recently, staff at the state attorney's office stated they felt "unsafe" when doing hearings at the receiving facility. We have a dedicated room for the hearings and have never had this problem before. I agreed to have an additional mental health technician sit directly behind the clients while in

hearing. Subsequently, the state attorney's office sent us letter stating they will "cease" all BA hearings at the facility unless we can change the venue. I have read the statute and find very little regarding this issue. Can you shed some light, as having to bring our clients to the county courthouse would be most traumatic?

This reason being given for an assistant state attorney to not attend a hearing may be unique. If it is safe enough for the magistrate, public defender, and staff, especially with the addition of another well-trained staff person, it's difficult to believe that safety should be an issue. The Baker Act addresses the location of the hearing in the following provision:

> **394.467. Involuntary inpatient placement**
>
> **(6) Hearing on involuntary inpatient placement.--**
>
> (a)1. The court shall hold the hearing on involuntary inpatient placement within 5 court working days, unless a continuance is granted.
>
> 2. Except for good cause documented in the court file, the hearing must be held in the county of the facility, as appropriate, where the patient is located, must 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. . . .

While historically Baker Act hearings were held at courthouses, nearly all courts conduct the hearings at the receiving facilities where the patient is held. The safety of the patient in transporting is a very real concern as is the privacy and dignity of moving such a person in the most acute phases of his/her illness through public places. Providing for the personal care of the patient in a courthouse is also incredibly difficult.

In addition, there have been some appellate decisions, such as *Wickland v. State*, 642 So. 2d 670 (Fla. 1st DCA 1994). In *Wickland* the court held that the trial court failed to comply with the Baker Act when it did not serve notice of an involuntary placement hearing on the state attorney, the state attorney did not appear at the hearing, the state's psychiatrist testified without asserting personal knowledge of the underlying facts of the case, and the trial court's order of involuntary placement for treatment quoted verbatim from the petition. The court reversed the trial court's order of involuntary placement for treatment under the Baker Act.

Finally, the Florida Supreme Court Commission on Fairness, on pp. 29–32 of the

1999 report, had much to say about the venue of such hearings:

Issue:

Should involuntary placement hearings be conducted in the courthouse or at the mental health facility? If the hearings are held in the facilities, are measures being taken to ensure that the patients understand the seriousness of the proceeding?

. . . . A balanced approach may be the most desirable resolution of this issue. The receiving facility may be the location that is both the most convenient to the patient and the safest. However, all involuntary placement hearings held in receiving facilities should include formalities consistent with a court hearing, to ensure that everyone understands the seriousness of the proceeding. When liberty interests are at stake, they should be addressed in a formal and appropriate manner. Food, drink, and side conversations at hearings, coupled with lax observance of procedures and rules of evidence, give the appearance that the system is trivializing involuntary placement cases. . . . .

Recommendation

The Subcommittee recommends that the chief judge of each circuit court require involuntary placement hearings held at mental health receiving facilities to be conducted in a room that is set up in the manner of a courtroom. If possible, that room should not be used for any other patient purposes. The presiding officer should wear a robe. United States and Florida flags should be present. Formal courtroom decorum should be observed. Patients should be dressed in street clothing. Food, drink, and side conversations should be prohibited. The presiding officer, state attorney, public defender, and other participants should introduce themselves prior to each case. Moreover, rules of evidence and procedure should be observed.

Issue:

Should involuntary placement hearings be conducted by video?

Discussion:

> Some court proceedings are conducted by video. An example is video arraignments, in which the judge remains at the courthouse while the defendant participates by live video link-up from the jail. At the November 12, 1998, meeting it was suggested that video hearings may be a convenient and less costly alternative for involuntary placement hearings. One of the judges who responded to the survey observed that allowing patients to attend hearings by video would alleviate the need for them to be transported to the courthouse. . . .
>
> ***Recommendation***
>
> **The Subcommittee strongly recommends against the use of video for involuntary placement hearings.**
> *[Editor's note: In Doe v. State, __ So. 3d __ (2016), 2016 WL 5407617 (Fla. 2d DCA 2016), the Second District Court of Appeal rejected a challenge to an announcement in Lee County that judges and magistrates would no longer travel to receiving facilities to hold Baker Act hearings but would preside remotely from the courthouse by videoconference. However, the court certified to the Florida Supreme Court the following question: "DOES A JUDICIAL OFFICER HAVE AN EXISTING INDISPUTABLE LEGAL DUTY TO PRESIDE OVER SECTION 394.467 HEARINGS IN PERSON?" The Supreme Court accepted jurisdiction, and oral argument is scheduled for February 7, 2017.]*

The Commission also had the following to say about assistant state attorneys in such hearings, on pp. 67–68 of the 1999 report:

> The state is the only entity with the authority to restrict a person's liberty. Involuntary mental health examination and placement involve a balancing of individual rights with the state's *parens patriae* authority and police power. Under Florida law, involuntary placement is clearly a state action; therefore, the facility and its attorneys have no authority to prosecute the petition. Nevertheless, the Subcommittee repeatedly heard that in some jurisdictions the state attorney's office never participates in involuntary placement proceedings. It was further reported that at some hearings the facility's attorney appears to prosecute the petition. It was even reported that in some instances the court takes on the prosecutorial role, because the state attorney is not available.

> Active participation by the state attorney's office is an integral part of the proceeding. . . . The Subcommittee finds that the office of the state attorney must be present at every involuntary placement proceeding in order to comply with the statutory mandate and to appropriately, adequately, and competently represent the state's interests.
>
> . . . . [T]he state attorney is *not* represented at more than 10 percent of the involuntary placement proceedings.
>
> ***Recommendation***
>
> **The Subcommittee recommends that:**
>
> **a. Each state attorney should ensure that an assistant state attorney is present at every involuntary placement hearing.**
>
> **b. The court should require the presence of the state attorney's office at every involuntary placement hearing. If a representative of the state attorney's office is not present at the hearing, the court should halt the hearing while the state attorney is summoned to immediately appear before the court.**

Regarding preparation and presentation of cases by the state attorneys' offices, the Commission stated on pp. 72–73 of the 1999 report:

> Regrettably, it appears they generally take little action to prepare these cases.
>
> The Subcommittee heard testimony about instances where individuals who were believed to be dangerous were discharged because the state attorney did not subpoena witnesses and conduct other pre-trial preparations necessary to sustain the petition. The court was left with no alternative but to dismiss the petition and discharge the patient. This conduct may place the public's safety at risk. Meanwhile, the individuals do not receive necessary treatment. . . .
>
> * * *
>
> ***Recommendation***
>
> **The Subcommittee recommends that:**

a. The Florida Legislature should provide adequate resources to enable state attorneys to provide quality representation for the state in involuntary placement proceedings.

b. Each state attorney should place a high priority on involuntary placement proceedings and properly prepare the cases on behalf of the state.

c. Each state attorney should ensure that experienced and trained attorneys are assigned to involuntary placement cases.

d. The Florida Legislature should direct and fund an interdisciplinary study on whether state attorneys should be authorized to have access to clinical records, facility staff, and other pertinent information.

The Subcommittee made recommendations for the Legislature and state attorneys to improve the quality of representation for the state.

On pp. 70–71 of the 1999 report, the Commission stated:

> The state attorney should gather information independently, and evaluate and confirm the information contained in the petitions. It is incumbent upon the state attorney to vigorously investigate and prosecute the petition.
>
> . . . . Further, if the state attorney's independent review does not show the statutory criteria are provable, then the state attorney should withdraw the petition.
>
> Chapter 394 specifically authorizes the attorney representing the patient to have access to the clinical record, facility staff, and other pertinent information. However, the law is silent as to whether the state attorney has the authority to access the same information. Thus, a study should be conducted on whether the law should be amended to allow the state attorney access [to] this information in order to evaluate the petition and prepare for the hearing.
>
> ***Recommendation***
>
> **The Subcommittee recommends that:**

a. Each state attorney's office should independently evaluate and confirm the allegations set forth in the petition for involuntary placement. If the information is found to be correct, the state attorney should vigorously prosecute the petition. If the allegations are not substantiated, the state attorney should withdraw the petition.

b. Assistant state attorneys representing the state in involuntary placement proceedings must be bound to the same legal and ethical obligations of assistant state attorneys prosecuting other cases.

c. The bar should be educated as to attorneys' roles and responsibilities in handling involuntary placement proceedings.

d. The Florida Legislature should direct and fund an interdisciplinary study on whether state attorneys should be authorized to have access to clinical records, facility staff, and other pertinent information.

While the Supreme Court Commission's recommendations have, for the most part, not been enacted by the Legislature, they should be persuasive in improving the administration of justice by Florida courts.

What specific language in chapter 394 requires the state attorney to represent/ make the case for involuntary commitment?

There is no reference in chapter 394, Florida Statutes, for the state attorney's participation in **continued** involuntary inpatient placement or involuntary outpatient services hearings (it is only mentioned with regard to the initial hearings); nor is there specific reference to it in chapter 27. The public defender's role is specified in chapter 394 (initial and continued hearings) as well as chapter 27.

However, section 394.467(1), Florida Statutes, requires in the continued hearings that there be clear and convincing evidence that all criteria for involuntary inpatient placement continue to be met. Some attorneys question how this evidence will get into the record if not by the state attorney. This may be of particular concern when a state hospital has been privatized and the "state" isn't present to determine sufficiency of the petition or be concerned with the deprivation of a person's liberty as it would be in other such cases.

Can the public defender and state attorney access the clinical record?

The public defender can access the clinical record, the person, and the staff in preparing for the involuntary placement hearing. The law doesn't expressly permit this same access to the state attorney prior to a hearing for involuntary inpatient placement (it is expressly permitted for involuntary outpatient services). In some circuits the state attorney has access. In any case, the clinical record is always available at the time of the hearing and is, at that time, available to the state attorney.

D. Independent Expert Examination

Who is responsible for paying the independent expert examiner under section 394.467(6)(a), Florida Statutes? I know the court is responsible for providing such an expert, but didn't know if this equates to the court paying for one. What specific authority has addressed the responsibility of the court paying for the expert?

A memorandum was sent to the chief judges from Judge Stan R. Morris, then-chair of the Trial Court Budget Commission, dated August 3, 2005. The paragraph in question is on page two of the memorandum, which states the following:

> More problematic are Baker Act evaluations under section 394.467(6)(a)1, Florida Statutes. In Baker Act situations, the patient has the statutory right to request an independent expert evaluation. This right arises after a professional has executed an involuntary inpatient placement certificate and the involuntary commitment process has started. The statute says: "If the patient cannot afford such an examination, the court shall provide for one." Thus, the statute clearly evidences legislative intent that if the person is not indigent, this cost is not paid by the public. However, when the person is indigent, section 394.473, Florida Statutes, states that the expert should be paid pursuant to section 27.5304, Florida Statutes. That section provides for payment by the Justice Administrative Commission. As a person subject to Baker Act commitment, the patient has the right to the appointment of the public defender or court-appointed counsel if indigent. Both section 29.006, Florida Statutes, (public defender) and section 29.007, Florida Statutes, (court-appointed counsel) specifically reference mental health professionals appointed pursuant to section 394.473, Florida Statutes. Clearly these witnesses are defense witnesses; they are appointed only

if requested by the patient and any report issued is confidential and not discoverable. See: section 394.467(6)(a)2, Florida Statutes. The language found in section 394.467(6)(a)2, Florida Statutes, {"the court shall provide for one"} does not transform what is essentially a defense witness into a state court expense when there is clear statutory guidance to the contrary.

E. Continuances

The public defender in our circuit automatically continues almost all cases, often two or three times. According to the CSU, the PD doesn't see or talk to the patient prior to requesting a continuance. We believe this may be adding to our capacity issues, because when folks finally get court ordered to the state hospital, they often have to wait an additional four to six weeks for admission, meaning they are on the units for several months (following the above-mentioned continuances). There are often legitimate reasons for continuance, but this seems excessive. How can we address this with the PD?

Actually, only the patient has the standing to request a continuance — with concurrence of counsel. No one else has such a right. There has been some criticism of defense counsel making such requests for continuances unless consistent with the client's wishes.

The law requires the hearing to take place within five days, unless a continuance is requested by the patient. This is the equivalent of a speedy trial in a criminal setting, and a deprivation of the person's liberty is at stake if the hearing is delayed. The court in *Handley v. Dennis*, 642 So. 2d 115, 117 (Fla. 1st DCA 1994), clearly stated that the role of the public defender is to serve "as an independent advocate for the patient, not as a neutral party charged with the responsibility of determining the best interests of the patient or the needs of society." The attorney is the voice of the patient when the patient's lack of capacity makes him/her unable to speak for himself/herself.

While some defense attorneys take the position that they can act for their clients without the client's agreement for purposes of trial strategy, the language of the law clearly indicates that the "patient" is the one with standing to request such a continuance — with the concurrence of counsel. The Florida Supreme Court Commission on Fairness emphasized that only the patient has the power to do this. The Commission also indicated that an attorney's duty to a Baker Act client is the same as in any other type of case.

The Commission also strongly recommended that whenever a continuance of a hearing on involuntary placement is considered, the court should proceed with a hearing to consider the person's competence to consent to treatment and the appointment of a guardian advocate if the person is found to be incompetent. The actual placement hearing would then take place at a later time.

One public defender often makes such requests to avoid a hearing in which a commitment to a state hospital might result, believing that another week or two of treatment might result in improved clinical condition. He states that he always talks to his clients before filing such a request for a continuance and lets the client know of the benefit of a delay. However, he says that if his client still wants his/her "day in court," they go forward with the hearing as scheduled. If the court conducts a hearing to appoint a guardian advocate, this might relieve part of the problem in some situations.

You may want to talk with the PD in your circuit first to find out the reason for routine continuances. While the PD's sole priority must be representing the client's wishes, the PD may not know that this practice is an anomaly. The PD also may not know that routine use of continuances results in serious service system issues for others who might need acute care examination or treatment. If this doesn't work, you might have to talk with a supervisor.

If it appears that any of individuals who are detained past the five working days following petition filing are unhappy about the delay in hearing, this needs to be brought to The Florida Bar's grievance process. This delay could potentially result in an unwarranted deprivation of liberty without due process. You might want to speak with the circuit DCF legal counsel about the situation. The patient could also file a petition for a writ of habeas corpus with the court.

Can the receiving facility or a doctor testifying at an involuntary placement hearing request a continuance?

No. Only the person is entitled, with the concurrence of counsel, to request a continuance. The Florida Supreme Court Commission on Fairness urges courts, when considering a motion for continuance, to "conduct a hearing and make a finding as to the [person's] capacity to consent to treatment if there is a pending request. If the court finds that the capacity to consent to treatment is lacking, a guardian advocate should be appointed at the time the involuntary placement hearing is continued." P. 49 of the 1999 report.

F. Transfers for Medical Care

I'm a Baker Act magistrate. I recently found a person to meet Baker Act criteria and entered a recommended order for her involuntary placement in a state mental health facility. The circuit judge entered his order accepting the recommendation the next day. The receiving facility (a general hospital) became concerned over the patient's heart rhythms and admitted her to the med/surg unit of the hospital. There's a notice of release or discharge in the file. The receiving facility regards the above as a discharge, so it has filed a new petition for involuntary placement. This new petition shows up on my docket for tomorrow. Was the receiving facility correct in treating the medical admission to the hospital as a discharge under the Baker Act? If so, is a new petition and a new hearing is necessary?

The receiving facility should have **"transferred"** the person for medical treatment instead of "discharging." The facility has the power to discharge only when the person no longer meets the involuntary criteria. While there is a "back office" discharge for financial or administrative reasons to prevent dual billing for the same day of care, the notation of "transfer" in the doctor's order in the medical record keeps the legal status and the guardian advocate intact. This is why persons are "transferred" to the state mental health facility — not "discharged." Unfortunately, once the patient was "discharged" and a notice of discharge filed, there may be no alternative to filing a new petition. It's possible that the state and defense can just stipulate to much of the evidence presented at the earlier hearing, but you still have to have a record that the hearing was conducted and that clear and convincing evidence was presented, prior to entering a new order. Hopefully, this won't happen again if you inform the receiving facility personnel at the hearing of the proper procedure. It's unfortunate that it happened because it has the potential of resulting in an extended period of confinement.

G. Waiver of Hearings and Waiver of Patient Presence at Hearing

Can the involuntary inpatient placement hearing be waived?

No. While the hearing cannot be waived, the court can waive the person's attendance at all or any part of the hearing if it is consistent with the best interests of the person and the person's counsel does not object. Appellate courts have ruled that such a waiver of the patient's presence must be documented in the court record as "knowing, intelligent, and voluntary."

We have a patient at our receiving facility who had his court hearing yesterday but did not attend because he was restrained at the time. He is requesting to appeal the decision. To my knowledge there is no provision in the Baker Act for an appeal process. What are this patient's options, if any, regarding being court ordered to receive treatment at this facility?

The appellate courts have found that involuntary placement under the Baker Act is such a substantial deprivation of liberty that any limitation on a person's ability to be present at or testify at his or her own hearing is grounds for reversal of the court order. The courts have said that a person's refusal to attend or testimony by his/her attorney of such refusal is an insufficient waiver of the right to be present without a separate independent inquiry by the court to confirm that the refusal was knowing, intelligent, and voluntary. In this situation, the individual wasn't refusing to attend — he was denied his strong desire and right to attend due to his/her acuity. The hearing could have been conducted if necessary in the restraint room to allow the person to attend/participate while preserving the safety of the person and others.

The person's public defender has the standing to appeal an order for involuntary placement if the hearing was conducted by a circuit court judge. If the hearing was conducted by a magistrate instead of by a judge, the public defender has the right to file an "exception" to the magistrate's recommended order. According to the First District Court of Appeal, the public defender "serves as an independent advocate for the client, not as a neutral party charged with the responsibility of determining the best interests of the patient or the needs of society." *Handley v. Dennis*, 642 So. 2d 115, 117 (Fla. 1st DCA 1994). The court also said that "if the patient wishes to be released or transferred and if there is a basis for that request, the public defender has a duty to advocate the cause of the patient." *Id.* Other relevant First District Court of Appeal cases include:

- *Ibur v. State*, 765 So. 2d 275, 276 (Fla. 1st DCA 2000). The court held that "[b]ecause involuntary commitment is a substantial deprivation of liberty at which fundamental due process protections must attach, the patient cannot be denied the right to be present, to be represented by counsel, and to be heard." It reversed the commitment order and remanded the case.

- *Joehnk v. State*, 689 So. 2d 1179 (Fla. 1st DCA 1997). The court held that the person's lawyer informing the trial court that the person did not wish to appear at an involuntary commitment hearing was an insufficient waiver of the person's fundamental right to be present at an involuntary commitment hearing. While the person could waive his rights to be personally present or constructively present through counsel, the trial court "must certify through

proper inquiry that the waiver is knowing, intelligent and voluntary." *Id.* at 1180. The court reversed the involuntary commitment order and remanded.

- *Williams v. State*, 692 So. 2d 257 (Fla. 1st DCA 1997). The court held that the person has a fundamental right to be present at a Baker Act commitment proceeding. Quoting *Joehnk*, the court stated that while the person may waive the right to be personally present or constructively present through counsel, "the court must certify through proper inquiry that the waiver is knowing, intelligent and voluntary." It reversed and remanded the case for a new commitment hearing since the record did not reflect whether the person had waived his right to be present at the commitment hearing.

If the patient believes his rights have been violated, he can file (or have filed on his behalf) a petition for a writ of habeas corpus. If the Public Defender's Office is unwilling to file an appeal/exception, the individual can contact, e.g., a legal aid organization or the ACLU to obtain legal representation. Finally, you may wish to refer this matter to your corporate attorney for assistance.

H. Conversion between Voluntary and Involuntary Status

We have a patient who is voluntary, and the MD wants to file a petition for involuntary placement. Does the MD also need to do a BA-52, or is initiating the petition for placement sufficient and timely filing with the court?

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

If a petition for involuntary inpatient placement has been filed but the patient was subsequently deemed competent (prior to court date), do we need to ask him/her to sign a whole new consent?

Yes. If a person has first been found to meet the criteria for involuntary inpatient placement and incompetent to consent to treatment, resulting in a petition being filed with the circuit court, and subsequently stabilizes before the scheduled hearing, you would indeed request withdrawal of the petition. The person would sign an application for voluntary admission and other forms required for voluntary status only after a physician had documented that the person is competent to

provide express and informed consent by use of the form CF-MH 3104, Certificate of Competency.

I. Witnesses

I am a new psychiatrist at a receiving facility. We are running into a problem with the opinions and are finding a need for the option of a "third opinion" for the BA-32, as there might be occasions when the first and second opinion psychiatrists may not be available. When this situation arose at a previous hospital, a third psychiatrist would complete a third opinion (on another "second opinion" portion), file it with the court, and present testimony at the hearing. When this was suggested as an alternative here, I discovered there is no provision in the statutes regarding this. The statute still explicitly states one of the psychiatrists who initiated the first or second opinion must be present in court. Can the law be amended to allow for a third opinion when neither the first or second opinion psychiatrists are available? What do you advise?

The law is quite specific that one of the two experts providing opinions on the petition must provide testimony at the involuntary placement hearing, but is silent as to whether the testimony must be done in court or through other methods. While the doctors know when the hearings are scheduled and usually make plans to attend as required by law, the statute wouldn't preclude such testimony from being done telephonically in exceptional circumstances. This might involve having someone available to swear in the doctor as a witness when done off site. If neither of the two doctors is able to testify, the court would have no choice but to dismiss the petition because there would be no clear and convincing testimony elicited to support the petition. It is the person's right to a hearing within the five-day period of the filing of the petition, unless the person requests a continuance — a Baker Act equivalent of "speedy trial" under criminal law.

The Florida Supreme Court Commission on Fairness addressing the Baker Act recommended that the state attorney's office withdraw the petition if the allegations in it are not substantiated. This means that if one of the two experts who prepared the petition is not available to testify, the petition must be withdrawn by the state attorney or dismissed by the court. The only provision for a "third opinion" is when the patient has requested an independent expert examination. The findings of this examination are confidential and not discoverable unless the expert is called as a witness for the patient at the hearing. One situation in which a psychiatrist failed to appear at Baker Act hearings to testify in support of petitions for involuntary placement resulted in her being reported to the Florida Board of Medicine, which reached a probable cause finding against her medical license.

Is there any provision in the Baker Act that prohibits psychiatrists who complete the first and second opinions for involuntary placement from being professionally affiliated; i.e., working in the same practice in the community?

There is no prohibition against psychiatrists who practice with each other from signing the first and second opinions on the same Petition for Involuntary Inpatient Placement (form CF-MH 3032). One would presume, unless there is evidence to the contrary, that each psychiatrist performed an evaluation independent from the other and reached their respective conclusions based on these evaluations.

Can an ARNP testify at the hearing on involuntary placement on behalf of the psychiatrist who provided one of the two expert opinions? I told them that they could not send an ARNP. However, in our county a clinical psychologist is authorized to provide the second opinion supporting the petition and "One of the two professionals who executed the involuntary placement certificate must be a witness. This role cannot be delegated to others." I would like to know whether a clinical psychologist (the one giving the second opinion) could replace the MD in the court.

You are correct that the ARNP is unable to provide the testimony on behalf of the psychiatrist. Only a psychiatrist is permitted to provide a first opinion. Only a second psychiatrist or a clinical psychologist is authorized to provide the second opinion. Either can provide the statutorily required court testimony. Only when the facility administrator has certified that neither a psychiatrist nor a psychologist is available to provide the second opinion can a physician who has post-graduate training and experience in diagnosis and treatment of mental illness or a psychiatric nurse provide the second opinion. A psychiatric nurse is not the same as an ARNP. The expert who performs one of the two examinations must testify and be subject to cross-examination. Psychologists can provide the court testimony instead of the psychiatrist, but they may be asked questions by the state attorney or public defender about co-occurring medical conditions as well as the medications that wouldn't be within the psychologists' area of expertise. The psychologist, if one is used for one of the two opinions, is authorized by law to examine and to testify as to the conclusions from that examination — an ARNP is not.

I provide most of the testimony at involuntary placement hearings for my receiving facility. My question is about criterion (1)(a)2.a for involuntary inpatient placement under section 394.467, Florida Statutes ("is incapable of surviving alone or with the help of willing and responsible family or friends, . . . 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"). I could not find a definition in the Florida statutes for the terms "neglect" (for adults) or "well-being" or regarding the concept of "self-care." It seems that the court and public defender's office have no difficulty accepting for this criterion behaviors such as not eating, not sleeping, neglect of hygiene, and refusal to take medical medications — obvious physical behaviors — but struggle with the ideas of refusing to take psychiatric medication, paranoia leading to isolation, having persecutory delusions, or other "psychological" or "emotional" concepts related to someone's well-being. In short, there is resistance to say that someone refusing psychiatric medication is experiencing neglect, even if they are paranoid, delusional, and suffering emotionally. Has this been brought up before?

Some assistant state attorneys don't elicit the testimony on these issues to support the petitions. As a result, some persons are released from receiving facilities who need to be held longer. The statutory language for involuntary examination and involuntary placement requires the neglect to be real, present, and substantial and be due to mental illness as defined in the Baker Act. It also needs to be documented that there isn't any other help available to assist the person to avoid this neglect and that there are no less restrictive treatment alternatives.

There aren't any other Baker Act-related statutory or regulatory provisions that would provide more guidance in this area. The only other statute governing the issue of neglect is in the Florida Adult Protective Services law. That law defines "neglect" as follows:

> **415.102. Definitions of terms used in ss. 415.101-415.113.**
>
> (16) "Neglect" means the failure or omission on the part of the caregiver or vulnerable adult to provide the care, supervision, and services necessary to maintain the physical and mental health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, which a prudent person would consider essential for the well-being of a vulnerable adult. The term "neglect" also means the failure of a caregiver or vulnerable adult to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness which produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death.

The burden of proof in the involuntary inpatient placement hearings is "clear and convincing evidence." Testimony given by witnesses that fails to meet this standard is not likely to be helpful in supporting the petition. The best source of information regarding your question is going to come directly from how the appellate courts have ruled on the subject of what constitutes clear and convincing evidence of self-neglect (see the compendium in Appendix II).

J. Hearings

I thought that hearings are to be held in each receiving facility, but I cannot find this in the law. Section 394.467(6)(a)2., Florida Statutes, just says the hearing "must 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." In our county, hearings for three facilities take place in one location.

Historically, these hearings were generally conducted in courthouses. Gradually, the hearings have been moved to the various Baker Act receiving facilities in most judicial circuits. This has been found to be much safer for the patients because they avoid transport, and it increases their privacy and confidentiality. This practice was recommended by the Florida Supreme Court Commission on Fairness, assuming that facilities were using space for the hearings not used by patients for any other program purpose. It is important, wherever the hearings are held, that the person understands that they've had their day in court — not just a clinical staff meeting or other event occurring in the cafeteria or activity room.

Can Baker Act involuntary placement hearings be done via remote video?

The Florida Supreme Court Commission on Fairness made many recommendations regarding the Baker Act, including a very strong recommendation against the use of any video or telephonic hearings or testimony in Baker Act related matters. This is because the person's appearance at a hearing done in this fashion may be altered by the use of such electronic means, particularly if the person's mental illness is characterized by paranoia or hallucinations. Certain rules governing juvenile procedures also limit video or telephonic means due to the minor's diminished capacity. By the same token, persons with mental illnesses may also have such a diminished capacity. However, certain courts are currently considering or have implemented video-conferenced hearings. In *Doe v. State*, __ So. 3d __ (2016), 2016 WL 5407617 (Fla. 2d DCA 2016), the Second District Court of Appeal rejected a challenge to an announcement in Lee County that judges and magistrates would preside remotely from the courthouse by videoconference. However, the

court certified to the Florida Supreme Court the following question: "DOES A JUDICIAL OFFICER HAVE AN EXISTING INDISPUTABLE LEGAL DUTY TO PRESIDE OVER SECTION 394.467 HEARINGS IN PERSON?" The Supreme Court accepted jurisdiction, and oral argument is scheduled for February 7, 2017.

A new public defender was recently assigned to Baker Act court. The strict wording of the statute on involuntary inpatient placement (section 394.467(6), Florida Statutes) is: "The court shall hold the hearing on involuntary inpatient placement within 5 days, unless a continuance is granted" (emphasis added). Page Appendix J-2 of the Baker Act Handbook states: "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." This is extremely important when it comes to weekends and holidays. The public defender has successfully had most petitions overturned, especially in light of extended holiday weekends such as at Thanksgiving and Christmas.

Until 2016, the statute referred only to "5 days," and a 1997 Attorney General opinion (Op. Att'y Gen. Fla. 97-81 (1997)) interpreted this as calendar days. Since that time, however, the courts have determined that this is five court working days, not calendar days. For example, in *D.M.H. v. Pietilla*, 33 So. 3d 800 (Fla. 5th DCA 2010), the appellate court held that rule 1.090, Florida Rules of Civil Procedure (now rule 2.514(a), Florida Rules of Judicial Administration), governs the computation of time prescribed for an involuntary inpatient placement hearing under section 394.467(6)(a)1., Florida Statutes. That rule provides that Saturdays, Sundays, and legal holidays are excluded when the time period is less than seven days. Therefore, the appellate court affirmed the trial court's denial of the patient's petition for a writ of habeas corpus that was based on the failure to hold a hearing within five calendar days. And in 2016, the statutory wording was changed to "within 5 ***court working*** days" (emphasis added).

If a petition for involuntary placement is filed on or near a holiday and the court tells you there will not be a hearing due to the holiday schedule, how should we proceed? The person is incompetent, and the immediate concern is for his or her safety. Does the court or monitoring agencies see that as a viable reason for keeping someone beyond the allotted time?

As long as your facility completes the petition (the facility administrator's signature and both opinions) and you have filed the petition with the clerk of court within 72 hours of the individual's arrival (could be less time if the individual had been held at a hospital ED or other receiving facility prior to arrival), you have met

your duty under the law. The law allows for the actual filing to be delayed until the next court working day only if the examination period ends on a weekend or legal holiday (not just a weeknight).

Once the petition has been timely filed with the court, you've met your duty to the individual and have the right to hold the individual until the hearing. The court must conduct the involuntary placement hearing within five court working days after the filing of the petition. The only legal way of delaying the hearing is if the individual requests a continuance of the hearing with the concurrence of legal counsel. If a holiday occurs on the day of a timely hearing, the court could conduct a hearing on an earlier day than the day scheduled. Further, the patient could file a petition for a writ of habeas corpus challenging the legality of any extended detention.

What are the required elements of an involuntary placement hearing?

The hearing is to determine if there is clear and convincing evidence that the person meets all criteria for involuntary placement and to consider testimony and evidence regarding the person's competence to consent to treatment. If the court finds the person is incompetent to consent to treatment, it is required to appoint a guardian advocate.

Can a judge merge a Baker Act involuntary placement hearing and an emergency guardianship proceeding, allowing the family/temporary guardians and the receiving facility status as intervenors in the Baker Act hearing?

Handley v. Dennis, 642 So. 2d 115 (Fla. 1st DCA 1994), may be on point here. The First District Court of Appeal held that when there is a conflict with the area of guardianship law (chapter 744, Florida Statutes) and the Baker Act (chapter 394, Florida Statutes), both the duty of the guardian and the power of the guardianship court must give way to the ward's rights under the Baker Act to be in the least restrictive environment. The court went on to say that a liberty interest asserted on behalf of an involuntary mental patient in a Baker Act hearing is superior to any conflicting right that could be asserted on behalf of the patient under the guardianship laws.

Another case that addressed this issue is *Auxier v. Jerome Golden Center for Behavioral Health*, 85 So. 3d 1164 (Fla. 4th DCA 2012). A writ of certiorari was granted after the public defender's office sought review of an order discharging it from representing a patient in a Baker Act proceeding. The magistrate dismissed

the PD because the patient had a plenary guardian and her rights had been transferred to her guardian and counsel for the guardian would represent her. The patient was not present at the hearing and did not have independent counsel. The Fourth District Court of Appeal found the magistrate and the circuit court departed from the essential requirements of the Baker Act, which requires appointment of the PD's office "unless the person is otherwise represented by counsel." The guardian's attorney represents the guardian, not the ward. The Fourth District concurred with the First District Court of Appeal ruling in *Handley v. Dennis*.

Having a combined hearing would be unusual. There could potentially be two hearings, one right after another, that might be allowable as long as the required notice was provided for each. Notice requirements for a Baker Act hearing are listed in section 394.4599(2)(d), Florida Statutes, including an independent expert provided by the court. Since the public defender's office must be appointed to represent the person in a Baker Act proceeding, unless the person is represented by private counsel, it is presumed that the person was appointed a different attorney to represent him/her under the guardianship matter. Both would be required to be an independent advocate for the least restrictive alternative for the client.

Family/temporary guardians and the hospital staff have no standing as "intervenors" in a Baker Act proceeding. Chapter 394 only permits the public defender representing the person, and the state attorney as the "real party in interest" representing the state, to call witnesses. These "intervenors" could have been called as witnesses by the state in support of the continued detention of the person, but counsel for the ward could have invoked the exclusionary rule to keep them out of the rest of the hearing. They would have had no standing.

Chapter 744, Florida Statutes, doesn't establish (nor could it) any superior rights of the guardian over the ward in the Baker Act case. While section 744.3725 allows extraordinary authority to be given to a guardian by the court, the court must first provide for the required array of protections specified in this section of the statute to the incapacitated person. Chapter 744 allows a court to give a guardian the power to have the ward committed voluntarily, but the Baker Act prohibits a facility from admitting as a voluntary patient anyone adjudicated incapacitated. § 394.4625(1)(d), Fla. Stat.

K. Involuntary Placement Orders

What is the statutory support for a person being ordered to a short-term residential treatment facility (SRT) under the Baker Act? I am fully aware that judges/magistrates order people to SRTs in other areas, but our Baker

Act judge wants to know what gives her the authority to do so. Is it classified as a "receiving facility" or a "treatment facility"?

The Baker Act gives the court the authority to order persons to a state mental health facility (treatment facility), to any receiving facility, or to receive services from a receiving facility. It is this last provision that has allowed courts in other circuits to order people for involuntary inpatient placement at SRTs for services provided by a receiving facility.

Your facility is designated as receiving facility. If the SRT is operated by or considered as part of the receiving facility, there is no problem with the judge ordering a person there for involuntary inpatient placement. If located on the same premises or at the same address as found on the CSU designation letter, there definitely wouldn't be a problem. However, if this is not the case, a petition for involuntary outpatient services might be needed to obtain a court order to services that aren't at or by a receiving or treatment facility.

When a court order for involuntary placement at a state hospital has been entered, there is often so long a wait for a bed that the person stabilizes and a less restrictive alternative is found to be appropriate. Is a subsequent order rescinding the involuntary placement order required, or does section 394.469, Florida Statutes, suffice?

The law requires the administrator of the facility to discharge the person at any time he/she is found to no longer meet the criteria for involuntary placement. The release of the person doesn't require an order of the court.

While a resident was at our SRT, the doctor filed a petition for involuntary treatment under the Marchman Act and an order for up to 60 days was entered by the circuit court. However, no bed has been available in the substance abuse program for him. Does the Baker Act expire when a Marchman Act is granted by the court?

Generally, the Baker and Marchman laws are considered mutually exclusive since substance abuse impairment is specifically excluded under the Baker Act definition of mental illness and substance abuse impairment is specifically required for involuntary admissions under the Marchman Act. While the two laws can't be applied simultaneously, they can be applied sequentially if it is determined as part of the clinical evaluation that one condition exists to the exclusion of the other or one is primary and the other secondary. The Baker Act states:

> If at any time before 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 services, the court may order the person evaluated for involuntary outpatient services 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 are governed by chapter 397.**

§ 394.467(6)(c), Fla. Stat. (emphasis added).

Co-occurring mental health and substance abuse disorders are frequent and should often be treated concurrently rather than sequentially. This can be done under a Baker Act order we long as the Baker Act criteria continue to be met.

Say a patient is admitted under the Baker Act to an inpatient unit of a receiving facility and the facility files the petition within 72 hours, the hearing is held, and the court orders the patient to remain in the facility for a period not to exceed 30 days. What does the law require the facility to do if the patient is in the hospital for 28 out of those 30 days, still needs continued inpatient treatment, and the 30 days will expire before the patient can be discharged? Also, the magistrate presiding over the Baker Act hearing is now required to provide the patient's date of birth for the court to include on the court order for the patient. The magistrate has concerns about the patient's confidentiality and would like to know if this is a new requirement.

In the circumstances you describe, you should file a petition for continued involuntary placement with the clerk of court prior to the expiration of the original order. The court may require you to file it sufficiently in advance of the order's expiration so a hearing can be conducted within that period of time. The court in *W.M. v. State*, 992 So. 2d 383 (Fla. 5th DCA 2008), held that the judiciary has concurrent jurisdiction with DOAH for continuation of all involuntary inpatient orders up to a six-month maximum.

It is unclear why the magistrate has to place the patient's birth date on the order. The model form CF-MH 3031 (Order for Continued Involuntary Inpatient Placement or for Release) doesn't have any such information included. The judiciary has the right to modify any form recommended by the executive branch

of government to achieve the purpose set forth in the law. Adding the birth date is not required by the Baker Act and is not a result of any requirement by the Legislature or DCF.

Does an order for involuntary placement need to be for six months?

No. The maximum period for which a person can be ordered for involuntary placement has traditionally been six months. However, most courts order the period of placement to be the length of time it is expected to take to stabilize the person. However, the 2016 Florida Legislature reduced the maximum length of an involuntary placement order to 90 days, effective July 1, 2016, other than orders to state treatment facilities, which are permitted for up to six months.

Magistrates in our area have been placing time restrictions on the orders for periods of weeks instead of the six months permitted by law. It is difficult to estimate how long it will take to stabilize the person on medication or predict difficulty with discharge placement issues that may prohibit the person from being discharged prior to the end of the order. Would this become subject to involuntary inpatient placement criteria requiring an administrative law judge from Tallahassee (requires a minimum of 20 days' notice prior to the expiration of the order) to perform the hearing? Or do we re-file a form CF-MH 3032 to get the hearing scheduled and a new court order entered?

Judges and magistrates throughout the state typically entered orders for less than six months, unless it was expected that the person would be sent to a state hospital. Section 394.467(6)(b), Florida Statutes, states that "[i]f the court concludes that the patient meets the criteria for involuntary placement, it may order that the patient be [transferred, retained, or treated] for up to 90 days. However, any order for involuntary mental health services in a [state] treatment facility may be for up to 6 months. . . . The facility shall discharge a patient any time the patient no longer meets the criteria for involuntary placement, unless the patient has transferred to voluntary status."

The Baker Act was originally written to place the burden on the receiving or treatment facility to make the clinical decision as to when, during the six-month period, the person no longer met the criteria. However, there has been an increasing use of shorter court orders, transferring the control over the maximum length of time a person could be held from the facility to the court.

The "continued involuntary inpatient placement" procedures provided for in section 394.467(7), Florida Statutes, are administrative hearings rather than

judicial ones. However, courts around the state have handled this issue in several ways. Some have considered anything within the first six months as within the court's jurisdiction. They do this by having the facility request a reconsideration of the court's original order or an amendment of the original order to extend the period of time the person can be held. Others have the facilities file a new petition for involuntary inpatient placement, prior to the expiration of the original order, initiating a new involuntary inpatient placement order. This allowed the facility to retain the person pending the second hearing and allowed the court to hear evidence as to what factors require a longer than anticipated length of stay (should the person still be retained when the second hearing is held).

This matter needs to be negotiated with the local courts. Each person has an attorney, and if that attorney and the assistant state attorney concur with the procedures used locally, due process has been provided.

In *W.M. v. State*, 992 So. 2d 383 (Fla. 5th DCA 2008), the Fifth District Court of Appeal established that concurrent jurisdiction between the judiciary and DOAH exists within the six months of the original order. The circuit court had ordered a patient involuntarily committed for three weeks. When she didn't respond to treatment, a petition for continued involuntary placement was filed and the court ordered six more months of treatment. The patient appealed, arguing that the court had no jurisdiction to order the continued treatment. The appellate court affirmed the order, stating that while continued involuntary placement hearings are to be administrative, the circuit court retains concurrent jurisdiction. The Legislature's intent was that the administrative hearing requirement applies after a patient is committed to long-term treatment at a treatment facility instead of a community-based receiving facility. Because the initial treatment ordered by the court was short-term, the court properly exercised jurisdiction to order further treatment. However, once long-term treatment is ordered, a petition for continued treatment must be addressed in an administrative hearing.

What authority does the court have to specify a particular program or facility in an involuntary inpatient placement order?

The court has the power to order that a person be transferred to a treatment facility or, if the person is at a treatment facility, that he/she be retained there or be treated at or receive services from any designated receiving or treatment facility. The recommended order for involuntary inpatient placement intentionally doesn't include a space for the name of a facility, so that a person's right to request transfer from one facility to another is expedited without having to return to court for an amended order. The court may modify the form. If it enters its order on a modified

form that includes a specific facility or program, the only alternative that program would have is to request the court to reconsider or amend its order or file an appeal of the order. An uncontested court order must be followed.

A circuit judge entered an order for our receiving facility to accept a person who was in jail on felony charges. The order provided that the inmate be sent to a state hospital as soon as a bed became available. Is this proper?

No. This is not a proper use of the Baker Act. However, one can't ignore a court order. There are procedures to be followed in challenging a court order — requesting reconsideration or having a rehearing, or appealing the order, as determined by the receiving facility's attorney. The attorney will probably want to discuss this matter with the judge to avoid having to respond to such orders later. The only way to legally order someone into a state hospital is under chapter 394, part I, Florida Statutes (Baker Act), or chapter 916, Florida Statutes (forensic). If the judge didn't follow either of these two statutes, it is essential that the facility properly question the order. The state hospital's attorney should also be consulted on the matter.

Does a facility have the discretion to release a person from an order for involuntary placement without the consent of the court?

Yes. The administrator has the duty to discharge a person at any time the person no longer meets the criteria for involuntary placement, unless the person has transferred to voluntary status.

Are there any Baker Act or Marchman Act appellate cases having to do with elopements after an order for involuntary placement has been entered?

There isn't any appellate case addressing elopements from facilities under the Baker Act. However, there is a Marchman Act case on point: *S.M.F. v. Needle*, 757 So. 2d 1265 (Fla. 4th DCA 2000). The circuit court had granted a petition for involuntary substance abuse treatment for a minor in response to a petition filed by her parent. The order was for 60 days of involuntary treatment, the maximum period permitted under law at that time, commencing upon her admission to the facility. However, the minor ran away prior to commencing treatment and was returned to the program after the initial court order had expired. She filed a petition for a writ of habeas corpus, arguing that she was entitled to immediate release because section 397.6977, Florida Statutes (1999), provided that "[a]t the conclusion of the 60-day period of court-ordered involuntary treatment, the client is automatically discharged unless a motion for renewal of the involuntary

treatment order has been filed with the court." The appellate court held that the automatic discharge would occur "at the 'conclusion of the 60-day period of court-ordered involuntary treatment,' not merely sixty-days after the entry of the order for treatment," and that the 60-day period had not expired, because the petitioner ran away before commencing treatment. The petition for writ of habeas corpus was denied.

L. Continued Involuntary Inpatient Placement

Why are continued involuntary inpatient placement orders under the jurisdiction of ALJs instead of circuit judges? Since the law authorized "up to 6 months" for these initial orders, why do the circuit courts enter the orders for shorter periods of time?

When the Baker Act was first enacted in the early 1970s, state-operated mental hospitals represented the majority of the care offered in Florida. Once persons were sent from their home communities to state hospitals on involuntary placement orders, it would have been a logistical nightmare for the patients to be brought back to their own circuits for continued involuntary hearings at the expiration of the original orders, and it would have created an undue burden on the circuits where the state hospitals were located to take on this workload. The problem was resolved by having ALJs from the DOAH circuit ride to the various state hospitals to conduct these hearings.

The law was written to allow up to six months for the orders and required receiving/treatment facility administrators to release the person or transfer to voluntary status at any time the criteria for involuntary placement were no longer met (section 394.467(6), Florida Statutes). For many years, all involuntary placement orders entered reflected a six-month time frame. Over the past decade or more, a trend emerged that fundamentally transferred the control over the time period a person could be held from facility administrators to the judiciary by limiting the period of time of the order to the length of time that evidence documented it would take to stabilize the person's condition. These shortened periods, as well as court order of persons to SRT settings, resulted in court orders for involuntary inpatient placement expiring while persons are still in the community. As of July 1, 2016, the maximum length or orders is 90 days, with the exception of orders to state treatment facilities, which remains six months.

I'm an assistant public defender. I received a copy of a Petition Requesting Authorization for Continued Involuntary Inpatient Placement (form CF-MH 3035). Where did this form originate, and was it ever approved for

implementation?

This form, along with most of the Baker Act form series, is a recommended one, but is not required. It was developed in 1998 and revised in 2005 — promulgated under the Administrative Procedure Act. The recommended forms can be modified as long as they retain the legal requirements. The recommended form tracks the requirements of section 394.467(7), Florida Statutes, but could be amended.

M. Baker Act Forms and Service of Process

Can we fax or email documents to the clerk of court if a hard copy is sent within a specific amount of time?

This issue isn't governed by the Baker Act. Many judicial circuits accept emailed or faxed filings and others do not. Clerks are actively working toward such electronic systems; some use FTP (File Transfer Protocol), which allows secure transfer of files over the Internet. You need to contact the office of clerk of court serving your county and determine what their requirements may be. The judicial branch determines how to conduct its business. Whatever is acceptable to your courts on petition filing would suffice.

Is the circuit court required to use the model Baker Act forms developed by DCF?

No. Separation of powers between each branch of government ensures that the executive branch can't compel the judicial branch to a specific action. However, the Florida Supreme Court Commission on Fairness recommended that each judicial circuit review and consider adapting and adopting the model forms prepared by DCF.

If a petition for involuntary inpatient placement is filed with the court, is the clerk of the court responsible for providing copies of the petition and the notice of hearing to all required parties?

Yes. Section 394.467(3), Florida Statutes, states that upon the filing of a petition for involuntary inpatient placement, "the clerk of the court shall provide copies of the petition 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." Section 394.4655(4)(c) assigns the same responsibility (along with including a copy of the proposed treatment plan) to the clerk of the court for involuntary outpatient services.

Section 394.4599(2)(d), governing notice of the filing of petitions for involuntary (inpatient or outpatient) placement, doesn't specify who is responsible for filing the notice of hearing. However, one can only conclude that responsibility lies with the clerk's office, because the procedure requires confirmation of petition filing, public defender appointment, the date/time/place of hearing, court appointment of an independent expert, change of venue information, etc. — all issues that are the responsibility of the court.

Who uses the form titled Order Requiring Involuntary Assessment and Stabilization for Substance Abuse and for Baker Act Discharge of Person (CF-MH 3114)? Does this take the place of a Marchman Act proceeding?

That form is used by the court when, prior to the conclusion of a hearing for involuntary inpatient placement or involuntary outpatient services under the Baker Act, it finds that the person instead meets the criteria for involuntary admission under the Marchman Act. This form can then be used to order the person to undergo such admission for involuntary assessment under the Marchman Act.

The magistrate recently dismissed our petition (CF-MH 3032) because we hadn't submitted a number of forms, including the Notice of Petition for Involuntary Placement, Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances, Certificate of Professional Initiating Involuntary Examination, Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate, and Certification of Person's Incompetence to Consent to Treatment and Notification of Health Care Surrogate/Proxy. Was this correct?

No. There is no requirement that these forms, other than the 3032 petition, be filed by the petitioner with the court. The public defender and state attorney generally review these forms at the facility prior to or at the time of the hearing. Submitting copies simultaneous with petition filing seems to be unnecessary.

N. Transfers of Persons under Involuntary Placement

Can persons on involuntary inpatient placement orders be transferred from one facility to another?

Yes. The Baker Act law and rules don't require that the name of the facility be incorporated into the court order for placement. In fact, the recommended model Involuntary Placement Order form (CF-MH 3008) doesn't include space for such limitation. This was deliberately done to facilitate a patient's right to request transfer from one facility to another without the delay involved in scheduling a

court hearing. It appears that the circuit court in your county has added the specific name of the facility to the form, retaining control over where the patient may be placed as opposed to allowing the patient, guardian, or facility the right given in the Baker Act to transfer from one facility to another without delay in waiting for another hearing.

The public defender assigned to represent persons on involuntary status in our receiving facility said that when an involuntary patient is transferred from our facility to another facility, it is his opinion that the Baker Act involuntary order is void because by transferring the patient our hospital effectively discharged the patient, and that by the discharge of the patient the Baker Act order is automatically rescinded and the patient has to have a new petition for involuntary placement filed. Could you clarify?

The Baker Act makes a very distinct difference between transfers and discharges. While a receiving facility would have to do some sort of a back-office (administrative/financial) discharge of a patient when a transfer to another receiving or treatment facility takes place, the Baker Act record should reflect that a transfer is taking place. A facility only has the power to discharge a person who no longer meets the criteria for involuntary placement. Otherwise the facility must retain the person or transfer to another facility.

O. State Treatment Facilities and Transfer Evaluations

Our hospital-based receiving facility has an individual who appears appropriate for the state hospital. I believe I read somewhere that before an individual can be admitted, a transfer evaluation must be made by the public receiving facility. Is this correct? If so would you please provide me with the law or rule that states this requirement?

In summary, no one may be transferred to a state mental health treatment facility (voluntary or involuntary) without a transfer evaluation. The following should help:

Criteria:

- Whether the person meets the statutory criteria for admission to a state treatment facility.
- Whether there are appropriate, more integrated, and less restrictive treatment resources available to meet the person’s needs.

Process:

- Following evaluation of the person, the community mental health center director recommends admission to a state treatment facility or, if the criteria for involuntary placement are not met, to alternative treatment programs, by completing and signing the "Transfer Evaluation" (form CF-MH 3089).

- The evaluation is forwarded to the court prior to the hearing ("the court shall receive and consider the information," section 394.461(2), Florida Statutes).

- Testimony is presented at the hearing by the evaluator or other knowledgeable staff as desired by the court.

Requirements in Florida Statutes:

- **394.455. Definitions**

  (9) "Community mental health center or clinic" means a publicly funded, not-for-profit center that contracts with the department for the provision of inpatient, outpatient, day treatment, or emergency services.

  * * *

  (46) "Transfer evaluation" means the process by which a person who is being considered for placement in a state treatment facility is evaluated for appropriateness of admission to the facility.

The rules implementing the requirements for transfer evaluations are found in rules 65E-5.1301, 65E-5.1302, and 65E-5.290, Florida Administrative Code.

- **394.461. Designation of receiving and treatment facilities.--**

  (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.

Prior to July 1, 2016, the definition of "treatment facility" required that the community mental health center or clinic prepare the transfer evaluation. However, the 2016 Legislature eliminated any specification as to responsibility for this function. The Florida Administrative Code continues to require this of the community health center or clinic, but there is no longer any specific statutory basis for this requirement.

A patient at a private receiving facility is scheduled to go to the state hospital. Which public entity should conduct the transfer evaluation?

The statutorily required transfer evaluation must be done prior to the person's involuntary inpatient placement hearing pursuant to the provisions in the Florida Administrative Code. See FAQs above regarding the entity to conduct the transfer evaluation. DCF could designate a single CMHC to do this county- or circuit-wide or assign to each CMHC the nearest private receiving facilities. A CMHC that has a public receiving facility would conduct transfer evaluations on persons in its own CSU. Since the 2016 legislative change eliminating specification of the community mental health center or clinic, DCF could designate the managing entity or other entity this responsibility.

P. Convalescent Status

I work for a clerk of court. Section 394.469(1)(c), Florida Statutes, refers to the placement of an improved patient "on convalescent status in the care of a community facility." What is convalescent status? There is confusion among the discharge planners at the facility as to the judges' authority to order a patient who no longer meets inpatient criteria into a secure facility upon discharge from the receiving facility. Would it be more appropriate to include the ALF placement as part of the treatment plan in an outpatient placement petition? Or does the judge actually have authority to include in the inpatient placement order discharge to a secure facility?

All references to convalescent status were removed from the statute in 1996 except for the one you reference regarding persons on involuntary inpatient placement:

> **394.469. Discharge of involuntary patients.--** (emphasis added)
>
> **(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.**

While this may have been an oversight by the Legislature, it remains in the statute. The decision to place an individual on Convalescent Status is made by a facility administrator, not the judge. When used, Convalescent Status is a temporary "leave of absence" from the facility where the individual has been ordered on involuntary inpatient status to determine whether a community placement will be successful before the individual is formally "discharged" from the order. This avoids the necessity for beginning the entire involuntary inpatient placement procedure all over again should the community placement be unsuccessful.

XVII. Selected Sample Baker Act Forms for Involuntary Inpatient Placement

Please note that these recommended forms were promulgated by DCF before the 2016 statutory amendments and do not incorporate those changes.

A. Petition for Involuntary Inpatient Placement

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 last four (4) digits of the person's social security number are _____ 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:

	Witness	**Witness**	**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.

_____ _____ _____ am pm

Signature of Facility Administrator or Designee Date Time

_____

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
☐ Person		am pm	
☐ Guardian		am pm	
☐ Public Defender		am pm	
☐ Representative		am pm	
☐ State Attorney		am pm	
☐ 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
Name of Person Date
from such 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:

_____ _____ _____ am pm
Signature of Psychiatrist Date Time

_____ _____
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:

_____ _____ _____ am pm
Signature of Examiner Date Time

_____ _____ _____
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)[d]3, 394.467, Florida Statutes
CF-MH 3032, Nov 11 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

B. Notice of Petition for Involuntary Placement

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 at _____.
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.

_____ _____ _____ am pm
Signature of Court Date Time

_____
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.

_____ _____ _____ am pm
Signature of Court Date Time

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), [d], Florida Statutes
CF-MH 3021, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

C. Application for Appointment of Independent Expert Examiner

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)[d]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
☐ Person		am pm	
☐ Guardian		am pm	
☐ Representative		am pm	

See s. 394.467(6)(a)2, Florida Statutes
CF-MH 3022, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

D. Notice to Court – Request for Continuance of Involuntary Placement Hearing

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.

_____ _____ _____ am pm
Signature of Counsel Date 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**

E. Order Requiring Involuntary Assessment and Stabilization for Substance Abuse and for Baker Act Discharge of Person

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT

IN AND FOR _____ COUNTY, FLORIDA

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**

F. Order Requiring Evaluation For Involuntary Outpatient Placement

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

See s. 394.4655(6)(c), Florida Statu[t]es
CF-MH 3115, Feb 05 (Recommended Form) **BAKER ACT**

G. Notification to Court of Withdrawal of Petition for Hearing on Involuntary Inpatient or Involuntary Outpatient Placement

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.

_____ _____ _____ am pm
Signature of Administrator or Designee Date Time

_____
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**

H. Order for Involuntary Inpatient Placement

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**

I. Petition Requesting Authorization for Continued Involuntary Inpatient Placement

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.

_____ _____ _____ am pm

Signature of Administrator or Designee Date Time

_____

Printed or Typed Name of Administrator or Designee

CONTINUED OVER

Petition Requesting Authorization for Continued Involuntary Placement (Page 2)

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.

_____ _____ _____ am pm
Signature of ☐ Physician ☐ Clinical Psychologist Date Time

_____ _____
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
☐ Person		am pm	
☐ Guardian		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	
☐ Public Defender or ☐ Private Attorney		am pm	

See s. 394.467(7), Florida Statutes
CF-MH 3035, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

J. Notice of Petition for Continued Involuntary Inpatient Placement

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	_____	_____	_____
	_____	_____	_____

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.

_____ _____ _____ am pm
Signature of Administrative Law Judge Date Time

_____
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), [d], 394.467(7), Florida Statutes
CF-MH 3024, Oct 11 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

K. Order for Continued Involuntary Inpatient Placement or for Release

IN RE: _____ CASE NO.: _____

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**

Chapter Six: Involuntary Outpatient Services

I. Introduction

See generally section 394.4655, Florida Statutes, and rule 65E-5.285, Florida Administrative Code.

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. *See* ch. 2004-385, Laws of Fla.

The legislative revisions permit the administrator of a Baker Act receiving facility or treatment facility to file a petition for involuntary placement in the circuit court when **inpatient or outpatient** treatment is deemed necessary. § 394.463(2)(g)4., Fla. Stat.

The 2016 Legislature renamed involuntary outpatient **placement** as involuntary outpatient **services**. Some references in text, forms, or FAQs might still use the term "IOP" or the word "placement" instead of "services," but this does not change the meaning of the law or other document.

II. 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 services 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." § 394.459(4)(a), Fla. Stat.

III. Criteria

A person may be ordered to involuntary **outpatient** services upon a finding by the court of 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 services hearing. Appellate courts have found that expert opinions and conclusions are not sufficient, without evidence to prove the allegations. The Florida Supreme Court has 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 in issue." Fla. Stand. Jury Instr. (Civil) 405.4.

The criteria, set forth at section 394.4655(2), Florida Statutes, are as follows:

- The person must be 18 years of age or older. Evidence of age must be substantiated whenever there is any question about it.

- The person has a mental illness. A diagnosis of mental illness must be substantiated by two professionals as provided in section 394.4655(3)(a), Florida Statutes, 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(28), Florida Statutes, and the clinical description of that diagnosis as described in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, American Psychiatric Association, which may be obtained from the American Psychiatric Association, 1000 Wilson Boulevard, Arlington, VA 22209-3901.

- The person is unlikely to survive safely in the community without supervision, based on a clinical determination. The clinical determination must be substantiated by evidence of current or past behaviors.

- The person has a history of noncompliance 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 noncompliant with treatment, including specific time periods.

- The person has either

  - at least twice within the last 36 months been involuntarily admitted to a receiving or 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 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. Either circumstance must be substantiated by evidence.

- The 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. This finding must be substantiated by behaviors, events, and statements by the person.

- In view of person's treatment history and current behavior, the person is in need of involuntary outpatient services 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.

- It is likely that the person will benefit from involuntary outpatient services. Evidence must be presented to substantiate this.

- All available less restrictive alternatives that would offer an opportunity for improvement of the person's condition have been judged to be inappropriate or unavailable. Evidence must be presented to substantiate each less restrictive alternative that was examined.

The person must meet **all** the above criteria.

IV. Petition

If the 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-hour period ends on a weekend or legal holiday, the petition must be filed no later than the next court working day thereafter. If involuntary outpatient services are 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 services. The petition must include a certificate recommending placement completed by psychiatrist and a psychologist or second psychiatrist, who have both examined the person within the

preceding 72 hours, that each of the criteria for involuntary outpatient services is met. A copy of a proposed treatment plan must be attached. No fee can be charged for filing the 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, the 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 the person is to reside at the time it is filed with the circuit court.

V. Service Provider

Prior to filing the petition for involuntary outpatient services, 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 pursuant to the existing psychiatric treatment relationship." § 394.4655(3)(a)2., Fla. Stat. 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 receiving facility;
- a facility licensed under chapter 397, Florida Statutes;
- a treatment facility;
- an entity under contract with DCF to provide mental health or substance abuse services;
- a community mental health center or clinic;
- a psychologist;
- a clinical social worker;
- a marriage and family therapist;
- a mental health counselor;
- a physician;

- a psychiatrist;
- an advanced registered nurse practitioner;
- a psychiatric nurse (as defined in the Baker Act); or
- a qualified professional as defined in section 39.01, Florida Statutes (which includes physician assistants).

§ 394.455(44), Fla. Stat. 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 services 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
- 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.

VI. Treatment Plan

A service provider must prepare a written proposed treatment plan in consultation with the person or the person's guardian advocate for the court's consideration in an involuntary outpatient treatment order. The treatment plan must:

- specify the nature and extent of the person's mental illness;
- address the reduction of symptoms; and

- include measurable goals and objectives for the services and treatment provided to help the person function in the community and to prevent a relapse or deterioration.

Section 394.4655(3)(a)3., Fla. Stat. 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 the court that the services in the plan are currently available and that the service provider agrees to provide them.

The confidentiality provisions of the Baker Act have been revised for purposes of determining whether a person meets the criteria for involuntary outpatient services 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.

VII. 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 services 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 the "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, as to 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.

VIII. Notice of Petition

A copy of the petition for involuntary outpatient services and proposed treatment plan must be provided within one working day after filing by the clerk of the court to the:

- respondent;
- DCF;
- 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 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 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. August 24, 2005, Commission Minutes, Agenda Item II.A. 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. § 394.467(6)(a)3., Fla. Stat.

IX. Hearing

A hearing on the petition for involuntary outpatient services must be conducted within five 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 four 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 one court working day after the petition is filed, unless the person is otherwise represented. Counsel for the person must 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 the person. A judge or magistrate may preside. If the facility administrator seeks to withdraw the petition for involuntary outpatient services prior to the hearing, recommended form CF-MH 3033, titled "Notification to Court of Withdrawal of Petition for Hearing 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 (*see* Fla. Admin. Code R. 65E-5.285(2)(d)) 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 services** or involuntary inpatient placement; or
- 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 before 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 involuntary outpatient services, the court may order the person evaluated for involuntary outpatient services." § 394.467(6)(c), Fla. Stat.

X. 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 the right to be personally present and 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 the involuntary outpatient services 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 services and are expected to testify in support of the petition must be identified in 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. The testimony must be factual as to events and dates, rather than 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.

XI. Court Order

If the court finds that the person meets all criteria for involuntary outpatient services, it shall issue an order for a period of up to 90 days. 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 DCF, via the BA Reporting Center, within one working day after received from the court accompanied by mandatory form titled "Cover Sheet to Department of Children and Families" (CF-MH 3118) to:

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

The court order and treatment plan must be part of the person's clinical record.

XII. Continued Involuntary Outpatient Services

A. Criteria

If the person continues to meet the criteria for involuntary outpatient services, the service provider must, prior to the end of the court order, file in the **circuit court** a petition for continued involuntary outpatient services. The existing order remains in effect until the continued involuntary outpatient services petition is disposed of.

Criteria for continued involuntary outpatient services are identical to the criteria for the original order, except that the 36-month time period for having (1) been at least twice involuntarily admitted to a receiving/treatment facility or received mental health services in a forensic or correctional facility, or (2) 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 services.

B. Petition

To request continued involuntary outpatient services, the service provider administrator shall, at least ten days prior to the expiration of the period for which the treatment was ordered, file a petition for continued involuntary outpatient services with the court that issued the order for involuntary outpatient services. The court must immediately schedule a hearing on the petition to be held within 15 days after the petition was filed. Recommended form titled "Petition Requesting Authorization for Continued Involuntary Outpatient Placement" (CF-MH 3180) may be used.

The petition must include:

- a statement from the person's physician or clinical psychologist justifying the request;
- a brief description of the person's treatment during the time period in the order; and
- an individualized plan of continued treatment developed by the service provider, in consultation with the person or the guardian advocate, if applicable.

§ 394.4655(8), Fla. Stat.

C. Notice of Petition for Continued Involuntary Outpatient Services

The clerk of court must provide copies of the petition and attachments to the person, DCF, guardian advocate, state attorney, and the person's attorney.

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 that the petition was filed with the with the criminal county court or the circuit court, as applicable, in the county in which the individual is hospitalized and the address of such court..
- Notice that a public defender has been appointed to represent the person, if the person is not otherwise represented.
- The date, time, and place of the hearing, and the name of each examining expert and every other person who is expected to testify in support of continued involuntary outpatient placement.
- Notice that the person, guardian/representative, health care surrogate or proxy, or administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the person's condition.
- Notice that the person is entitled to an independent expert examination, and that if he/she can't afford an examination, the court will provide for one.

§ 394.4599(2)(d), Fla. Stat.

The public defender must be appointed and notified within one court working day, and 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 the interests of the person, regardless of the source of payment to the attorney. The state attorney is appointed to represent the state as the real party in interest, rather than the petitioner.

D. Hearing on Continued Involuntary Outpatient Services

The court may appoint a magistrate to preside over continued involuntary services 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 services 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 the decision is made within 24 hours prior to the hearing, in which case notification must be made immediately. The same procedure must be repeated before expiration of each additional period the person is placed in treatment.

E. Order for Continued Involuntary Outpatient Services

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 services, 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).

XIII. Modification to Court Order for Involuntary Outpatient Services

After an order for involuntary outpatient placement or continued involuntary outpatient services 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 any substitute decision maker agree, or if the person or substitute decision maker objects to the modifications proposed by the service provider or wishes 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 Request for Approval of Material Modifications to Plan" (CF-MH 3160) may be used.

XIV. Change of Service Provider

If the person who is subject to an order for involuntary outpatient services (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.

XV. Noncompliance with Court Order

If a physician has determined that the person who is subject to a court order for involuntary outpatient services or continued involuntary outpatient services has failed or refused to comply with the court-ordered treatment, 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.

Some courts have considered whether contempt powers should be used to compel compliance with the approved treatment plan. Two appellate cases, one related to

the Baker Act and the other to the Marchman Act, might be considered as reasons why contempt should not be used:

- *C.N. v. State*, 433 So. 2d 661 (Fla. 3d DCA 1983). A petition for the involuntary hospitalization of C.N. was filed, and the court found that she met the statutory criteria for involuntary placement, but ordered outpatient treatment as the "least restrictive means of intervention." After C.N. failed to continue the outpatient treatment, she was found in contempt of court and ordered into involuntarily placement. She appealed, and the appellate court reversed, holding that "exercise of the court's contempt power to compel hospitalization and treatment was inappropriate. . . . The evidence presented did not support a finding of contemptuous intent, an element of criminal contempt" because all three physicians who testified at the contempt hearing said C.N. had a personality problem related to her disorder that gave her "difficulty in following directions." It held further that "where a court has ordered outpatient care . . . as an alternative to involuntary hospitalization, that least restrictive intervention can be revoked and the patient deprived of her liberty only in proceedings which substantially meet the requirements of Section 394.467. There is no statutory authority for the court to retain jurisdiction for the purpose of modifying an action taken on an earlier petition. The imposition of a more restrictive intervention, *i.e.*, involuntary placement, requires, at the minimum, a new petition for involuntary hospitalization, a notice of hearing and a hearing on the petition. For a court to order involuntary hospitalization, it is not sufficient that the patient merely failed to follow a plan for outpatient treatment."

- *Steven Cole v. State*, 714 So. 2d 479 (Fla. 2d DCA 1998). The circuit court convicted Cole of indirect criminal contempt for violating its order to complete a substance abuse treatment program and sentenced him to 90 days in jail. He filed petitions for a writ of habeas corpus, a writ of certiorari to quash the conviction and sentence, and a writ of mandamus (treated as a petition for writ of prohibition) to prevent further improper proceedings in his Marchman Act case. The appellate court issued the writs. While it held that "the proceedings were flawed to an astonishing degree," most of the errors were not appealable because of time issues. But the conviction of indirect criminal contempt was erroneous because "Cole was not given meaningful prior notice of the charges against him" and the written judgment "includes findings of fact that contradict the record." Further, he "was tried without notice to the public defender." The Marchman Act proceedings were "void for lack of subject matter and personal jurisdiction."

XVI. Discharge from Involuntary Outpatient Services

A service provider has a duty to (1) discharge a person at any time the order for involuntary outpatient services or continued involuntary outpatient services expires or at any time the person no longer meets the criteria for involuntary outpatient services, or (2) 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 the 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 services or continued involuntary outpatient services, or another person on his or her behalf, believes any one of the criteria for involuntary outpatient services 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.

XVII. Alternatives to Involuntary Outpatient Services Orders

Use of the involuntary outpatient services provisions of the Baker Act have been scarce and inconsistent, partly due to the lack of appropriate community-based treatment programs. One circuit has continued to use the involuntary **inpatient** placement provisions under section 394.467(6)(b), Florida Statutes, which permits the court to order an individual not only to be treated **at** an appropriate receiving facility, but to **receive services from** a receiving facility on an involuntary basis for up to six months:

> If the court concludes that the patient meets the criteria for involuntary inpatient placement, it may 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 facility, **or** that the patient **receive services**, on an involuntary basis, for up to 90 days. . However, any order for involuntary mental health services in a treatment facility may be for

> up to 6 months. The order shall specify the nature and extent of the patient's mental illness. The court may not order an individual with traumatic brain injury or dementia who lacks a co-occurring mental illness to be involuntarily placed in a state treatment facility. 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. (emphasis added)

In addition to the above, section 394.469, Florida Statutes (emphasis added), governing the discharge of involuntary patients, states:

> **(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.

The above provision permits convalescent status in a less restrictive setting while the person is still under an involuntary inpatient placement order. This allows the individual to be returned to the receiving or treatment facility that arranged the convalescent status within the term of the existing court order without requiring a new involuntary examination or involuntary placement order.

XVIII. Involuntary Outpatient Placement Flowchart
(DCF flowchart; 2016 legislative changes are not incorporated.)

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

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"

↓

Person discharged from facility

↓

Psychiatrist determines person meets all criteria for involuntary outpatient placement. Psychologist or second psychiatrist concurs. Both opinions entered on petition, signed by administrator.

↓

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

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State of Florida Department of Children & Families

XIX. Continued Involuntary Outpatient Placement Flowchart
(DCF flowchart; 2016 legislative changes are not incorporated.)

Appendix K

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.

Involuntary Outpatient Placement Baker Act Handbook and User Reference Guide • 2014
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XX. Frequently Asked Questions

We have a person who we think meets the criteria for involuntary outpatient services. He has a long history of noncompliance and is at high risk for a stroke. My question is around the treatment plan. We have two mental health residential treatment beds — a part of the unit. While they are on the locked unit, the persons in the beds have the freedom to come and go and are there voluntarily. Can we use an RTF bed placement as part of the involuntary outpatient services treatment plan?

There should be no reason why a licensed residential treatment bed couldn't be used as part of an involuntary outpatient services treatment plan. It needs to be clear to the individual and staff that the person must be able to enter and exit at will; otherwise the involuntary inpatient placement provisions would apply.

If a person who has a plenary guardian is ordered to involuntary outpatient services, does the court still have to seek the guardian's authority to determine housing and treatment, or does the IOP takes precedence?

There is no legal reason why an IOP court order would need to include housing or treatment, because the circuit court has already authorized the plenary guardian to make such decisions. It may be that the guardian believes that the additional IOP court order will assist in getting the ward to comply, considering that a judge has specifically ordered it rather than just authorizing the guardian to make the decisions.

Can the court order treatment that is not readily available in the community?

No. A court order is based on a proposed treatment plan developed by a service provider with the person. The plan cannot be submitted to the court for consideration unless the provider has certified that:

- sufficient services for improvement and stabilization are currently available in the local community;
- there is space available for the person;
- funding is available for the program or service;
- services are clinically appropriate as determined by a physician, clinical psychologist, clinical social worker, or psychiatric nurse (each as defined in the Baker Act); and

- a service provider agrees to provide the services.

One of our group homes is providing treatment for a person under an involuntary outpatient commitment order. The person has a guardian advocate appointed who approves the course of treatment, including medication (injections). The person is verbally refusing the injections. Can we give the injection or is an emergency treatment order (ETO) required?

Regardless of whether the person is on an involuntary inpatient or involuntary outpatient services order, if found by the court to be incompetent to consent to treatment, he/she is also incompetent to refuse consent to treatment. If the guardian advocate has been provided full disclosure so express and informed consent has been obtained, and the GA has spoken directly to the doctor and the person about the proposed treatment, the GA can provide the consent and no ETO is necessary. An ETO is needed only when no legally authorized consent can be obtained. Logistically this can be a problem in that the person may actually fight against the injection. However, this would happen whether or not it was a result of an ETO. Efforts need to be made to prevent any physical harm to the person or others in the process. Physically holding a person during a procedure to forcibly administer psychotropic medication is a physical restraint.

The involuntary outpatient provisions of the Baker Act refer to notifying the court of material changes to a treatment plan ordered by the court. How is "material" defined?

"Material" is defined in Black's Law Dictionary as "Important; more or less necessary; having influence or effect; going to the merits; having to do with matter, as distinguished from form."

Our CMHC is serving a man under an involuntary outpatient order. He recently switched to a Medicaid HMO that contracts with a private mental health center to provide services. The new provider would like for him to remain under the IOP. Does the Baker Act allow us to submit to the court a service modification for a different (private) provider? Should the new provider submit a new treatment plan, listing it as the provider? Is the modification the only documentation that is necessary if the treatment plan remains the same? Does the new provider submit the modification or should we?

This shouldn't be a difficult matter if the man agrees with the change of provider. If he agrees and the treatment plan remains the same — just a change of provider

— simple notice to the court should suffice. However, before doing that you should get written confirmation from the new service provider that it agrees to be the provider and that the services identified in the court-ordered treatment plan are available and will be provided. The court may require such a statement since this must have been provided by the original service provider and it remains a condition of IOP. While a change of provider agreeable to the client may not be "material," it would always be appropriate to notify the court since this modifies the terms of the court's order.

Section 394.4655(7)(b)2., Florida Statutes, deals with this issue:

> After the order for involuntary services is issued, the service provider and the patient may modify the treatment plan. For any material modification of the treatment plan to which the patient or, if one is appointed, the patient's guardian advocate agrees, 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 applicable, must be approved or disapproved by the court consistent with subsection (3).

If a person on an involuntary outpatient order is re-hospitalized, is that order void?

No. An order for involuntary outpatient services would not be invalidated by an admission for involuntary examination. In fact, section 394.4655(7)(b)3., Florida Statutes, provides:

> 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 facility. **The involuntary outpatient services order shall remain in effect unless the service provider determines that the patient no longer meets the criteria for involuntary outpatient services 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 applicable, does agree, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan that are contested by the patient or a guardian advocate must be approved or disapproved by the court consistent with subsection (3). (emphasis added)

Section 394.4655(7)(b)1., Florida Statutes, provides:

> If the court concludes that the patient meets the criteria for involuntary outpatient services pursuant to subsection (2), the court shall issue an order for involuntary outpatient services. The court order shall be for a period of up to 90 days. The order must specify the nature and extent of the patient's mental illness. The order of the court and the treatment plan must be made part of the patient's clinical record. **The service provider shall discharge a patient from involuntary outpatient services 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. (emphasis added)

How can organizations share information about treatment planning for involuntary outpatient treatment, given protections offered by the state's Baker Act and the federal HIPAA law?

The Baker Act allows such exchange of information pursuant to involuntary outpatient services. Even HIPAA permits release of information for purposes of a person's treatment.

What can be done when a person under an involuntary outpatient services order refuses to comply with court-ordered treatment?

If a physician determines that:

- the person has failed or refused to comply with the treatment ordered by the court,
- efforts were made to solicit compliance, and
- the person may meet the criteria for involuntary examination,

the physician can then complete the appropriate sections of the Certificate of a

Mental Health Professional form (CF-MH 3052b) and have the person brought to a receiving facility. It is important that all appropriate efforts to remind the person of appointments, arrange transportation, provide medications, and other efforts be demonstrated before noncompliance is found.

If it is determined after examination at a receiving facility that the person doesn't meet the criteria for involuntary inpatient placement, he/she must be discharged. 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.

Some courts have considered whether the court's contempt powers should be used to compel compliance with the approved treatment plan. The case of *C.N. v. State*, 433 So. 2d 661 (Fla. 3d DCA 1983) might be considered when determining whether contempt should be used. A petition for the involuntary hospitalization of C.N. was filed, and the court found that she met the statutory criteria for involuntary placement, but ordered outpatient treatment as the "least restrictive means of intervention." After C.N. failed to continue the outpatient treatment, she was found in contempt of court and ordered into involuntarily placement. She appealed, and the appellate court reversed, holding that "exercise of the court's contempt power to compel hospitalization and treatment was inappropriate. . . . The evidence presented did not support a finding of contemptuous intent, an element of criminal contempt" because all three physicians who testified at the contempt hearing said C.N. had a personality problem related to her disorder that gave her "difficulty in following directions." It held further that "where a court has ordered outpatient care . . . as an alternative to involuntary hospitalization, that least restrictive intervention can be revoked and the patient deprived of her liberty only in proceedings which substantially meet the requirements of Section 394.467. There is no statutory authority for the court to retain jurisdiction for the purpose of modifying an action taken on an earlier petition. The imposition of a more restrictive intervention, *i.e.*, involuntary placement, requires, at the minimum, a new petition for involuntary hospitalization, a notice of hearing and a hearing on the petition. For a court to order involuntary hospitalization, it is not sufficient that the patient merely failed to follow a plan for outpatient treatment."

XXI. Selected Model Baker Act Forms for Involuntary Outpatient Services

Please note that these recommended forms were promulgated by DCF before the 2016 statutory amendments and do not incorporate those changes.

A. Petition for Involuntary Outpatient Placement

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 last four (4) digits of the person's social security number are _____ 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.

   ☐ 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:

	Witness	**Witness**	**Witness**
Name:	_____	_____	_____
Relationship	_____	_____	_____
Address	_____	_____	_____
	_____	_____	_____
Telephone:	(_____)_____	(_____)_____	(_____)_____

CONTINUED OVER

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.

_____ _____ _____ am pm
Signature of Facility Administrator or Designee Date Time

_____
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
☐ Person		am pm	
☐ Guardian		am pm	
☐ Public Defender		am pm	
☐ Representative		am pm	
☐ State Attorney		am pm	
☐ 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: _____
[2]. The person has a mental illness, as substantiated by the following evidence _____
_____
_____

[3]. 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: _____
_____

_____ _____ _____ am pm
Signature of Psychiatrist Date Time

_____ _____
Typed or Printed Name of Psychiatrist License Number

CONTINUED OVER

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: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____ am pm
Signature of Examiner Date Time

_____ _____ _____
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)[d]3, 394.467, Florida Statutes **BAKER ACT**
CF-MH 3130, Nov 11 (Recommended Form)

B. Designation of Service Provider for Involuntary Outpatient Placement

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)

C. Proposed Individualized Treatment Plan for Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement

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:

CONTINUED OVER

Proposed Individualized Treatment Plan for Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement (page 2)

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 3)

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**

D. Order for Involuntary Outpatient Placement or Continued Involuntary Outpatient Placement

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT, IN AND FOR _____ COUNTY, FLORIDA

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 Statu[t]es
CF-MH 3155, Feb 05 (Recommended Form) **BAKER ACT**

E. Notice to Court of Modification to Treatment Plan for Involuntary Outpatient Placement and/or Petition Requesting Approval of Material Modifications to Plan

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA

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

Pursuant to 394.4655(6)(b)3, Florida Statutes,

See s. 394.467(6)(c), Florida Statutes
CF-MH 3160, Feb 05 (Recommended Form) **BAKER ACT**

F. Petition for Termination of Involuntary Outpatient Placement Order

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA
IN RE: _____ CASE NO.: _____

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.

_____ _____ _____ am pm
Signature of Petitioner Date Time

☐ Person ☐ Guardian ☐ Guardian Advocate ☐ Service Provider ☐ Attorney for Person

_____ _____
Printed or Typed Name of Petitioner Address of Petitioner

See s. 394.467(6)(c), Florida Statutes
CF-MH 3170, Feb 05 (Recommended Form) **BAKER ACT**

G. Petition Requesting Authorization for Continued Outpatient Placement

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.

_____ _____ _____ am pm

Signature of Administrator or Designee Date Time

_____

Printed or Typed Name of Administrator or Designee

CONTINUED OVER

Petition Requesting Authorization for Continued Involuntary Placement (Page 2)

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.

_____ _____ _____ am pm
Signature of ☐ Physician ☐ Clinical Psychologist Date Time

_____ _____
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
☐ Person		am pm	
☐ Guardian		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	
☐ Public Defender or ☐ Private Attorney		am pm	

See s. 394.467(7), Florida Statutes
CF-MH 3035, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

H. Notice to Court of Waiver of Continued Involuntary Outpatient Services Hearing and Request for an Order

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**

Chapter Seven: Rights of Persons with Mental Illnesses

I. In General

The Baker Act ensures many rights to persons who have mental illnesses. *See* § 394.459, Fla. Stat.; Fla. Admin. Code R. 65E-5.140. Some of these rights are as follows:

- **Individual dignity**: All constitutional rights are ensured, and persons must be treated in a humane way while being transported or treated for mental illness.

- **Treatment**: The Baker Act 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 that the least restrictive appropriate available treatment be used based on the individual needs of each person.

- **Express and informed consent**: People are encouraged to voluntarily apply for mental health services when they are competent to do so, choose their own treatment, and 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**: The Baker Act 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 are required.

- **Communication, abuse reporting, and visits**: Persons in mental health facilities have 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**: Persons may keep their own clothing

and personal effects, unless they are removed for safety or medical reasons. If they are removed, a witnessed inventory is required.

- **Voting in public elections**: Persons are guaranteed the right to register and vote in any elections for which they are qualified voters.

- **Habeas corpus**: Persons are guaranteed 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**: The Baker Act guarantees the opportunity to participate in treatment and discharge planning and to seek treatment from the professional or agency of the person's choice upon discharge.

- **Sexual misconduct prohibited**: Any staff member 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**: There is a right to a representative selected by the person (or by the facility when the person can't/won't make the selection) 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 a 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, access or release the person's clinical record without the person's consent, or request the transfer of the person to another facility.

- **Confidentiality**: All information about a person in a mental health facility is maintained as confidential and released only 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 in 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.

II. Frequently Asked Questions

A. In General

The Baker Act uses terms such as "shall," "may," "may not," etc. What are the legal differences of these terms?

This staff in the Florida Legislature Bill Drafting Office state as follows (*see* pp. 17–18 of the Florida Senate Manual for Drafting Legislation (6th ed. 2009)):

- "Shall" requires.
- "May" grants permission.
- "May not" prohibits — it is not in any way permissive as some believe.

If a federal and a state statute are in conflict, which one takes precedence?

When a federal law and a state law are in conflict, the federal law generally takes precedence. Where both laws deal with a subject and are not in conflict, both laws must be followed. The law most protective of the individual's rights will generally prevail. Generally, if two state laws governing the same issue are in conflict, the more specific law takes precedence over the more general law.

Should all patients receive a copy of their rights, even if they are involuntary and incompetent to consent? Should we amend the recommended form to reflect the patients' responsibilities while they are at our hospital to include that their financial obligations should be fulfilled as promptly as possible, that they may be civilly or criminally liable if they deliberately hurt another patient/employee or destroy or steal property, etc.?

The Baker Act requires that all persons, regardless of age, stage of development, legal status, or competency, be provided with a written copy and verbal explanation of their rights, along with copies to their designated representative and substitute decision maker. This must be documented in the chart. The CF-MH 3103 form generally used for this purpose could be amended if you wish, but it might be better if the responsibilities of the patients are listed on a separate form.

I work at a receiving facility for persons who are age 55 and over. Most of the patients have guardian advocates because they suffer from different stages of dementia. When involuntary patients are served with court-related paper work, they become extremely agitated, causing unnecessary stress. Do these patients need to see/receive this paper work? Most of these patients don't understand and/or misinterpret what they are looking at.

The law requires that the person who is subject of an involuntary placement petition be provided notice of the filing of the petition, along with his or her guardian, guardian advocate, attorney, and representative. While sensitivity by staff to the feelings of persons served is commendable, deprivation of liberty entailed in a Baker Act proceeding is sufficient to require due process — part of this is being advised of such proceedings. No exception is made when a person lacks capacity. If the notice isn't given as required by law, it could result in any order for placement being denied by the court or reversed by an appellate court.

Does a patient have the right to request a transfer from one receiving facility to another?

Yes. A patient or the guardian, guardian advocate, or health care surrogate/proxy can request a transfer between public and private receiving facilities and between private receiving facilities. The facility to which the person would be transferred must approve the transfer in advance. In the case of a transfer from a private to a public receiving facility, the cost of the transfer is the responsibility of the transferring facility. A public facility must respond within two working days after the receipt of the transfer request, except from a hospital that has treated a person's emergency medical condition, in which case the patient must be transferred within 12 hours. In any transfer situation, the federal EMTALA law prevails where a conflict with state law exists.

Does a person or someone on his or her behalf have the right to request a change of physicians?

The relationship between doctor and patient could be considered a contract, and if one of the two parties wishes to terminate or change the conditions of the contract he or she may do so. If a person wants to terminate the relationship with his or her psychiatrist and retain another psychiatrist instead, this should be allowed unless there is some very unusual reason for disapproving it, such as daily requests for change of physician, drug seeking behavior, etc., in which case it should be referred to the hospital's medical review process.

If a person has an emergency medical condition and cannot or will not provide informed consent to examination and treatment, can the person be Baker Acted in order to authorize these procedures?

No. The Baker Act is Florida's Mental Health Act and it can't be used to authorize medical intervention, with the exception of the physical examination of each person within 24 hours of arrival at a receiving facility. Other statutes must be

used, including chapter 395 (hospitals), 401 (EMS), 765 (advance directives), 744 (guardianship), or 415 (adult protective services), or rule 5.900, Florida Probate Rules, governing expedited medical treatment.

If it is posted as part of our protocol, can we lock patients out of their rooms during group times when they refuse to attend group?

Neither the Baker Act law nor the administrative rules prohibit locking patients out of their rooms. You would need to check your national accrediting standards as well as the federal Conditions of Participation (developed by Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS)) to ensure that they don't prohibit the practice. If this practice is used, it might be limited to when treatment activities are conducted. Each facility — public and private — is required to post the times of daily activities as described in rule 65E-5.1601, Florida Administrative Code (General Management of the Treatment Environment). Locking people out of their rooms when therapeutic activities aren't scheduled, for the convenience of staff, would not be appropriate.

A police officer initiated a Baker Act proceeding for a person after a suicide attempt and took him to an ER. The person was discharged the following day after the psychiatrist certified that he did not meet Baker Act criteria. The person is very upset with the police because she received an itemized bill from the ER for $4,429.23.

The Baker Act doesn't speak to the issue of who pays for care initiated under the Act. The Legislature appropriates a very limited amount of funding to support public receiving facilities, which are required to charge fees on a sliding scale based on ability to pay. Care at private receiving facilities or other hospitals are the responsibility of the person or the person's insurer, if any. The law requires law enforcement officers to take any person they have reason to believe meets the criteria of the Act to the appropriate or nearest receiving facility, unless they believe the person to have an emergency medical condition, in which case the person is to be taken to the nearest ER regardless of whether it is designated as a receiving facility. Officers aren't expected to be diagnosticians. The situation you describe sounds as though it was handled appropriately by all concerned — the law enforcement officer and the receiving facility.

The Florida Attorney General has addressed the issue of payment in several opinions, including:

- Op. Att'y Gen. Fla. 07-11 (2007), regarding hospital authorities and

undocumented immigrants: "The intent of the West Volusia Hospital Authority's enabling legislation appears to be to provide medical services to those indigents who are living within the district. . . . [T]he term 'residents of the district' . . . was intended by the Legislature as a pure residence requirement, and not as a requirement for domicile, legal residence, or citizenship. Thus, the enabling legislation for the authority would appear to permit the authority to provide services to otherwise qualified indigent illegal aliens living within the district. Inasmuch as Chapter 04-421, Laws of Florida, does not distinguish between the types of indigent residents, it appears that the hospital authority should provide healthcare access to these aliens on the same basis as other indigent residents." The opinion quoted *Warren v. Warren*, 75 So. 35, 42 (Fla. 1917): "Any place of abode or dwelling place constitutes a 'residence,' however temporary it may be, while the term 'domicile' relates rather to the legal residence of a person, or his home in contemplation of law. As a result one may be a resident of one jurisdiction although having a domicile in another."

- Op. Att'y Gen. Fla. 93-49 (1993), regarding who is responsible for the payment of an involuntary Baker Act placement: The opinion advised the Lafayette County Board of County Commissioners that "[t]he county is not the primary source for reimbursement of hospital costs for the treatment of an involuntary Baker Act commitment. However, a county may be liable for such payments in the event a person in the county is arrested for a felony involving violence against another person, is taken to a receiving facility and specified sources for reimbursement are not available." The patient is responsible for the payment of any hospital bill for involuntary placement under the Baker Act, but if the patient is indigent the state (formerly the Department of Health and Rehabilitative Services) "is obligated to provide treatment at a receiving or treatment facility [and] provides treatment for indigent Baker Act commitments without any cost to the county."

- Op. Att'y Gen. Fla. 74-271 (1974), regarding involuntary hospitalization in a psychiatric facility: "A circuit court judge may order a patient involuntarily hospitalized at a private psychiatric facility not under contract with the State . . . provided the patient meets the statutory criteria for involuntary hospitalization, the facility has been designated by [DCF], and the cost of treatment is to be borne by the patient, if he is competent, or by his guardian if the patient is incompetent. When state funds are to be expended for involuntary hospitalization of a patient in a private psychiatric facility, such facility must be under a contract with the state."

Do mental health professionals have any specified rights under the Baker Act?

Section 394.460, Florida Statutes, "Rights of Professionals," states: "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." Just because a professional employed at or under contract with or with privileges at a hospital or other receiving facility refuses to provide a service doesn't mean the facility doesn't remain responsible for carrying out its duties. It must find another professional to perform the duty.

B. Habeas Corpus

Does a voluntary patient need to be advised of the right to habeas corpus?

Yes. The Baker Act requires that all persons "held" in a facility be advised of their right to file a petition for habeas corpus. No distinction is made regarding the patient's age, legal status, or competency. Since patients are entitled to file a petition for being unjustly denied a right or privilege granted under the law, this may apply to persons on voluntary as well as involuntary status.

Who has standing to file a petition for a writ of habeas corpus?

The Baker Act limits the individuals who have standing to file a petition for a writ to the patient regardless of age or legal status, a relative, friend, guardian, guardian advocate, representative, or attorney, or DCF. As a receiving facility, you must be sure that each person admitted to one of your facilities (and representative) has been informed of the right to file a habeas petition and, if requested, provide a copy of the petition form and offer assistance. Any petition received must be filed by the facility with the clerk of court within one working day after receipt.

Can a petition for writ of habeas corpus be used to file a grievance about staff treatment or conditions at a facility if you are a voluntary patient? I directed the patient to our facility grievance procedures as a voluntary patient. For practical purposes, the petition will not be heard by a judge for matters more appropriately handled by the internal grievance procedure — the judge's time is more valuable than that.

Every person who enters a receiving facility or who is held in any hospital while under voluntary and involuntary status must be informed of the right to file a petition for a writ of habeas corpus. While habeas usually refers to detention, the right to petition for redress of grievances is covered in the same section of the law. In any case, the Baker Act ensures that all constitutional rights of each person at a

receiving or treatment facility or held in a hospital under the Baker Act be protected.

Any person held in a receiving or treatment facility may file a petition for a writ of habeas corpus at any time. This petition may be used to question the legality of the detention and/or allege that a right or privilege has been denied or a procedure of the Baker Act has been abused. A person held voluntarily has the same right to file a petition for a writ of habeas corpus as a person held involuntarily. The law makes no distinction between persons held voluntarily and involuntarily in this regard. Facility staff should not be in the position of deciding, based on legal criteria or otherwise, whether a petition for a writ of habeas corpus is valid or appropriate. The petition is an opportunity for individuals to seek redress directly from the court; it is up to the court to decide the merits of the petition. While it may be true that these petitions are often unlikely to have practical consequences, it is not for facility staff to make that determination; that would be the fox guarding the henhouse.

None of this is to disparage internal complaint procedures, which certainly have value and are required to be made available to individuals in receiving facilities (see Fla. Admin. Code R. 65E-5.180(6)).

What is the facility's responsibility when a patient wants to file a petition for a writ of habeas corpus for what appears to be a frivolous matter?

The facility has no discretion to determine what is serious and what is frivolous. In any case, the staff should give the petition form (CF-MH 3090 recommended) to the person and offer assistance in completing the form. No matter what form is chosen by the patient to file a petition or whether the patient accepts the assistance of staff, the petition must be filed with the clerk of court within one working day.

We have an incompetent patient who drafts written complaints about her treatment in the facility. We interpret her documents as writ petitions and file with the circuit court. Upon direction from the judge we drafted responses to the petition for redress of grievances, which we believe will satisfy the judge. The patient continues to write similar complaints and she is addressing her complaints "Dear Judge." These complaints consist of her being held hostage and being given medications that cause severe side effects. Should we continue to interpret her handwritten documents as writ petitions and continue to file with the court? Or should we contact the guardian advocate (her mother) and ask what she would like us to do with the document?

You were correct in interpreting the woman's complaints as a writ petition and filing them with the court. Such a complaint doesn't have to be on the recommended state form. You should forward current and future complaints to the court if she is addressing them as "Dear Judge." The Baker Act doesn't limit the filing of such petitions to persons with capacity — it clearly says "person," which could be of any age, legal status, or competence status. It further specifically includes persons who have been adjudicated incapacitated with a guardian or incompetent to consent with a guardian advocate. § 394.459, Fla. Stat.

If at any time, the patient wants access to the Abuse Registry or other advocacy/ regulatory agencies, such access should also be facilitated. It is unlikely she'll be satisfied with a grievance procedure within the hospital, but section 394.459, Florida Statutes, sets forth the following requirement:

> **(4) Quality of treatment.--**
>
> (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:
>
> * * *
>
> 3. A system for investigating, tracking, managing, and responding to complaints by persons receiving services or individuals acting on their behalf.

How is the court expected to respond to a petition for a writ of habeas corpus?

The Florida Supreme Court Commission on Fairness strongly urged all courts to treat petitions for a writ of habeas corpus as emergency matters and expeditiously resolve these issues and ensure that the petitioner receives notice of the disposition. However, judicial response is solely subject to the courts.

C. Clinical Records and Confidentiality

How is a clinical record defined? What is considered a part of the clinical record?

Section 394.459, Florida Statutes, defines "clinical record" to mean "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 and treatment."

Does a person have a right to see his or her own clinical record?

Yes. The Baker Act requires that persons have reasonable access to their clinical records, unless such access is determined by the person's physician to be harmful to the person. Facilities and mental health professionals should make every possible effort to ensure persons have this access. Facilities should have policies and procedures addressing what is "reasonable access," what is "harmful," who makes the decision to permit access, who is authorized to restrict access, how the record will be reviewed to determine if harmful material is included, how the record's integrity will be protected, and whether a copy of the record will be provided to the person, if requested.

A patient's sister is his court-appointed guardian, and she has asked the hospital for his records. The hospital's risk manager says we don't have to provide those records until after discharge, per section 395.3025(1), Florida Statutes. However, section 395.3025(2) clearly states that subsection (1) does not apply to records maintained at any facility governed by the provisions of section 394.4615. Is the hospital correct?

The hospital is not correct. All hospitals are required to uphold the rights of persons held under the Baker Act, regardless of whether the hospital is designated as a receiving facility. With regard to access to records, section 395.3025 provides (emphasis added):

> (1) Any licensed facility shall, upon written request, and **only after discharge of the patient**, furnish . . . a true and correct copy of all patient records. . . .
>
> (2) This section does not apply to records maintained at any licensed facility the primary function of which is to **provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by the provisions of s. 394.4615**.
>
> (3) This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.

Section 394.4615 (clinical records; confidentiality) provides:

> (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.

If the guardianship is plenary rather than limited, the guardian has all rights the person would have if capacitated. HIPAA yields to state law regarding substitute decision makers who are standing in the shoes of the patient.

Our facility will be going live with electronic medical records. Is it okay to have bar codes with the hospital logo on the mandatory Baker Act forms so they can be scanned into the electronic record after a person's discharge? We can download directly into the chart an electronically signed BA 52b and it can be signed via an ePad. Can we copy this form and give this to a law enforcement officer? Technically there is no "hard copy" with an "original" signature, since it is all done electronically.

Yes. Generally, the mandatory forms cannot be altered. In this situation the mandatory form is not being altered; only a logo and bar code are added for purposes of electronic recordkeeping or preprinting the name and address of the receiving facility to the form. However, retyping the form or changing the format in any significant way is not acceptable.

The Baker Act makes no reference to "originals," and all references to "originals" have been removed from the rule and the forms. DCF has actively encouraged the use of electronic medical records, and the technology has progressed faster than the law or rules. As long as the mental health professional's initiation form (BA-52b) replicates the form adopted in rule, there shouldn't be any problem with lack of a hard copy with an "original" signature. If the law enforcement officer hesitates, there should be no reason why the initiating professional couldn't initial next to the electronic signature on the copied completed form.

We are now on electronic records, including treatment plans. Since we need to have the patient review, make comments on, and sign the treatment plan, how would we do this in a paperless system? We thought we could review the plan via the computer, type patients' comments for them on the plan, and then state that the patient signed it by using two patient identifiers as we use in any electronic signature for patients. Would this meet the standard for the Baker Act relating to the patient acknowledging the treatment plan?

DCF has consistently supported hospital efforts to develop electronic medical records. The law never makes reference to originals of documents, and all references to originals in the rule and forms have been removed. However, the law states that the person must have had an opportunity to assist in preparing and reviewing the treatment plan prior to its implementation and there must be space for the person's comments. What you propose would meet the statutory requirements. It would be best to include the person's own words to reflect that he/she actually understood the contents of the plan and agreed to it.

A psychiatrist who was ordered to perform an independent expert examination pursuant to an involuntary placement hearing is requesting a copy of the inpatient record to take with him for his review. Is there any provision that would allow this, outside of patient consent or court order?

Since the independent expert is appointed by the court and would be a witness for the individual's defense, access to the record is implied. Review of existing clinical records is a normal part of a psychiatric examination. If you are asking whether the psychiatrist can remove a copy of the record from the premises of the receiving facility rather than access the record itself, the above provisions don't address this issue. However, copies of charts (or information from the charts) are frequently sent to other entities outside the organization creating the record with the consent of the person or an order of the court. The psychiatrist's request would be handled the same way.

When can a court order the release of clinical records from a Baker Act receiving facility, and is the law the same regarding orders for the release of records from an outpatient therapist?

Summaries of several appellate cases are included below that clearly distinguish between the authority of the court to order release of Baker Act records **after a good cause hearing** and the lack of authority to order release of other psychiatric records in an outpatient context. This is further supported by appellate courts:

- *Katlein v. State*, 731 So. 2d 87 (Fla. 4th DCA 1999). As the Florida Supreme Court stated in *State v. Roberson*, 884 So. 2d 976, 978 (Fla. 2004), the court in *Katlein*

> set out a mechanism for determining when it is appropriate for a court to order the release of [Baker Act] records, which we find to be fair and reasonable. The party seeking the records must first make a threshold showing that the privileged records are

> likely to contain relevant evidence. "The defendant must advance a good faith factual basis which is not 'merely a desperate grasping at a straw.' . . . In other words, no fishing expeditions." *Katlein*, 731 So.2d at 90. If a showing is made that the records are likely to contain relevant evidence, the court will do an *in camera* inspection. If the court concludes after inspecting the records that they contain relevant information, it should then allow the parties access to them in order to determine whether disclosure of the information to the trier of fact is required to ensure a fair trial. The burden is on the party seeking disclosure to demonstrate that disclosure is required.

However, privilege has also been addressed as follows:

- *Jaffee v. Redmond*, 518 U.S. 1, 116 S.Ct. 1923, 135 L.Ed.2d 337 (1996). This case involved a fatal shooting by a police officer. The administrator of the decedent's estate sought records of the officer's post-shooting sessions with her therapist, but the U.S. Supreme Court held a psychotherapist privilege existed under the federal rules of evidence. The Court stated:

  > Like the spousal and attorney-client privileges, the psychotherapist-patient privilege is "rooted in the imperative need for confidence and trust." . . . Effective psychotherapy depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communication made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede disclosure of the confidential relationship necessary for successful treatment."

  The Court stated that protecting the confidentiality of communications between a patient and psychotherapist serves private and public interests. The patient is able to talk more freely to the therapist, and society benefits because "appropriate treatment for individuals suffering the effects of a mental or emotional problem" is facilitated. The Court also extended the privilege to licensed social workers providing psychotherapy. "Their clients often include the poor and those of modest means who could not afford the assistance of a psychiatrist or psychologist, . . . but whose counseling

sessions serve the same public goals."

While rejecting the balancing component of the privilege implemented by some jurisdictions, where the trial judge may in camera weigh the patient's privacy interests and the other party's "evidentiary need for disclosure," the Court in a footnote stated that it did "not doubt that there are situations in which the privilege must give way, for example, if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist."

- *State v. Famiglietti*, 817 So. 2d 901 (Fla. 3d DCA 2002). The court held that a defendant in a criminal case could not "invade the victim's privileged communications with her psychotherapist [even] if the defendant can establish a reasonable probability that the privileged matters contain material information necessary to his defense." The only exceptions are for communications that are (1) relevant in proceedings to compel hospitalization of a patient for mental illness, (2) made during a court-ordered examination of a patient's mental or emotional condition, or (3) relevant to the patient's mental or emotional condition in a proceeding where the patient is relying on the condition as an element of his/her own claim or defense "or, after the patient's death, in any proceeding in which any party relies upon the condition as an element of the party's claim or defense." § 90.503(4), Fla. Stat.

  The court noted that in *State v. Pinder*, 678 So. 2d 410, 417 (Fla. 4th DCA 1996), the court found a due process balancing test existed ("To obtain in camera review of confidential communications or records under section 90.5035, a defendant must first establish a reasonable probability that the privileged matters contain material information necessary to his defense. Only then may a trial court conduct an in camera hearing to determine if, in fact, the privileged communications contain such information"). But the court disagreed and certified conflict with *Pinder*.

Can information from a psychiatric clinical record for a person in a Baker Act facility be released in response to a subpoena?

No. A court order is required. In determining whether there is good cause for disclosure, the court must weigh the need for the information to be disclosed against the possible harm of disclosure to the person to whom the information pertains.

Can a guardian advocate review the contents of the clinical record?

Yes. The Baker Act requires that the guardian advocate be given access to the appropriate clinical records of the patient and may also 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.

Is there a requirement for facilities to give notice when a foreign national is held involuntarily under the Baker Act?

Yes. These are individuals who are citizens of another country, even if they have dual citizenship with the United States. The Vienna Convention on Consular Relations is clear in the treaty itself that the consulate must be notified anytime a foreign national is detained by law enforcement.

The following FAQs from the United States Department of State Consular Notification and Access website may be helpful:

Q. If we have a foreign national detained in a hospital, do we have to provide consular notification?

A. Yes, if the foreign national is detained pursuant to governmental authority (law enforcement, judicial, or administrative) and is not free to leave. He/she must be treated like a foreign national in detention, and appropriate notification must be provided.

Q. When we notify the consulate, should we tell them the reasons for the detention?

A. Generally you may use your discretion in deciding how much information to provide consistent with privacy considerations and the applicable international agreements. Under the VCCR, the reasons for the detention do not have to be provided in the initial communication. The detainee may or may not want this information communicated. Thus we suggest that it not be provided unless requested specifically by the consular officer, or if the detainee authorizes the disclosure. Different requirements may apply if there is a relevant bilateral agreement. (Some of the bilateral agreements require that the reasons for the detention be provided upon request.) If a consular official insists that he/she is entitled to information about an alien that the alien does not want disclosed, the Department of State can provide guidance.

The State Department's website on Consular Notification and Access provides excellent information on this requirement, based on the Vienna Convention. You can get any information from the State Department website at: http://travel.state.gov/content/travel/english/consularnotification.html

The U.S. State Department website is www.state.gov. The department's Consular Notification and Access Manual (4th ed. 2014) has extensive information about consular notification and access for foreign nationals, including FAQs, contact information for foreign embassies and consulates in the U.S., and instructions for federal, state, and local law enforcement and other officials concerning the rights of foreign nationals in the United States.

If an individual is deemed incompetent, can a facility notify the "emergency contact" when it is obvious the patient cannot notify anyone because of the patient's current mental status? We are only wishing to notify someone of the client's whereabouts and safety or verify admission if the family is calling to find the patient. Sometimes individuals are transferred not once but twice to get to us, which causes confusion for the family.

The current statute requires that you notify the person's representative. The law doesn't require express and informed consent for the notification of the representative to be made.

How does the HIPAA privacy rule change the laws concerning consent for treatment?

The privacy rule relates to uses and disclosures of protected health information, not to whether a person consents to the health care itself. As such, the privacy rule does not affect informed consent for treatment, which is addressed by state law.

Does the HIPAA privacy rule change how a person can grant another person health care power of attorney?

No. Nothing in the privacy rule changes the way in which an individual grants another person power of attorney for health care decisions. State (or other) law regarding health care powers of attorney continues to apply. The intent of the provisions regarding personal representatives was to complement, not interfere with or change, current practice regarding health care powers of attorney or the designation of other personal representatives. Such designations are formal, legal actions which give others the ability to exercise the rights of, or make treatment decisions related to, an individual. The privacy rule provisions regarding personal representatives generally grant persons who have authority to make health care

decisions for an individual under other law the ability to exercise the rights of that individual with respect to health information.

D. Duty to Warn

If a patient in a Baker Act receiving facility discloses information that poses a possible risk of harm to a potential victim, is there a duty to warn the intended victim?

The Baker Act permits such disclosure but does not create a duty to warn. HIPAA and professional codes of ethics also permit such disclosure. Even though no duty to warn exists in Florida, a legitimate threat should always be taken seriously and warning provided to the intended victim, assuming this is also the position of the facility's attorney, risk manager, or compliance officer. See section 394.4615(3)(a), Florida Statutes, which provides: "Information from the clinical record may be released . . . [w]hen 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."

Federal and state appellate courts have further addressed this issue. Many people believe that *Tarasoff v. Regents of University of California*, 551 P.2d 334 (Cal. 1976) (therapist who determines, or should determine, patient presents serious danger of violence to another has duty to exercise reasonable care to protect intended victim), applies to Florida. However, since Florida law makes such disclosure permissive rather than mandatory, appellate courts to date have found no liability for failure to disclose such a threat; see, e.g.:

- *Boynton v. Burglass*, 590 So. 2d 446 (Fla. 3d DCA 1991). The Third District Court of Appeal rejected the approach taken in *Tarasoff* and found no duty to warn.

- *Green v. Ross*, 691 So. 2d 542 (Fla. 2d DCA 1997). The Second District Court of Appeal agreed with *Boynton* and concluded that "the *permissive* language waiving confidentiality in sections 455.2415 [now section 456.059 and 491.0147 does not equate to the legislative creation of a cause of action not previously recognized in Florida."

However, the First District Court of Appeal did establish a "duty to inform" the guardians of a minor of such threats. *O'Keefe v. Orea*, 731 So. 2d 680 (Fla. 1st DCA 1998), was a medical malpractice action by the mother of a 17-year old

patient. Three days after the patient's discharge, his mother told the psychiatrist that her son was out of control and she and the boy's father, who were also patients of the psychiatrist, could no longer care for him at home. Allegedly, the psychiatrist's response was to order a different medication. The next day the patient attacked his parents, injuring his mother and killing his father. The court stated that the psychiatrist's

> duty to warn the O'Keefes concerning their son's condition derives from the fiduciary relationship between [him] and the parents of his minor patient, as well as the physician-patient relationship between [him] and Mr. and Mrs. O'Keefe. In view of these fiduciary relationships, [the psychiatrist] had a duty to inform [the patient's] parents concerning their child's diagnosis, including the diagnosis of other physicians who had observed [him], together with his personal treatment recommendations and the treatment recommendations of other physicians. In addition, [the psychiatrist] had a duty to disclose the information available in the nurse's notes concerning [the patient's] hallucinations, violence, threats to staff, suicidal tendencies, and the fact that at various times two male guards were required to control him.

The federal circuit court in *U.S. v. Chase*, 340 F.3d 978 (9th Cir. 2003) held that psychiatrists can't testify against patients who make dangerous or threatening confessions during therapy. It held that although psychiatrists are sometimes required to report incidents to authorities that could lead to violence, prosecutors couldn't use testimony from doctors to help convict their patients. The court concluded that "the gain from refusing to recognize a dangerous-patient exception to the psychotherapist-patient testimonial privilege in federal criminal trials outweighs the gain from recognizing the exception." *Id.* at 991–992. It stated that "although incarceration is one way to eliminate a threat of imminent harm, in many cases treatment is a longer-lasting and more effective solution. A criminal conviction with the help of a psychotherapist's testimony is almost sure to spell the end of any patient's willingness to undergo further treatment for mental health problems." *Id.* at 991. The court did note that its ruling doesn't extend to proceedings in civil court to determine whether the patient should be committed to a hospital.

E. Americans with Disabilities Act (ADA)

How does the federal ADA apply to people held in Baker Act facilities?

Reports of facilities failing to provide qualified interpreters for persons with hearing problems and of people being refused by receiving facilities for being obese (no staff or equipment for lifting/transferring), for using a cane, crutches, or walkers (without an offer of a wheelchair as an accommodation), for having a service animal, for being incontinent, etc. have arisen recently — all these may be ADA violations. The Baker Act has the following provision in section 394.459, Florida Statutes (emphasis added):

> **(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. . . .

All hospitals and receiving facilities should establish criteria that include, rather than exclude, people needing the services. This may mean making accommodations as necessary.

F. Right to Dignity and Privacy

Can we have Baker Act patients in our ER, mixed with non-Baker Act patients?

There is nothing in the Baker Act that would prevent you from co-locating persons under the Baker Act with other patients in your hospital, just as there is nothing to prevent persons on voluntary vs. involuntary status from being co-located.

Can facility staff, while doing safety checks, routinely go through a patient's belongings, bedside cabinets, and closets to look for contraband, or does this violate the patient's right to privacy and dignity? I understand we need to search belongings upon admission or with a doctor's order if there is clear evidence a patient has contraband.

With regard to searches, there are several references in the law and rules, as follows:

- Rules 65E-5.180(9)(a) and (10)(h)1., Florida Administrative Code, require that persons be searched before they are placed into seclusion or restraint. However, the law and rule don't specifically address searches of persons

upon arrival at the facility or otherwise, except as designated below. Practice throughout the state generally includes a complete search of the person and the person's belongings upon arrival at the facility.

- Section 394.459(6), Florida Statutes, and rule 5E-5.200, Florida Administrative Code, govern the right of persons to the care and custody of personal effects. This guarantees persons the right to the possession of their clothing and personal effects, but allows the facility to take temporary custody of such effects when required for medical and safety reasons. The rule and law require that an inventory be conducted/witnessed. This certainly would entail a search of the person and his/her belongings to determine whether there are items to be removed for safety reasons.

- Section 394.459(5)(b), Florida Statutes, governing communication, requires that persons be able to receive sealed, unopened correspondence and that such correspondence can't be "opened, delayed, held, or censored by the facility unless there is reason to believe it contains items or substances which may be harmful to the person or others, in which case the administrator may direct reasonable examination of such mail and may regulate the disposition of such items or substances." In these circumstances, staff typically has the person open any packages in the presence of staff.

Many facilities prohibit visitors from bringing handbags and other items onto a psychiatric unit. Some even "wand" every patient and visitor upon arrival at the unit. The federal Conditions of Participation or the Joint Commission accreditation standards may require additional standards in terms of searches.

G. Communication Restrictions

Can a facility enforce visiting hours for family members without any clinical justification? Does the Baker Act permit a facility to restrict family members from visiting an individual outside of normal visiting hours, without providing specific clinical justification for the particular case? Recently, a question has arisen regarding the Baker Act's requirements regarding visitation and visiting hours.

Section 394.459(5)(c)–(5)(d), Florida Statutes, governs the access that the facility must provide. Language is fairly directive that denial of visitation to specified parties can be done only when "access would be detrimental to the patient."

While the law requires visitation rules, such rules can't be contrary to the express language of the statute. Limitation on visitation by the above parties can be imposed only when access is documented as detrimental, and it must be communicated to the patient, attorney, guardian, guardian advocate, and representative. However, the right to visits by friends or others is not specified in the law as it is as to those specified above and can be restricted to visiting hours established by the facility. Other types of restrictions of communication (phone or mail) to any person (other than abuse reporting and communication with his/her attorney) can be governed by facility policies as well and would require notice of such restriction and that the reasons for the restriction be served on the patient and the patient's guardian, guardian advocate, health care surrogate or proxy, attorney, and representative.

Is a Baker Act patient entitled to visitors during the time he/she is in the ED? We have several issues with nursing staff allowing inappropriate people in the room. Do we also have to make phones available?

Rights of persons held under the Baker Act who are held in hospital EDs are addressed in the Florida hospital licensing law (chapter 395, Florida Statutes), under which the rights of any person held under the Baker Act on voluntary or involuntary placement in any licensed hospital must be protected, regardless of whether the hospital has been designated as a receiving facility or whether the individual is held in the psychiatric unit or in a different unit because of the individual's clinical needs or space availability of the hospital. There are multiple provisions of the licensure law in the Florida Statutes that apply to persons held under the Baker Act (see sections 395.003(5)(a), 394.003(5)(b), 395.1041(6), 395.1055(5), 395.1065(4), and 395.3025, Florida Statutes).

The rights guaranteed to any person held under the Baker Act are enumerated in section 394.459(5), Florida Statutes, one of which is the right to communication and visits. Families must be allowed immediate access to any patient unless such access would be detrimental to the patient. Your hospital can't have a policy prohibiting family contact with your ED patients held under the Baker Act, but it can limit such contact on a case-by-case basis with sufficient justification documented in the chart of how the visit by family would be detrimental. There is no right to have persons visit other than those specified in the law.

Can a parent restrict the communication of his or her child in a receiving facility?

No. Only the physician or authorized facility staff is permitted to restrict a person's

communication, regardless of the age of the patient. Staff should be aware of the parents' reason for requesting no communication, as the physician may concur and issue such an order.

Does a court-appointed guardian have the power to restrict a person's visitation rights when in a Baker Act receiving facility?

No. Section 394.459, Florida Statutes, governs rights of persons in receiving facilities and all hospitals in the state of Florida. Further, the statute is clearly supported by *Handley v. Dennis*, 642 So. 2d 115 (Fla. 1st DCA 1994), which states that the rights of the person protected by the Baker Act trump the rights of the guardian under chapter 744. For instance, if the person wishes to have visits by family members or others, he or she should be allowed to do so. If staff believes the individual has abused, neglected, or exploited the person, a report to the abuse line should be made. Otherwise, the preferences of the person should prevail. Further, if the guardian is not acting in the best interests of the ward, this should be reported to the court. This may be especially important if it is a temporary emergency guardianship, where the court may decide to appoint someone else as guardian at the time when the hearing takes place, based on such information.

H. Custody of Personal Possessions

What restrictions does the Baker Act place on a person's right to keep his/her own belongings?

Section 394.459, Florida Statutes, governs rights of persons in psychiatric facilities. Subsection (6) ensures persons the right to retain their clothing and personal effects. If the right is restricted for medical or safety reasons, the reasons must be documented in the person's clinical record. The items removed must be identified on an inventory that must be given to the patient, guardian, guardian advocate, or representative. Form CF-MH 3043, "Inventory of Personal Effects," can be used to document this removal, although you may use a different form if it contains no less than the statutorily required information.

Can a person be forced to wear specialized clothing in a receiving facility to designate his/her status as a suicide or escape risk?

No. Use of special clothing for identification purposes would be a violation of individual dignity, confidentiality, and privacy. However, if the physician orders special clothing for medical reasons, no such violation would occur.

I am an assistant state attorney. Can you tell me how the Baker Act addresses

a person's right to have a firearm and/or the ability of law enforcement to remove such a weapon?

The Baker Act is silent on the issue of weapons with two exceptions. One is that no one is allowed to bring firearms or other deadly weapons onto the grounds of a hospital providing mental health services. § 394.458(1)(b), Fla. Stat. In addition, persons served in such facilities are allowed to keep their personal effects, other than those removed for medical or safety reasons. However, the items removed must be returned to the person or, if detrimental to the person, to his/her representative, at the time of release from the facility. § 394.459(6), Fla. Stat.

The legal advisor for the Miami-Dade Police Department gave direction to officers related to return of weapons in a Baker Act situation. Legal Note 2005-4. If the incident report prepared by law enforcement in a Baker Act situation referenced "breach of peace," the weapon could be taken and returned only upon an order of the court.

However, according to Op. Att'y Gen. Fla. 09-04 (2009) (regarding confiscation and return of firearms by law enforcement agencies when a firearm owner is subject to Baker Act evaluation), "[i]n the absence of an arrest and criminal charge against the person sent for evaluation under the Baker Act, the Sheriff . . . may not retain firearms confiscated. . . . Baker Act proceedings are not criminal proceedings." The opinion suggested that the sheriff seek legislation to address the problem.

Other Florida statutes that relate to persons with mental health issues include:

- Sections 790.17 and 790.175 (furnishing or transferring of weapons) refer to people of "unsound mind."

- Section 790.06 (license for concealed carry) refers to adjudication of incapacity (under chapter 744, guardianship), commitment under the Marchman Act (chapter 397), and commitment under the Baker Act (chapter 394). Commitment isn't defined here, but presumably this would pertain to involuntary placement provisions ordered by a court after a judicial hearing and not an involuntary examination initiated by a law enforcement officer or mental health professional.

- Section 790.065 (sale and delivery) was modified effective February 1, 2007, to require the clerk of court to notify FDLE whenever the court enters an order under the guardianship statute or the Marchman Act, or for Baker

Act involuntary inpatient placement. It was further revised by the 2013 Florida Legislature to require that before individuals can be transferred from involuntary to voluntary status under the Baker Act and continue to be considered "imminently dangerous," they must be reported to the circuit court for review and reporting to FDLE/FBI to prevent purchase of weapons or eligibility for a concealed weapon permit.

I. Designated Representative

We often use the next of kin name and address that is identified on the medical record as the representative. Should we verify with the patient that the patient wants this person acting as his/her representative?

The patient must be allowed to select his/her own representative. Only when he/she can't or won't select a representative is the receiving facility required to select one from the prioritized list included in the Baker Act.

Can you explain the difference between a representative and an "emergency contact"?

Persons on voluntary status only have an emergency contact, not a designated representative. However, an adult on involuntary status who doesn't have a court-appointed guardian will always have a representative designated. That representative will serve as the person's emergency contact. For persons determined by a physician to be incompetent to consent to their own admission or for their own treatment (unable to made well-reasoned, willful, and knowing decisions), they must be on involuntary status and a guardian advocate must be appointed by the court.

What is the role of a designated representative?

A representative is designated when a person is admitted to a facility on an involuntary basis or is transferred from voluntary to involuntary status. § 394.4597(2), Fla. Stat. The representative must:

- receive notice of the individual's admission;
- receive notice of proceedings affecting the individual;
- have immediate access to the individual held or admitted for mental health treatment, unless such access is documented to be detrimental to the individual;

- receive notice of any restriction of the individual's right to communicate or receive visitors;

- receive a copy of the inventory of personal effects upon the individual's admission and may request amendment to the inventory at any time;

- receive disposition of the individual's clothing and personal effects, if not returned to the individual, or to approve an alternate plan;

- be notified of the right to petition on behalf of the individual for a writ of habeas corpus to question the cause and legality of the individual's detention, or to allege that the individual is being unjustly denied a right or privilege granted or that an authorized procedure is being abused;

- be notified of the right 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;

- receive written notice of any restriction on the individual's right to inspect his or her clinical record;

- receive notice of release of the individual from a receiving facility where an involuntary examination was performed;

- receive a copy of any petition for the individual's involuntary placement filed with the court; and

- be informed by the court of the individual's right to an independent expert.

The designated representative does not have the authority to make any treatment decisions, cannot access or release the patient's clinical record without the patient's consent, and cannot request the transfer of the patient to another facility.

J. Right to Discharge

A hospital discharged our client last week and told us that, according to the Baker Act, our client must have a doctor's appointment within seven days, so the hospital would give the client a prescription for only seven days of medication. The Baker Act says the client must have access to psychotropic medications or prescriptions until aftercare appointment or 21 calendar days. Does this acknowledge that clients cannot always get an appointment with their psychiatrist within seven days?

Rule 65E-5.1303, Florida Administrative Code, which governs discharge from receiving and treatment facilities, states in paragraph (2)(e) that

> prescribed psychotropic medications, prescriptions, or multiple partial prescriptions for psychotropic medications, or a combination thereof, shall be provided to a person when discharged to cover the intervening days until the first scheduled psychotropic medication aftercare appointment, or for a period of up to 21 calendar days, whichever occurs first. Discharge planning shall address the availability of and access to prescribed psychotropic medications in the community.

The "aftercare appointment" specified in the rule is not defined because each community has different access to resources. The greater the amount of time between inpatient discharge and the first aftercare appointment, the greater the likelihood the person won't show up at all.

The hospital staff's statement that the treatment center must give a doctor's appointment within seven days, and thus limiting the prescription to seven days, reflects a lack of knowledge on the hospital's part. It is the hospital's responsibility to make these arrangements for the person as part of its discharge planning obligations, and if it takes up to 21 days for the aftercare appointment, that is the period for which the hospital should provide medications, prescriptions, or a combination of such. However, in the absence of the person's psychiatrist, arranging for another psychiatrist or ARNP at the community mental health center (CMHC) to temporarily oversee the person's care is entirely appropriate. It appears that you very appropriately provided for the person's care. This should ideally be an appointment with the attending psychiatrist who will follow the person on an outpatient basis. It might be the person's primary care physician. It might be an ARNP with the CMHC who can continue the medications prescribed by the inpatient psychiatrist. It might even be a case manager who can link the person to an appropriate provider in a timely way. Whatever it takes to ensure the person connects to continuity of care would meet this requirement.

If the appointment can't be arranged within the seven-day period called for in the rules, the inpatient provider may have to prescribe medications for a period of up to 21 days. Some of those inpatient settings can provide medications only in-house because they don't have an outpatient pharmacy license. In such cases, they may be able to only provide prescriptions. For safety's sake, they may not want to give 21 days of medication at a single time and may be able to give a smaller amount of medications, along with prescriptions for the remainder of the 21 days. Some

communities have quick access to IDP (indigent drug program) medications, while others have access to emergency centers, free clinics, samples, or county clinics.

K. Advance Directives

We recently had our Joint Commission survey and had some issues with advance directives. Our chaplains had been told in the past not to complete living wills with Baker Act patients. Are advance directives addressed in the Baker Act? What is the law regarding persons under the Baker Act making advance directives if they have a guardian advocate acting on their behalf? I understand that a demented, confused person is unable to make a living will, but if the person is under the Baker Act due to suicidal ideation, paranoia, etc., can the person make a living will?

An advance directive can be completed only by a person competent to do so. Issues related to advance directives are governed by chapter 765, Florida Statutes, which has several provisions that may apply to your situation:

> **765.204. Capacity of principal; procedure**
>
> (1) A principal is presumed to be capable of making health care decisions for herself or himself unless she or he is determined to be incapacitated. While a principal has decisionmaking capacity, the principal's wishes are controlling. Each physician or health care provider must clearly communicate to a principal with decisionmaking capacity the treatment plan and any change to the treatment plan prior to implementation of the plan or the change to the plan. Incapacity may not be inferred from the person's voluntary or involuntary hospitalization for mental illness or from her or his intellectual disability.
>
> **765.101. Definitions**
>
> (10) "Incapacity" or "incompetent" means the patient is physically or mentally unable to communicate a willful and knowing health care decision. . . .
>
> **765.104. Amendment or revocation**
>
> (1) An advance directive may be amended or revoked at any time by a competent principal. . . .

765.202. Designation of a health care surrogate

(5) A principal may designate a separate surrogate to consent to mental health treatment in the event that the principal is determined by a court to be incompetent to consent to mental health treatment and a guardian advocate is appointed as provided under s. 394.4598. However, unless the document designating the health care surrogate expressly states otherwise, the court shall assume that the health care surrogate authorized to make health care decisions under this chapter is also the principal's choice to make decisions regarding mental health treatment.

If a person has a guardian advocate appointed by the court, it is because the person has been found by clear and convincing evidence to be incompetent to provide consent to treatment. Clearly such a person wouldn't at that time be competent to complete any type of advance directive.

You should discuss this issue with your hospital's attorney as it might be presumed that a person meeting criteria for an acute care psychiatric hospital stay might not be competent to make such a directive. Further, a setting like this might be perceived to have some coercive aspect. It might be considered wise to give a form and instructions to a person interested in having such an advance directive at the time of discharge rather than at admission or during acute psychiatric treatment.

The Baker Act recognizes advance directives for mental health care prepared at a time when the person was competent. A recommended mental health advance directive is provided at the end of this chapter. This is not a living will — it relates only to mental health care. It includes language that witnesses sign stating the person is of sound mind and under no constraint or undue influence. This might be a difficult thing for a person in an acute psychiatric episode.

The Baker Act rules indicate that when a person has not executed an advance directive, health care decisions may be made by an eligible proxy during the interim period between the time the person is determined by the 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. Would there be any conflict with HIPAA allowing a proxy to make decisions, since the person did not have an advance directive?

No. HIPAA defers to the state laws in recognizing who is authorized to "stand in the shoes of the person" for decision-making purposes in each state. This includes

guardians, guardian advocates, and health care surrogates/proxies in Florida.

III. Forms

Please note that these recommended forms were promulgated by DCF before the 2016 statutory amendments and do not incorporate those changes.

A. Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances

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.

_____	_____	_____ am pm
Signature of Administrator or Designee	Date	Time

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
☐ Person		am pm	
☐ Guardian		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	
☐ 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**

B. Petition for Writ of Habeas Corpus or for Redress of Grievances

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.

_____ _____ _____ am pm
Signature of Administrator or Designee Date Time

_____
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
☐ Person		am pm	
☐ Guardian		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	
☐ 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**

C. Advance Directive for Mental Health Care

Advance Directive for Mental Health Care

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 now will ensure that your treatment choices are known at a time of crisis. You can choose now what types of treatment you do or do not want and appoint a friend or family member to make the mental health care decisions that you want carried out. You can always change your mind about your care 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, an employee of the Department of Children and Families, or a member of the Florida Local Advocacy Council.

- 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 he/she is aware you have chosen him/her to be your surrogate. The advance directive is still valid if he/she doesn't sign the form or if a surrogate or alternative is not named in the document.

- You must sign the form in front of two witnesses.

- Have copies made and give them to your surrogate, alternate, your case manager, your doctor, the hospital or crisis unit at which you are most likely be treated, your family, or 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.

Your advance directive doesn't take effect unless a physician decides that you are not competent to make your own treatment decisions. If you are in a mental health 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 hearing master. A health care surrogate can't have you admitted to a facility on a voluntary basis or consent to your treatment if you are on voluntary status. If voluntary, you will make the decisions for yourself.

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 is/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.

I hereby appoint and request immediate notification of my mental health care surrogate, who 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 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 he/she determines is the decision I would make if I were competent to do so.
_____Yes _____No

B. My choice of treatment facilities is as follows:

- 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: _____
- 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:

- _____ My representative may be notified of my involuntary admission
  ___ Yes ___ No

- _____ Any person who seeks to contact me while I am in a facility may be told I am there.
  ___ Yes ___ No

- _____ 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: _____

- I consent to release of information about my current condition and treatment plan
  ____ Yes ____ No

  To the following persons: _____ _____
  _____ _____
  _____ _____

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:

- _____I wish to have the medications that Dr. _____ recommends.

- _____I wish to have 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.

- _____I specifically do not want 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):
  _____
  _____

- _____ I want the medications that are 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.

- 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 want to be included in experimental drug studies or drug trials

_____ I do not want 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 a Personal Safety Plan to this advance directive.

I. Other instructions I wish to make about my mental health or medical 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 or medical treatment.

Signature (Declarant): _____ Date: _____
Printed Name (Declarant) _____

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 health care surrogate, and at least one of us is neither the person's spouse nor blood relative.

Dated at _____ this _____ day of _____, _____.
(County and 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)

*Signed acknowledgment by the surrogate/alternate is not required for the advance directive to be valid.

Chapter Eight: Firearm Prohibition for Certain Individuals With Mental Illnesses

I. Background

In 2013 the Florida Legislature passed House Bill 1355, which became state law on July 1, 2013. It provides conditions under which an individual who has been allowed to transfer to voluntary status in lieu of court-ordered involuntary commitment after being admitted for involuntary examination at a Baker Act receiving facility, and is certified by a physician to be of imminent danger to self or others, may be prohibited from purchasing firearms or obtaining or retaining a license for a concealed weapon.

There are key components of this bill that may directly impact a variety of individuals and organizations. Mental health receiving facilities, the doctors who work in or contract with the facilities, magistrates and judges who review the documents, clerks of court who must process the documents and forward information to FDLE, and FDLE itself (which must provide the information to the FBI for the National Instant Criminal Background Check System (NICS)) are all stakeholders in this process.

Before addressing the new provisions of Florida's weapons statute, it is important to address the application of the law prior to 2013. The law's application may not have been apparent to staff of mental health and substance abuse facilities throughout the state, but it is well known to the clerks of court, judges and magistrates, and FDLE. In the past, when courts have found in certain circumstances that an individual has met conditions of impairment due to mental illness or substance abuse (and other reasons), they were required to report information to FDLE for incorporation into state and federal databases to prevent such individuals from purchasing firearms. These sections of the law include:

> **790.06. License to carry concealed weapon or firearm** (emphasis added)
>
> (2) The Department of Agriculture and Consumer Services shall issue a license if the applicant:
>
> * * *

(f) Does not **chronically and habitually use alcoholic beverages or other substances** to the extent that his or her normal faculties are impaired. It shall be presumed that an applicant chronically and habitually uses alcoholic beverages or other substances to the extent that his or her normal faculties are impaired if the applicant has been **committed under chapter 397** or under the provisions of former chapter 396 or has been convicted under s. 790.151 or has been deemed a habitual offender under s. 856.011(3), or has had two or more convictions under s. 316.193 or similar laws of any other state, within the 3-year period immediately preceding the date on which the application is submitted;

* * *

(i) Has not been adjudicated an **incapacitated person under s. 744.331**, or similar laws of any other state, unless 5 years have elapsed since the applicant's restoration to capacity by court order;

(j) Has not been **committed to a mental institution under chapter 394**, or similar laws of any other state, unless the applicant produces a certificate from a licensed psychiatrist that he or she has not suffered from disability for at least 5 years before the date of submission of the application[.]

* * *

(10) A license issued under this section shall be **suspended or revoked** pursuant to chapter 120 if the licensee:

* * *

(e) Is committed as a **substance abuser under chapter 397**, or is deemed a habitual offender under s. 856.011(3), or similar laws of any other state;

* * *

(g) Is **adjudicated an incapacitated person under s. 744.331**, or similar laws of any other state; or

(h) Is **committed to a mental institution under chapter 394**, or similar laws of any other state.

Notwithstanding s. 120.60(5), service of a notice of the suspension or revocation of a concealed weapon or firearm license must be given by either certified mail, return receipt requested, to the licensee at his or her last known mailing address furnished to the Department of Agriculture and Consumer Services, or by personal service. If a notice given by certified mail is returned as undeliverable, a second attempt must be made to provide notice to the licensee at that address, by either first-class mail in an envelope, postage prepaid, addressed to the licensee at his or her last known mailing address furnished to the department, or, if the licensee has provided an e-mail address to the department, by e-mail. Such mailing by the department constitutes notice, and any failure by the licensee to receive such notice does not stay the effective date or term of the suspension or revocation. A request for hearing must be filed with the department within 21 days after notice is received by personal delivery, or within 26 days after the date the department deposits the notice in the United States mail (21 days plus 5 days for mailing). The department shall document its attempts to provide notice and such documentation is admissible in the courts of this state and constitutes sufficient proof that notice was given.

790.065. Sale and delivery of firearms

(2) Upon receipt of a request for a criminal history record check, the Department of Law Enforcement shall, during the licensee's call or by return call, forthwith:

(a) Review any records available to determine if the potential buyer or transferee:

* * *

4. Has been adjudicated mentally defective or has been **committed to a mental institution** by a court or as provided in sub-sub-subparagraph b.(II), and as a result is prohibited by state or federal law from purchasing a firearm.

a. As used in this subparagraph, "adjudicated mentally defective" means a determination by a court that a person, as a result of marked subnormal intelligence, or **mental illness, incompetency, condition, or disease, is a danger to himself or herself or to others** or lacks the

> mental capacity to contract or manage his or her own affairs. The phrase includes a judicial **finding of incapacity** under s. 744.331(6)(a), an **acquittal by reason of insanity** of a person charged with a criminal offense, and a judicial finding that a criminal defendant is **not competent to stand trial.**
>
> b. As used in this subparagraph, "**committed to a mental institution" means**:
>
> (I) **Involuntary commitment,** commitment for mental defectiveness or **mental illness**, and commitment for **substance abuse**. The phrase includes involuntary inpatient placement as defined in s. 394.467, involuntary outpatient [services] as defined in s. 394.4655, involuntary assessment and stabilization under s. 397.6818, and involuntary substance abuse [services] under s. 397.6957, but does not include a person in a mental institution for observation or discharged from a mental institution based upon the initial review by the physician or a voluntary admission to a mental institution. . . .
>
> * * *
>
> c. In order to check for these conditions, the department [FDLE] shall compile and maintain an automated database of persons who are prohibited from purchasing a firearm based on court records of adjudications of mental defectiveness or commitments to mental institutions.
>
> (I) Except as provided in sub-sub-subparagraph (II), clerks of court shall submit these records to the department within 1 month after the rendition of the adjudication or commitment. Reports shall be submitted in an automated format. The reports must, at a minimum, include the name, along with any known alias or former name, the sex, and the date of birth of the subject.

The 2013 Florida Legislature amended the above provisions of the state's weapons law to expand its applicability to individuals at designated Baker Act receiving facilities who meet certain criteria for imminent danger due to their mental illnesses but do not have a court order for placement under the Baker Act or for substance abuse assessment, stabilization, or treatment. The following selected provisions of section 790.065(2)(a)4, Florida Statutes, govern who can be denied a license to carry a concealed weapon or purchase

a firearm, including the responsibilities of various individuals in carrying out these provisions:

b. . . . .

(II) Notwithstanding sub-sub-subparagraph (I), voluntary admission to a mental institution for outpatient or inpatient treatment of a person **who had an involuntary examination under s. 394.463, where each of the following conditions have been met**:

(A) An examining physician found that the person is **an imminent danger** to himself or herself or others.

(B) The examining physician certified that **if the person did not agree to voluntary treatment, a petition for involuntary outpatient or inpatient treatment would have been filed** under s. 394.463(2)([g])4., or the examining physician certified that a petition was filed and the person subsequently agreed to voluntary treatment prior to a court hearing on the petition.

(C) Before agreeing to voluntary treatment, the **person received written notice of that finding and certification, and written notice** that as a result of such finding, he or she may be prohibited from purchasing a firearm, and may not be eligible to apply for or retain a concealed weapon or firearms license under s. 790.06 and the person acknowledged such notice in writing, in substantially the following form:

> "I understand that the doctor who examined me believes I am a danger to myself or to others. I understand that if I do not agree to voluntary treatment, a petition will be filed in court to require me to receive involuntary treatment. I understand that if that petition is filed, I have the right to contest it. In the event a petition has been filed, I understand that I can subsequently agree to voluntary treatment prior to a court hearing. I understand that by agreeing to voluntary treatment in either of these situations, I may be prohibited from buying firearms and from applying for or retaining a concealed weapons or firearms license until I apply for and receive relief from that restriction under Florida law."

(D) A judge or a magistrate has, pursuant to sub-sub-subparagraph c.(II), reviewed the record of the finding, certification, notice, and written acknowledgment classifying the person as an imminent danger to himself or herself or others, and ordered that such record be submitted to the department.

c. . . . .

(II) For persons committed to a mental institution pursuant to sub-sub-subparagraph b.(II), **within 24 hours after the person's agreement to voluntary admission, a record of the finding, certification, notice, and written acknowledgment must be filed by the administrator of the receiving or treatment facility, as defined in s. 394.455, with the clerk of the court** for the county in which the involuntary examination under s. 394.463 occurred. No fee shall be charged for the filing under this sub-sub-subparagraph. **The clerk must present the records to a judge or magistrate within 24 hours after receipt of the records**. A judge or magistrate is required and has the lawful authority to review the records ex parte and, if the **judge or magistrate determines that the record supports the classifying of the person as an imminent danger to himself or herself or others, to order that the record be submitted to the department. If a judge or magistrate orders the submittal of the record to the department, the record must be submitted to the department within 24 hours.**

II. Applicability of the Law

The law doesn't apply to persons in the following circumstances:

- Persons entering a facility on voluntary status and remaining on voluntary status regardless of their potential imminent dangerousness. The Baker Act law and multiple appellate cases place no duty on mental health professionals to initiate involuntary status even if the criteria for involuntary status are documented.

- Persons entering a facility on involuntary status on the basis of self-neglect instead of active danger, regardless of the severity of their mental illnesses.

- Persons on involuntary examination status who are discharged because they fail to meet any one of the involuntary placement criteria, without being converted to voluntary status.

- Persons whose potential for ”dangerousness” is not considered by a physician as “imminent.”

- Persons whose hearing on involuntary placement takes place and the petition is dismissed by the court because a less restrictive setting is found, regardless of the criteria related to active danger.

- Persons on involuntary examination status who are first taken to hospitals not designated by DCF as receiving facilities for examination or treatment of medical conditions and are released directly by a physician or psychologist or are transferred by such hospitals to voluntary status before transfer to a designated receiving facility.

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

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

III. Responsibility of Various Entities to Implement Section 790.06, Florida Statutes

A. Physicians Practicing at Baker Act Receiving or Treatment Facilities

A person for whom an involuntary examination has been initiated must have a physician or clinical psychologist, without unnecessary delay, conduct and document the mandatory initial involuntary examination, including:

- review the person’s recent behavior;

- review the “Transportation to Receiving Facility” form (CF-MH 3100);

- 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 a brief psychiatric history; and
- conduct a face-to-face examination to determine whether the person meets the criteria for release.

An individual who has had an involuntary examination initiated and been found to be of imminent danger, who requests transfer to voluntary status in lieu of a petition for involuntary placement (form CF-MH 3032) or requests withdrawal of a petition already filed, is subject to this reporting to the court.

Since chapter 790, Florida Statutes, doesn't define "imminent danger," the definition found in the criteria for involuntary placement (section 394.467(1)(a)2.b, Florida Statutes) may be used: "There is substantial likelihood that in the near future he or she will inflict serious bodily harm on self or others, as evidenced by recent behavior causing, attempting, or threatening such harm."

The law requires a notification to and acknowledgement by the individual that information will be provided by the facility to the court that will lead to a prohibition against firearm purchases or having a concealed weapon permit. A certification of competence (form CF-MH 3104) conducted by a physician should be completed to ensure the individual is competent to make well-reasoned, willful, and knowing decisions.

The form included in this chapter titled "Finding and Certification by an Examining Physician of Person's Imminent Dangerousness" can be used to document the individual's imminent dangerousness and competence to fully understand the meaning and consequences of converting to voluntary status.

The physician's finding and certification must be provided to facility staff to give the patient a full explanation that the conversion to voluntary status may result in a prohibition against firearm purchase. A copy of the physician's finding and certification must be retained in the individual's clinical record.

B. Baker Act Receiving Facility Administrators (or Designee)

If an individual who is found competent to consent to treatment isn't released from the facility and desires to convert to voluntary status but is found by the physician

to be imminently dangerous, and the patient is permitted to convert from involuntary to voluntary status, the physician must document that finding and certification. Facility staff should fully explain to the individual that the conversion to voluntary status may result in a prohibition against firearm purchases and obtaining or retaining a concealed weapons permit. The form titled "Patient's Notice and Acknowledgment" found below can be used for this purpose. A copy of the signed and witnessed Notice and Acknowledgment form must be retained in the individual's clinical record.

Staff will submit to the administrator of the receiving or treatment facility the following:

- Cover Sheet
- Physician's Finding and Certification
- Patient's Notice and Acknowledgment forms
- Application for Voluntary Admission

If a petition for involuntary inpatient placement has already been submitted to the clerk of court, a Notification to Court of Withdrawal of Petition (form CF-MH 3033) must be filed within one business day of the decision to convert to voluntary status with the court and sent to the state attorney, public defender, and guardian or designated representative. If the decision is made within 24 hours prior to the hearing, the notification must be made immediately by phone to all required parties, followed by submission of the written notice.

The packet of forms referenced above must be submitted by the facility to the clerk of court within 24 hours of the decision to convert the individual from involuntary to voluntary status. This cannot be delayed because of weekends or legal holidays. No fee shall be charged for this filing.

C. Clerks of Court

Upon receipt of the packet of forms from a Baker Act Receiving or Treatment Facility, the clerk will assign a case number and other activities routinely done upon petition filing. Within 24 hours, the clerk will submit the petition and other related forms to a judge or magistrate for review.

Rule 2.514, Florida Rules of Judicial Administration, defines how hours and days are computed for court use when a statute doesn't specify how it is to be done

(applies only to courts, not to mental health facilities). Rule 2.514(a)(2) provides that when a law states a period of time in "hours," the computation of hours is as follows:

> (A) begin counting immediately on the occurrence of the event that triggers the period;
>
> (B) count every hour, including hours during intermediate Saturdays, Sundays, and legal holidays; and
>
> (C) if the period would end on a Saturday, Sunday, or legal holiday, or during any period of time extended through an order of the chief justice . . . , the period continues to run until the same time on the next day that is not a Saturday, Sunday, or legal holiday and does not fall within any period of time extended through an order of the chief justice.

D. Judges or Magistrates

Upon receipt of the petition and related forms from the clerk of court, the judge or magistrate must review the record of the finding, certification, notice, and written acknowledgment classifying the person as an imminent danger to self or others.

> A judge or magistrate is required and has the lawful authority to review the records ex parte and, if the judge or magistrate determines that the record supports the classifying of the person as an imminent danger to himself or herself or others, to order that the record be submitted to the department [FDLE]. If a judge or magistrate orders the submittal of the record to the department, the record must be submitted to the department within 24 hours.

§ 790.065(2)(a)4.c.(II), Fla. Stat. The clerk of court must submit these records of an individual converting from involuntary to voluntary status to FDLE within **24 hours** (as defined above) in an automated format. The reports must include at least the individual's name (including any known aliases or former names), sex, and date of birth. § 790.065(2)(a)4.c, Fla. Stat.

Other records relating to firearm prohibition must be submitted by the court within **one month** after the rendition of the adjudication or commitment, including:

- Ordered to involuntary substance abuse assessment (§ 397.6818)

- Ordered to involuntary substance abuse services (§ 397.6957)
- Ordered to involuntary inpatient placement (§ 394.467)
- Ordered to involuntary outpatient services (§ 394.4655)
- Adjudicated incapacitated under § 744.331 or any similar law of any other state
- Acquittal by reason of insanity of a person charged with a criminal offense (§ 916.15)
- Judicial finding that a criminal defendant is not competent to stand trial (§ 916.12)
- Deemed a habitual offender under § 856.011(3) or other similar laws of Florida
- Convicted under § 790.151
- Has had two or more convictions under § 316.193 or similar laws of any other state

§ 790.06(1), (10), Fla. Stat.

E. Florida Department of Law Enforcement

> In order to check for these conditions, the department [FDLE] shall compile and maintain an automated database of persons who are prohibited from purchasing a firearm based on court records of adjudications of mental defectiveness or commitments to mental institutions. . . . The department is authorized to disclose data collected . . . to agencies of the Federal Government and other states for use exclusively in determining the lawfulness of a firearm sale or transfer. The department is also authorized to disclose this data to the Department of Agriculture and Consumer Services for purposes of determining eligibility for issuance of a concealed weapons or concealed firearms license and for determining whether a basis exists for revoking or suspending a previously issued license pursuant to s. 790.06(10).

§ 790.065(2)(a)4., Fla. Stat.

IV. Relief from a Firearm Disability

Persons who have had their right to purchase a firearm prohibited may petition the court for relief of this firearm disability under section 790.065(2)(a)4.d, Florida Statutes, as follows:

> A person who has been adjudicated mentally defective or committed to a mental institution, as those terms are defined in this paragraph, may petition the court that made the adjudication or commitment, or the court that ordered that the record be submitted to the department pursuant to sub-sub-subparagraph c.(II), for relief from the firearm disabilities imposed by such adjudication or commitment. A copy of the petition shall be served on the state attorney for the county in which the person was adjudicated or committed. The state attorney may object to and present evidence relevant to the relief sought by the petition. The hearing on the petition may be open or closed as the petitioner may choose. The petitioner may present evidence and subpoena witnesses to appear at the hearing on the petition. The petitioner may confront and cross-examine witnesses called by the state attorney. A record of the hearing shall be made by a certified court reporter or by court-approved electronic means. The court shall make written findings of fact and conclusions of law on the issues before it and issue a final order. The court shall grant the relief requested in the petition if the court finds, based on the evidence presented with respect to the petitioner's reputation, the petitioner's mental health record and, if applicable, criminal history record, the circumstances surrounding the firearm disability, and any other evidence in the record, that the petitioner will not be likely to act in a manner that is dangerous to public safety and that granting the relief would not be contrary to the public interest. If the final order denies relief, the petitioner may not petition again for relief from firearm disabilities until 1 year after the date of the final order. The petitioner may seek judicial review of a final order denying relief in the district court of appeal having jurisdiction over the court that issued the order. The review shall be conducted de novo. Relief from a firearm disability granted under this sub-subparagraph has no effect on the loss of civil rights, including firearm rights, for any reason other than the particular adjudication of mental defectiveness or commitment to a mental institution from which relief is granted.

The above provisions of chapter 790 apply to persons for whom the court has ordered specified interventions, including:

- Ordered to involuntary substance abuse assessment (§ 397.6818)
- Ordered to involuntary substance abuse services (§ 397.6957)
- Ordered to involuntary inpatient placement (§ 394.467)
- Ordered to involuntary outpatient services (§ 394.4655)
- Adjudicated incapacitated under § 744.331 or any similar law of any other state
- Acquittal by reason of insanity of a person charged with a criminal offense (§ 916.15)
- Judicial finding that a criminal defendant is not competent to stand trial (§ 916.12)

  A person who has been adjudicated mentally defective or committed to a mental institution, as those terms are defined in this paragraph, may petition the court that made the adjudication or commitment, or the court that ordered that the record be submitted to [FDLE], for relief from the firearm disabilities imposed by such adjudication or commitment. A copy of the petition shall be served on the state attorney for the county in which the person was adjudicated or committed. The state attorney may object to and present evidence relevant to the relief sought by the petition.

§ 790.065(2)(a)4.d, Fla. Stat.

> The hearing on the petition may be open or closed as the petitioner may choose. The petitioner may present evidence and subpoena witnesses to appear at the hearing on the petition. The petitioner may confront and cross-examine witnesses called by the state attorney. A record of the hearing shall be made by a certified court reporter or by court-approved electronic means. The court shall make written findings of fact and conclusions of law on the issues before it and issue a final order. The court shall grant the relief requested in the petition if the court finds, based on the evidence presented with respect to the petitioner's reputation, the petitioner's mental health

> record and, if applicable, criminal history record, the circumstances surrounding the firearm disability, and any other evidence in the record, that the petitioner will not be likely to act in a manner that is dangerous to public safety and that granting the relief would not be contrary to the public interest.

Id.

"Upon receipt of proper notice of relief from firearm disabilities [FDLE] shall delete any mental health record of the person granted relief from the automated database of persons who are prohibited from purchasing a firearm based on court records of adjudications of mental defectiveness or commitments to mental institutions." § 790.065(2)(a)4.e, Fla. Stat.

> If the final order denies relief, the petitioner may not petition again for relief from firearm disabilities until 1 year after the date of the final order. The petitioner may seek judicial review of a final order denying relief in the district court of appeal having jurisdiction over the court that issued the order. The review shall be conducted de novo. Relief from a firearm disability granted under this sub-subparagraph has no effect on the loss of civil rights, including firearm rights, for any reason other than the particular adjudication of mental defectiveness or commitment to a mental institution from which relief is granted.

§ 790.065(2)(a)4.d, Fla. Stat.

Below are four flowcharts that reflect the decision points to be made:

- Admission by Voluntary Status
- Admission by Involuntary Status
- Firearm Prohibition Process
- Petition for Relief from Firearm Disability

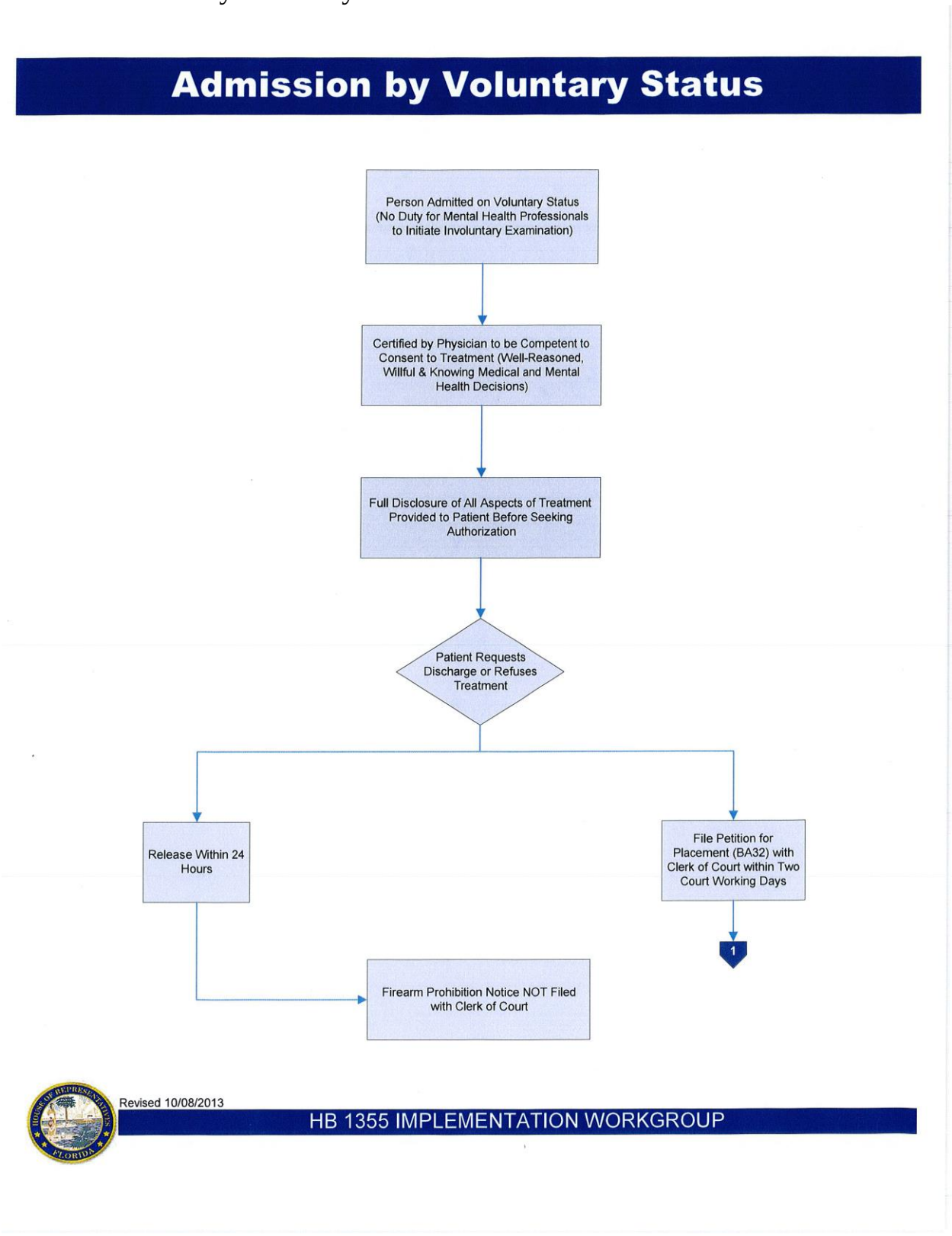
Also below are sample forms that can be used to implement the provisions of firearm prohibition legislation:

- Cover Sheet to be filed by a Receiving or Treatment Facility Administrator to the Clerk of Court

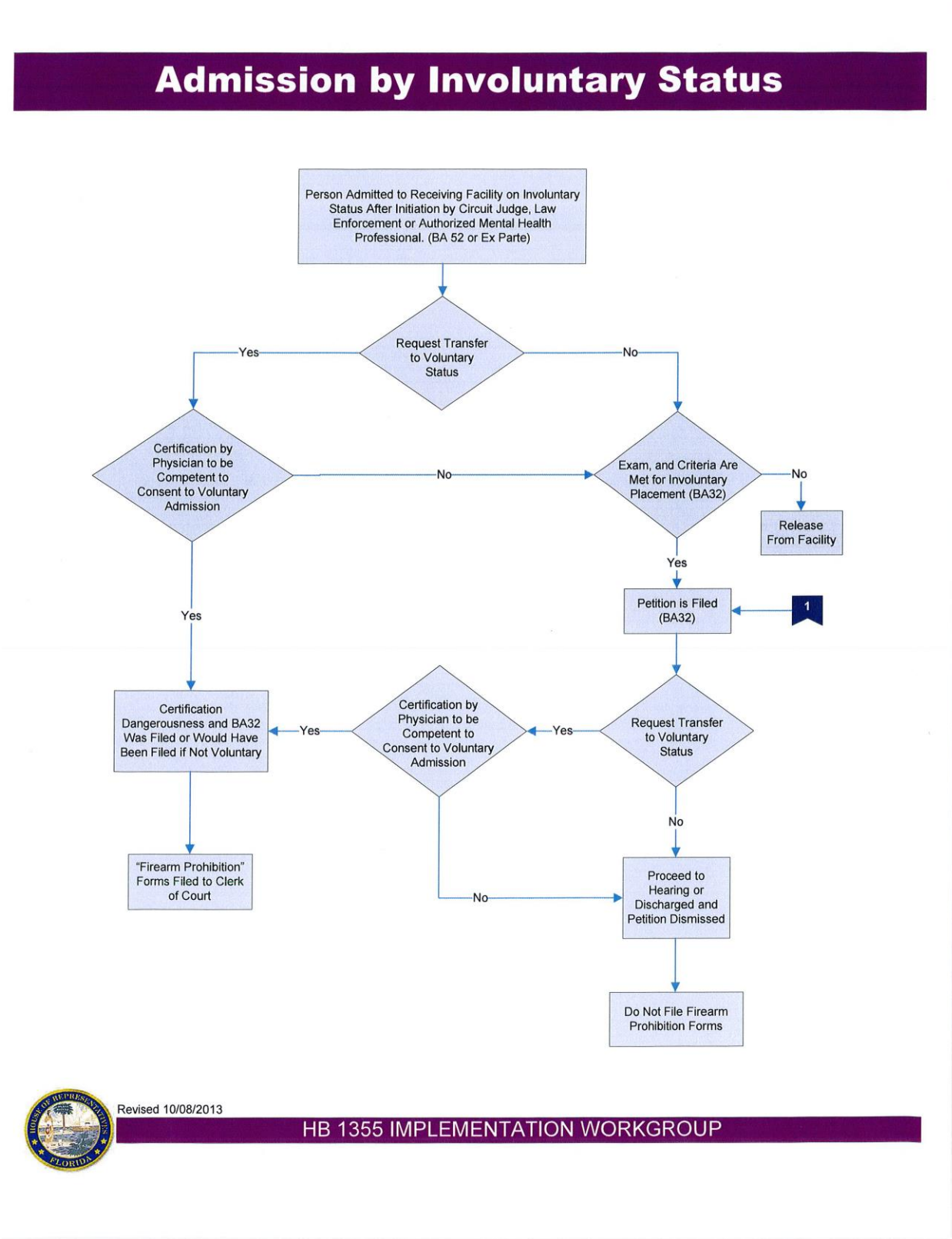
- Finding and Certification by an Examining Physician of Person's Imminent Dangerousness
- Patient's Notice and Acknowledgment
- Application for Voluntary Admission of an Adult to a Receiving Facility
- Notification to Court of Withdrawal of Petition for Hearing on Involuntary Inpatient or Involuntary Outpatient Placement
- Order of Court to Present Record of Finding to FDLE or Requiring Further Documentation on Voluntary Transfer
- Petition and Order for Relief from Firearm Disabilities Imposed by the Court

V. Flowcharts

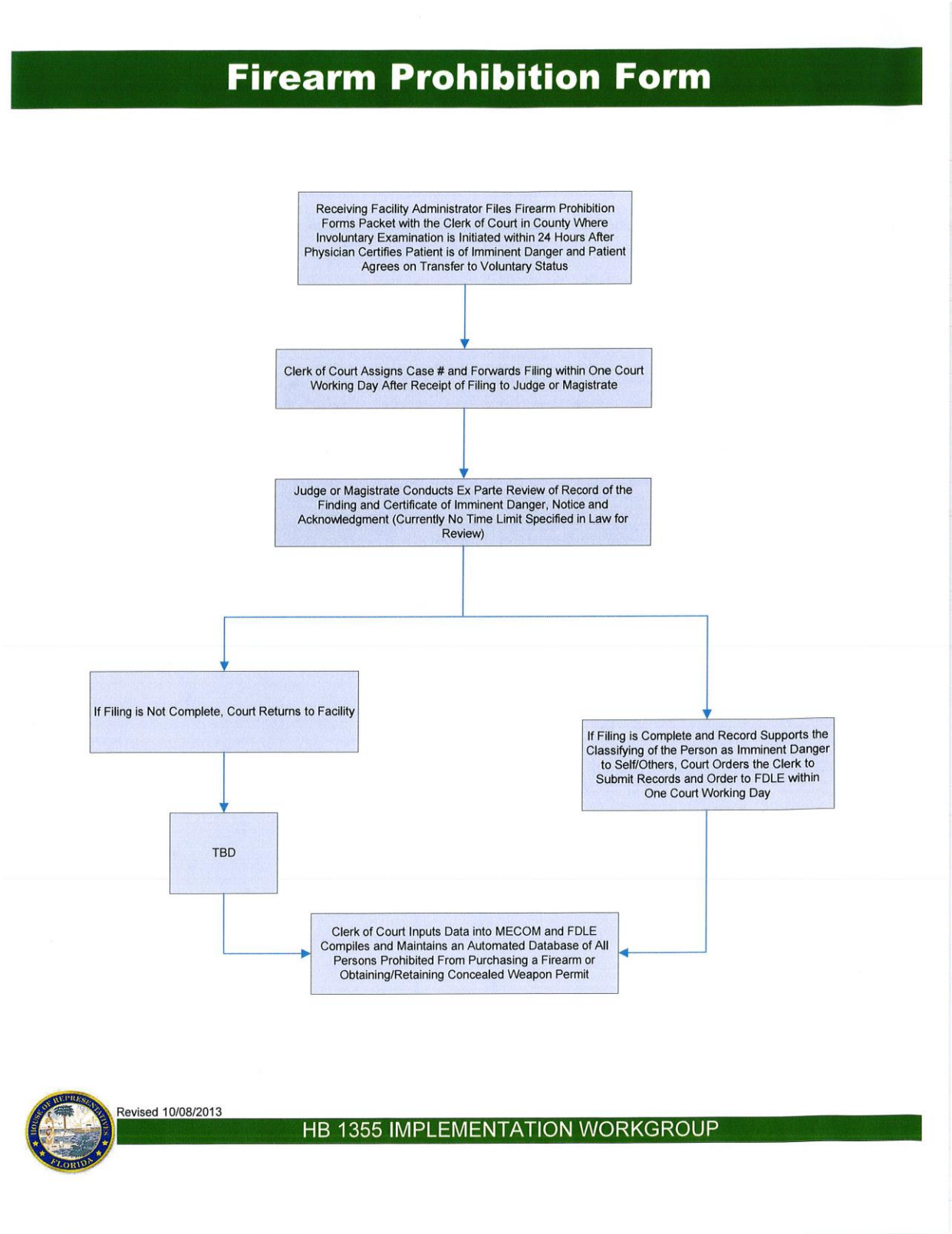
A. Admission by Voluntary Status



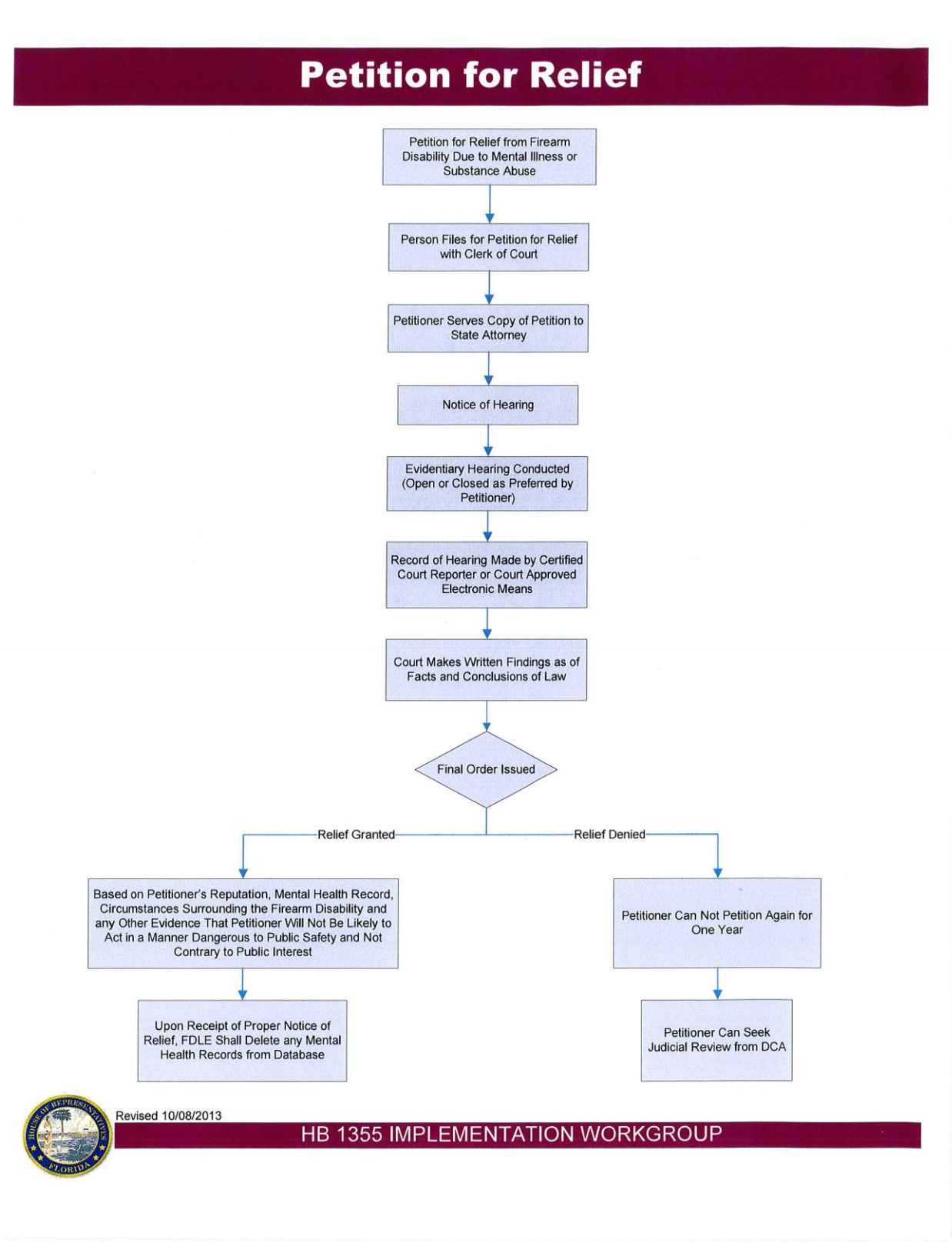
B. Admission by Involuntary Status



C. Firearm Prohibition Process



D. Petition for Relief from Firearm Disability



VI. Frequently Asked Questions

A. Applicable State Statutes

What state law requires the submission of mental health data to FDLE for the purpose of firearm purchase approval?

Section 790.065(2)(a), Florida Statutes, "Sale and delivery of firearms," outlines the firearm purchase prohibition for persons adjudicated as mentally defective or committed to a mental institution. The terms are defined in section 790.065(2)(a)4. as follows:

> a. . . . . "[A]djudicated mentally defective" means a determination by a court that a person, as a result of marked subnormal intelligence, or mental illness, incompetency, condition, or disease, is a danger to himself or herself or to others or lacks the mental capacity to contract or manage his or her own affairs. The phrase includes a judicial finding of incapacity under s. 744.331(6)(a), an acquittal by reason of insanity of a person charged with a criminal offense, and a judicial finding that a criminal defendant is not competent to stand trial.
>
> b. . . . . "[C]ommitted to a mental institution" means . . . an involuntary commitment, commitment for mental defectiveness or mental illness, and commitment for substance abuse. The phrase includes involuntary inpatient placement as defined in s. 394.467, involuntary outpatient [services] as defined in s. 394.4655, involuntary assessment and stabilization under s. 397.6818, and involuntary substance abuse [services] under s. 397.6957, but does not include a person in a mental institution for observation or discharged from a mental institution based upon the initial review by the physician or a voluntary admission to a mental institution. . . .

Chapter 2013-249, Laws of Florida, effective July 1, 2013, amended the definition of "committed to mental institution" to include

> voluntary admission to a mental institution for outpatient or inpatient treatment of a person who had an involuntary examination under s. 394.463, where each of the following conditions has been met:
>
> (A) An examining physician found that the person is an imminent danger to himself or herself or others.

(B) The examining physician certified that if the person did not agree to voluntary treatment, a petition for involuntary outpatient or inpatient treatment would have been filed under s. 394.463(2)([g])4., or the examining physician certified that a petition was filed and the person subsequently agreed to voluntary treatment prior to a court hearing on the petition.

(C) Before agreeing to voluntary treatment, the person received written notice of that finding and certification, and written notice that as a result of such finding, he or she may be prohibited from purchasing a firearm, and may not be eligible to apply for or retain a concealed weapon or firearms license under s. 790.06 and the person acknowledged such notice in writing. . . .

(D) A judge or a magistrate has . . . reviewed the record of the finding, certification, notice, and written acknowledgment classifying the person as an imminent danger to himself or herself or others, and ordered that such record be submitted to the department.

B. Mental Competency (MECOM) Database

What is the Mental Competency (MECOM) Database?

Section 790.065(2)(a)4.c, Florida Statutes, authorizes FDLE to establish and maintain "an automated database [designated as the Mental Competency (MECOM) database] of persons who are prohibited from purchasing a firearm based on court records of adjudications of mental defectiveness or commitments to mental institutions." The database contains information submitted by the clerks of court.

FDLE must check this database before approving the sale of a firearm by a licensed dealer, to determine whether the potential purchaser is prohibited by federal law from purchasing (or possessing) a firearm because of having been adjudicated mentally defective or committed to a mental institution. The data entered by the clerks gets uploaded to the National Instant Criminal History Background Check System (NICS), maintained by the FBI, to comply with federal law requiring background checks on prospective firearm purchasers. The data is included in the NICS Index, which is used nationwide in determining firearm purchase eligibility. The MECOM database is also used by the Florida Department of Agriculture and Consumer Services, Division of Licensing (DOACS), for the purpose of issuing or retaining a concealed weapon/firearm license.

Can the mental health data be submitted to FDLE in more than one way?

Entry by the clerk directly into the MECOM database is the preferred method. FDLE has assisted clerks by accepting faxes and mailed or emailed submissions because of the critical nature of the information. FDLE will continue to so as resources permit; however, the responsibility to enter the data remains with the clerks.

What are the mandated fields for MECOM database entry?

The fields necessary for entry into the MECOM database include name, any known alias or former name, sex, date of birth, and uniform case number (UCN). The MECOM database is designed to reject records that do not meet the minimum identification requirements outlined in the law. Because the system is structured to allow for searching records based on name and other personal identifying information, the more information provided to FDLE, the easier it will be to identify an individual attempting to purchase a firearm. For this reason, the clerks' offices may receive calls requesting additional data to assist in making informed decisions.

What kind of information would be beneficial as additional record subject identifiers?

If available, the subject's social security number, place of birth, driver license number, and last known address would be helpful.

What timeframe does the information need to be entered or submitted into the MECOM database?

Under section 790.065(2)(a)4.c.I, Florida Statutes, "clerks of court shall submit these records to the department within 1 month after the rendition of the adjudication or commitment." These records would include:

- Ordered to involuntary substance abuse assessment (§ 397.6818)
- Ordered to involuntary substance abuse services (§ 397.6957)
- Ordered to involuntary inpatient placement (§ 394.467)
- Ordered to involuntary outpatient services (§ 394.4655)

- Adjudicated incapacitated under § 744.331 or any similar law of any other state
- Acquittal by reason of insanity of a person charged with a criminal offense (§ 916.15)
- Judicial finding that a criminal defendant is not competent to stand trial (§ 916.12)
- Deemed a habitual offender under § 856.011(3) or other similar laws of Florida
- Convicted under § 790.151
- Has had two or more convictions under § 316.193 or similar laws of any other state

§§ 790.06, Fla. Stat., 790.065, Fla. Stat.

However, when persons are committed to a mental institution following an involuntary examination under section 394.463, Florida Statutes, clerks must submit the record to FDLE within 24 hours of the order.

If a person is the subject of more than one qualifying adjudication of mental defectiveness or commitment to a mental institution, should data on the later adjudications or commitments continue to be entered in the MECOM database?

Yes. The most recent data will be displayed when the database is queried. It is important for all persons involved in the firearm purchase background check process to have access to the most complete, current, and accurate information. Such information will be vital in making the correct decisions at the initial approval stage, during any appeal of a denial, and when removal of a name from the database is requested.

How do clerks and their employees access the MECOM database?

The MECOM database is available through the Florida Criminal Justice Network (CJNet). The access form found on the first page of the database must be completed and then faxed, mailed, or emailed to FDLE, after which a password and username will be assigned to the individual. As a security precaution, the password and username (logon) should not be shared with anyone else. Whenever

information is added or updated in the database, the system automatically records the date and identifies the person who updated or added the information by his or her logon name.

If an error is found in the MECOM database, should the clerks correct the error?

If an error is identified, contact the Firearm Purchase Program at (850) 410-8139 for correction.

Is the data in the MECOM database public record?

FDLE understands civil orders (adjudication or commitment) to be confidential. Under section 790.065(2)(a)4.f, Florida Statutes, if the records submitted by the clerks are confidential or exempt from disclosure in the custody of the courts, they will retain that status in the MECOM database. See the Florida Attorney General's Government-In-The-Sunshine Manual (2015 ed.), Part II.D.10. FDLE is authorized by the law to disclose information to the Department of Agriculture and Consumer Services for determining the eligibility of an applicant for a concealed weapons license. FDLE is also authorized to disclose data to federal or state agencies with regard to the lawfulness of the sale or transfer of a firearm.

Who should be called with questions about the MECOM database?

Questions should be directed to the Firearm Purchase Program at (850) 410-8139.

C. Substance Abuse

Does the law apply to substance abuse?

Yes, the definition of "committed to a mental institution" in the law includes "commitment for substance abuse" and refers to "s. 397.6818, and involuntary substance abuse [services] under s. 397.6957."

Should defendants who have been referred to drug court be entered in the database?

Referral to drug court, alone, is not a sufficient basis to enter a person in the MECOM database. See the previous answer.

Should all persons detained or held under the Baker or Marchman Acts be reported to FDLE?

Only persons who are committed to a mental institution or adjudicated mentally defective should be entered into the MECOM database. If such a court order was not issued as a result of the Baker Act or Marchman Act, the person should **not** be entered into the MECOM database.

Should data on persons who voluntarily admit themselves for substance abuse treatment be entered into the database?

No, unless there is further action by a physician and court under the process established by chapter 2013-249, Laws of Florida. See the section on chapter 2013-249, Laws of Florida, for further details about the new requirements.

Should an order for involuntary treatment, pursuant to section 397.6818, Florida Statutes, which orders the subject to attend an outpatient treatment program, such as AA meetings or group therapy sessions, be entered into the database?

An order for involuntary assessment and stabilization under section 397.6818, Florida Statutes, qualifies for entry in the database. Following involuntary assessment and stabilization, per section 397.6822, Florida Statutes, the client may "where appropriate, [be] refer[red] . . . to another treatment facility or service provider, or to community services." Such referral could include attending AA meetings, group therapy sessions, etc.

Where a petition for involuntary treatment for substance abuse is filed under chapter 397, Florida Statutes, and the respondent signed a waiver of hearing authorizing the court to enter an order for involuntary treatment, should such an order be entered into the database?

A court order placing someone in a substance abuse services program under the authority of chapter 397, Florida Statutes, is a prohibitor for the purchase of a firearm and should be entered into the database. The waiver of hearing does not negate the effect of the order.

D. Juveniles

Should juveniles who are not able to stand trial because of their age be entered into the MECOM database?

No. If a minor defendant is found to be "incompetent" to proceed solely because of his or her age, the resulting order is not considered to be an adjudication of mental incompetency and does not qualify for entry into the MECOM database.

Should juveniles who have been found mentally incompetent be entered into the MECOM database?

The federal law that prohibits a person "who has been adjudicated as a mental defective or who has been committed to a mental institution" from purchasing a firearm, 18 U.S.C. § 922(g)(4), does not mention an age limit for such adjudication or commitment, nor does the expanded definition of this phrase, found at 27 C.F.R. § 478.11. Accordingly, it has been concluded that an adjudication or commitment of a minor meeting the requirements of the law should be reported.

E. Capacity/Competency

Should an order determining someone totally incapacitated which does not refer to section 744.331, Florida Statutes, be entered into the database?

An order determining someone to be totally incapacitated as authorized under section 744.331, Florida Statutes, would qualify for entry, even if a different (or no) statute is cited.

If a defendant is found incompetent to stand trial, should he or she be entered into the database? What happens if the defendant is later found competent to stand trial?

If a defendant is found incompetent to stand trial by the court, that should be entered in the MECOM database. If the defendant is later determined to be competent to proceed to trial, that fact alone will not authorize removal from the database. The law authorizes a process for restoration of firearm rights following loss due to, for example, a finding of incompetency to stand trial. The outcome of the trial may or may not impose a separate firearm purchase prohibitor (e.g., a felony conviction).

F. Relief from Disability

How can a person be removed from the MECOM database?

A process for restoration of firearm rights, also referred to as "Relief from Disability," is authorized at section 790.065(2)(a)4.d, Florida Statutes, which could allow for the removal of persons from the MECOM database.

Is the process for removal from the MECOM database automatic following the restoration of firearm rights?

No, "upon receipt of proper notice of relief from firearm disabilities granted [by a court]," FDLE will remove the subject from the database; the process is not automatic.

If a person believes his or her name should be removed from the database, or needs information in this regard, to whom should the clerk's office direct him or her?

Contact the Firearm Purchase Program at (850) 410-8139. The person should be referred to section 790.065, Florida Statutes, for the legal basis for removal.

G. Provisions of Chapter 2013-249, Laws of Florida

How did this law amend section 790.065, Florida Statutes, "Sale and Delivery of Firearms"?

Chapter 2013-249, Laws of Florida, effective July 1, 2013, amended the definition of "committed to mental institution" to include

> voluntary admission to a mental institution for outpatient or inpatient treatment of a person who had an involuntary examination under s. 394.463, where each of the following conditions has been met:
>
> (A) An examining physician found that the person is an imminent danger to himself or herself or others.
>
> (B) The examining physician certified that if the person did not agree to voluntary treatment, a petition for involuntary outpatient or inpatient treatment would have been filed under s. 394.463(2)([g])4., or the examining physician certified that a petition was filed and the person subsequently agreed to voluntary treatment prior to a court hearing on the petition.
>
> (C) Before agreeing to voluntary treatment, the person received written notice of that finding and certification, and written notice that as a result of such finding, he or she may be prohibited from purchasing a firearm, and may not be eligible to apply for or retain a concealed weapon or firearms license under s. 790.06 and the person acknowledged such notice in writing. . . .
>
> (D) A judge or a magistrate has . . . reviewed the record of the finding, certification, notice, and written acknowledgment classifying

the person as an imminent danger to himself or herself or others, and ordered that such record be submitted to the department.

What are examples where the new law does not apply?

The law doesn't apply to persons in the following circumstances:

- Persons entering a facility on voluntary status and remaining on voluntary status regardless of their potential imminent dangerousness. The Baker Act law and multiple appellate cases place no duty on mental health professionals to initiate involuntary status even if the criteria for involuntary status are documented.

- Persons entering a facility on involuntary status on the basis of self-neglect instead of active danger, regardless of the severity of their mental illnesses.

- Persons on involuntary examination status who are discharged because they fail to meet any one of the involuntary placement criteria, without being converted to voluntary status.

- Persons whose potential for "dangerousness" is not considered by a physician as "imminent."

- Persons whose hearing on involuntary placement takes place and the petition is dismissed by the court because a less restrictive setting is found, regardless of the criteria related to active danger.

- Persons on involuntary examination status who are first taken to hospitals not designated by DCF as receiving facilities for examination or treatment of medical conditions and are released directly by a physician or psychologist or are transferred by such hospitals to voluntary status before transfer to a designated receiving facility.

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

What is the duty of physicians at receiving or treatment facilities?

The physician or clinical psychologist must, without unnecessary delay, conduct and document the mandatory initial involuntary examination, including:

- review the person's recent behavior;
- review the "Transportation to Receiving Facility" form (CF-MH 3100);
- 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 a brief psychiatric history; and
- conduct a face-to-face examination to determine whether the person meets the criteria for release.

Under the 2013 requirements, what forms must the receiving or treatment facility file with the clerk of court?

Upon meeting the conditions, the administrator of the receiving or treatment facility must file the following forms with the clerk of court for the county in which the involuntary examination occurred:

- Finding and Certification by an Examining Physician of Person's Imminent Dangerousness.
- Patient's Notice and Acknowledgment (of firearm disabilities).
- If applicable, Notification to Court of Withdrawal of Petition for Hearing on Involuntary Inpatient or Involuntary Outpatient Placement.

When must the receiving or treatment facility file the forms with the clerk of court?

Forms must be filed with the clerk of court within 24 hours of the patient's certification as an imminent danger and agreement to transfer to voluntary status.

When must the clerk of court present the filed records to a judge or magistrate?

The clerk of court is required to present the records to a judge or magistrate within 24 hours after receipt of such records from the receiving or treatment facility.

If a judge or magistrate issues an order, when must the clerk of court enter the information into the MECOM database?

The law requires the clerk of court to submit the record to FDLE, by entering the information directly into the MECOM database, within 24 hours of the order.

What is meant by the timeframe of 24 hours for the courts?

- Rule 2.514, Florida Rules of Judicial Administration, defines how hours and days are computed for court use when a statute doesn't specify how it is to be done (applies only to courts, not to mental health facilities). Rule 2.514(a)(2) provides that when a law states a period of time in "hours," the computation of hours is as follows:

  (A) begin counting immediately on the occurrence of the event that triggers the period;

  (B) count every hour, including hours during intermediate Saturdays, Sundays, and legal holidays; and

  (C) if the period would end on a Saturday, Sunday, or legal holiday, or during any period of time extended through an order of the chief justice . . . , the period continues to run until the same time on the next day that is not a Saturday, Sunday, or legal holiday and does not fall within any period of time extended through an order of the chief justice.

What must the patient's notice and acknowledgment include?

Under section 790.065(2)(a)4.b(II)c, Florida Statutes, the notice must be substantially as follows:

> I understand that the doctor who examined me believes I am a danger to myself or to others. I understand that if I do not agree to voluntary treatment, a petition will be filed in court to require me to receive involuntary treatment. I understand that if that petition is filed, I have the right to contest it. In the event a petition has been filed, I understand that I can subsequently agree to voluntary treatment prior to a court hearing. I understand that by agreeing to voluntary treatment in either of these situations, I may be prohibited from

buying firearms and from applying for or retaining a concealed weapons or firearms license until I apply for and receive relief from that restriction under Florida law."

Am I required to use the forms included in this chapter?

No. Receiving and treatment facilities may develop their own forms. The sample forms below are provided as examples, but they may also be used if a facility chooses to do so.

VII. Forms

The following forms at A, B, C, F, and G are recommended forms and were developed by the Florida Department of Law Enforcement. The forms at D and E are recommended forms promulgated by DCF.

A. Firearm Prohibition Cover Sheet

Firearm Prohibition

Cover Sheet

Confidential Information

Submission to Clerk of Court of Statutorily Required Documents for Review by Judge or Magistrate Regarding Purchase of Firearms or Applying/Retaining Concealed Weapons or Firearms License by Persons Who Have a Mental Illness and Are Deemed Imminently Dangerous

Attached are the following forms regarding the determination an individual in this receiving or treatment facility has been found to be an imminent danger to self or others:

☐ Finding and Certification by an Examining Physician of Person's Imminent Dangerousness

☐ Patient's Notice and Acknowledgment (Purchase of Firearms and Application for or Retention of a Concealed Weapons or Firearms License)

☐ Application for Voluntary Admission of an Adult (Receiving Facility)

☐ Notification to Court of Withdrawal of Petition for Hearing on Involuntary Inpatient or Involuntary Outpatient Placement

_____ _____ _____
Signature of Administrator or Designee Date Time

_____ _____
Printed Name of Administrator or Designee Name of Receiving or Treatment Facility

Printed Name of Patient _____ Gender _____

Date of Birth _____ Race _____

Social Security Number: _____

See s. 394.463(2)(i)4, 790.06 and 790.065 Florida Statutes
Confidential Information
Revised 03/14

B. Finding and Certification by an Examining Physician of Person's Imminent Dangerousness

Finding and Certification by an Examining Physician of Person's Imminent Dangerousness

I, _____, a physician licensed pursuant to chapter 458 or 459, Florida Statutes, examined _____, a patient in _____ (name of receiving or treatment facility) on _____ (date) at _____ a.m./p.m.

I determined this individual is an imminent danger to self or others based on the following:

_____

_____

_____

_____

_____

Please Check One

☐ I certify if the person had not agreed to voluntary treatment, a petition for involuntary outpatient or inpatient treatment would have been filed.

☐ I certify a petition was filed and the person subsequently agreed to voluntary treatment prior to a court hearing on the petition.

I have found this person has the capacity to make well-reasoned, willful, and knowing decisions concerning his or her medical or mental health treatment and therefore is competent to transfer to voluntary status and to consent to treatment.

_____	_____	_____
Signature of Examining Physician	Date	Time
_____	_____	
Printed Name of Examining Physician	License Number	

Printed Name of Patient _____ Gender _____

Date of Birth _____ Race _____

Social Security Number: _____

See s. 790.06 and 790.065 Florida Statutes
Confidential Information
Revised 03/14

C. Patient's Notice and Acknowledgment

Patient's Notice and Acknowledgment

Purchase of Firearms and Application for or Retention of a Concealed Weapons or Firearms License

I, _____ do hereby
(Full printed name of person whose admission is being requested)

confirm I have received written notice of the finding and certification from an examining physician advising if I do not agree to voluntary admission, a petition for involuntary outpatient or inpatient treatment will be filed under s. 394.463(2)(i)4, F.S., or the examining physician certified a petition was filed and I have subsequently agreed to voluntary treatment prior to a court hearing on the petition.

I further acknowledge I understand the doctor who examined me believes I am an imminent danger to myself or to others. I understand if I do not agree to voluntary treatment, a petition will be filed in court to require me to receive involuntary treatment. I understand if that petition is filed, I have the right to contest it. I understand by agreeing to voluntary treatment in either of these situations, I may be prohibited from purchasing firearms and from applying for, or retaining, a concealed weapons or firearms license until I apply for, and receive, relief from that restriction under Florida law.

I understand that the doctor's finding and certification, this notice and signed acknowledgment, and my application for voluntary admission will be filed with the court.

Signature of Competent Adult	Printed Name	Date	Time
Signature of Witness	Printed Name	Date	Time

Printed Name of Patient _____ Gender _____

Date of Birth _____ Race _____

Social Security Number: _____

See s. 394.463(2)(i)4, 790.06 and 790.065, Florida Statutes
Confidential Information
Revised 03/14

D. Application for Voluntary Admission of an Adult (Receiving Facility)

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 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 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.

_____		_____	_____ a.m. p.m.
Signature of Competent Adult		Date	Time
_____	_____	_____	_____ a.m. p.m.
Printed Name of Witness	Signature of Witness	Date	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.

See s. 394.455(9), 394.459, 394.4625, Florida Statutes
CF-MH 3040, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

E. Notification to Court of Withdrawal of Petition for Hearing on Involuntary Inpatient or Involuntary Outpatient Placement

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 Outpatient Placement ☐ Involuntary Inpatient Placement ☐ Continued Involuntary Outpatient Placement

The respondent has ☐ or has not ☐ been determined to be an imminent danger to self or others.

If yes, the record of the finding, certification, notice, and written acknowledgement is attached to this Notification 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

_____
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.

Printed Name of Patient: _____ Gender: _____

Date of Birth: _____ Race: _____

Social Security Number: _____

Confidential Information
Revised 03/14

F. Order of Court to Present Record of Finding to FDLE or Requiring Further Documentation on Voluntary Transfer

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
OF THE STATE OF FLORIDA, IN AND FOR _____COUNTY

IN RE: **CASE NO:** _____

_____
(Patient)

DIVISION:_____

(When provided)
Gender: _____ **Race:** _____ **Date of Birth:** _____ **Social Security Number:** _____

ORDER OF COURT:
☐ **TO PRESENT RECORD OF FINDING TO FLORIDA DEPARTMENT OF LAW ENFORCEMENT** ***or***
☐ **REQUIRING FURTHER DOCUMENTATION ON VOLUNTARY TRANSFER**

THIS MATTER came before the Court on _____, 20___, upon the filing of a record by _____ *(name of receiving facility)* on _____, 20___, relating _____ *(patient),* who is now voluntarily in a mental health treatment facility pursuant to the provisions of Chapter 394, Florida Statutes, and having been considered by the undersigned judge or magistrate, pursuant to Section 790.065, Florida Statutes, and the undersigned having reviewed the filing, finds as follows:

- ☐ The following records were filed by the administrator of the receiving or treatment facility with the Clerk of the Court for the county in which the involuntary examination occurred:
  - ☐ Record of findings and certification by examining physician of patient's imminent dangerousness;
  - ☐ Record of examining physician's certification relating to filing of petition for involuntary treatment
  - ☐ Record of written notice provided to patient
  - ☐ Record of patient's written acknowledgement of notice
  - ☐ Record of application for voluntary admission
  - ☐ Record Notification to Court of Withdrawal of Petition (when applicable)

- ☐ The examining physician found that the patient is an imminent danger to himself or herself or others; ***and***

- ☐ The examining physician certified that if the patient did not agree to voluntary treatment, a petition for involuntary outpatient or inpatient treatment would have been filed; ***or***
- ☐ The examining physician certified that a petition for involuntary outpatient or inpatient treatment was filed and the patient subsequently agreed to voluntary treatment prior to a court hearing on the petition, ***and***

- ☐ The patient received written notice of that finding and certification, and written notice that as a result of such finding, he or she may be prohibited from purchasing a firearm, and may not be eligible to apply for or retain a concealed weapon or firearms license, and the person acknowledged such notice in writing.

(continued)

ORDER OF COURT:
TO PRESENT RECORD OF FINDING TO FLORIDA DEPARTMENT OF LAW ENFORCEMENT *or* REQUIRING FURTHER DOCUMENTATION ON VOLUNTARY TRANSFER (Page 2)

☐ The records described were / were not *(circle one)* filed within the 24-hour time prescribed by law and computed as specified by Rule of Judicial Administration 2.514, after the patient's agreement to voluntary admission.

☐ Within 24 hours after receipt, computed as specified by Rule of Judicial Administration 2.514, the Clerk of the Court presented the record to the undersigned.

☐ The record supports the classifying of the patient as an imminent danger to self or others and therefore meets the criteria for forwarding to the Florida Department of Law Enforcement.

In consideration of the foregoing it is hereby

☐ **ORDERED AND ADJUDGED** that the record be submitted to the Florida Department of Law Enforcement within 24 hours for the purpose of entering the patient's name into the National Instant Check System database of people who are prohibited from purchasing firearms. The 24-hour period shall be computed as provided in Rule of Judicial Administration 2.514(a)(2).

or

☐ **ORDERED AND ADJUDGED** that the record presented to the Court is incomplete and the Court cannot at this time find that the above-referenced patient's voluntary commitment procedure met the requirements of Section 790-065, Florida Statutes, so as to require that he/she be prohibited from purchasing a firearm or that his/her name be added to the FDLE's Mental Competency (MECOM) database. It is therefore further

ORDERED that the _____ *(name of receiving facility)* file with this Court adequate documentation of this voluntary commitment procedure within 3 days. The Court reserves jurisdiction to enter further orders in this matter. It is further

ORDERED that a failure to timely file the documentation requested will result in:
(a) A dismissal of the matter with prejudice, without further order of this Court,
(b) The person's record will not be submitted to the FDLE database, and
(c) The person will not be precluded from purchasing a firearm because of this specifically referenced voluntary admission to a mental institution.

DONE AND ORDERED in Chambers in _____ County, Florida, on _____, 20___.

☐ **Circuit Court Judge**
☐ **General Magistrate**

Copies to:
☒ Receiving Facility*
☒ Patient*
☐ SAO
☐ PDO/Patient's Counsel

**The Receiving Facility is to print the patient's copy and provide it to patient at the facility.*

Confidential Information
Revised 03/14

G. Petition and Order for Relief from Firearm Disabilities Imposed by Court

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT

IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE #: _____
DIVISION: _____

PETITION FOR RELIEF FROM FIREARM DISABILITIES IMPOSED BY THE COURT

1. THIS MATTER is presented to the Court on _____ (date) by Petitioner, _____, on a Petition for Relief from Firearms Disabilities Imposed by the Court on _____.

2. The Petitioner was:

☐ Ordered to Involuntarily Substance Abuse Assessment and Stabilization (s. 397.6818, F.S.) on _____
☐ Ordered to Involuntary Substance Abuse Treatment (s. 397.6957, F.S.) on _____
☐ Ordered to Involuntary Inpatient Placement (s. 394.467(6), F.S.) on _____
☐ Ordered to Involuntary Outpatient Placement (394.4655, F.S.) on _____
☐ Found by Court to be of Imminent Danger but permitted by physician to transfer to voluntary status in lieu of involuntary placement order above (s. 790.065, F.S.) on _____
☐ Adjudicated incapacitated (s. 744.331, F.S.) or any similar law of any other state on _____
☐ Acquitted by reason of insanity (s. 916.15 F.S.) of a person charged with a criminal offense on _____
☐ Criminal defendant found by Court to be not competent to stand trial (s. 916.12, F.S.) on _____

3. The Petitioner will not be likely to act in a manner that is dangerous to public safety and that granting the relief would not be contrary to the public interest as follows:
_____
_____
_____

4. Based upon these facts, THE FOLLOWING IS REQUESTED:

a. That the firearms disability imposed dated _____, be set aside and are no further in force and effect.

b. That pursuant to Florida Statute (790.065), The court shall grant the relief requested in the petition if the court finds, based on the evidence presented with respect to the petitioner's reputation, the petitioner's mental health record and, if applicable, criminal history record, the circumstances surrounding the firearm disability, and any other evidence in the record, that the petitioner will not be likely to act in a manner that is dangerous to public safety and that granting the relief would not be contrary to the public interest.

(Continued)

PETITION FOR RELIEF FROM FIREARM DISABILITIES IMPOSED BY THE COURT (Page 2)

c. That pursuant to Florida Statute (790.065), the Florida Department of Law Enforcement shall delete any mental health record of _____ from the automated database of persons who are prohibited from purchasing a firearm based on court records.

5. Under penalties of perjury, I declare that I have read the foregoing Petition for Relief from the Firearm Disabilities Imposed by the Court and that the facts stated in it are true.

Signature of Petitioner _____

Printed Name of Petitioner: _____

Date of Birth: _____

Mailing Address: _____

_____
City State ZIP Code

Race: _____ Gender: _____

Social Security Number: _____

Name and Address of Attorney for Petitioner (if any):

_____

_____

Confidential Information
Revised 03/14

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For use of the Court only:

Office of the State Attorney notified of this petition on _____ via _____.

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE #: _____

ORDER ON PETITION FOR RELIEF FROM FIREARM DISABILITIES

THIS MATTER is presented to the Court by Petitioner, _____ on a Petition for Relief from Firearms Disabilities Imposed as a result of the _____ order issued by the Court on _____(date).

The Court, having heard testimony and having received other evidence, finds as follows:

1. _____ was ordered to _____
2. _____ successfully _____
3. _____ currently lives with _____
   Works at _____, and _____

Office of the State Attorney was notified of this petition on _____ via _____.

Based on the evidence presented and the Court's conclusions derived therefrom, IT IS THEREFORE ORDERED AND ADJUDGED that:

☐ The firearm disability imposed on _____ shall remain in force and effect and the petition filed on _____ (date) is DENIED.

☐ The firearm disability imposed on _____ on _____ (date) is SET ASIDE and is of no further in force and effect.

Pursuant to Florida Statute 790.065, the Court grants the relief requested in the petition. With respect to evidence presented as to petitioner's reputation, mental health, the absence of criminal record that would preclude gun ownership, the firearm disability, and other evidence in the record, the petitioner will not be likely to act in a manner that is dangerous to public safety and that granting the relief would not be contrary to the public interest.

Pursuant to Florida Statute 790.065, the Florida Department of Law Enforcement shall delete any mental health record of _____ from the automated database of persons who are prohibited from purchasing a firearm based on court records of _____ (MECOM).

DONE AND ORDERED in _____ County, Florida this ____ day of _____, 20___.

_____
Circuit Court Judge

Full name of Petitioner _____ Date of Birth _____

Mailing Address: _____ Race: _____ Gender _____

_____
City State Zip Code Social Security Number:_____

Confidential Information -- Revised 03/14

APPENDIX I:

Recommendations from 1999 Report of the Supreme Court Commission on Fairness, Subcommittee on Case Administration

Supreme Court Commission on Fairness
Subcommittee on Case Administration

Judicial Administration of the Baker Act
and Its Effect on Florida's Elders

The following recommendations were included in the 1999 Report, and are taken from the Executive Summary of the full report.

The **Executive Office of the Governor** and the **Florida Supreme Court** should jointly sponsor a statewide interdisciplinary summit on mental health issues related to Chapter 394. The objectives of the summit should include:

- educating participants on mental health issues;
- sharing information on "best practices" in regard to Baker Act cases; and
- providing a forum for the participants to discuss new and emerging mental health issues.

Participants should include chief judges, probate judges, general masters, state attorneys, public defenders, clerks of court, administrative law judges, law enforcement officers, service providers, individuals with psychiatric disabilities, advocates, public and private guardians, and others involved in Baker Act proceedings.

Courts

1. The State Courts System, state attorneys, public defenders, and clerks of court should continue to seek, and the Florida Legislature should fund adequate resources for, proceedings under Chapter 394

2. The Florida Legislature should direct and fund an interdisciplinary study on whether probable cause hearings should be held within 24 to 48 hours for all individuals who are involuntarily examined pursuant to Chapter 394.

3. The State Courts System should request, and the Legislature should approve, additional funding to allow the establishment of general masters for involuntary placement proceedings in every jurisdiction that needs and wants such a resource.

4. All participants should be mindful that patients must be treated with respect and consideration.

5. Chief judges, state attorneys, and public defenders should ensure continuity and consistency of the judges, general masters, assistant state attorneys, and assistant public defenders assigned to Baker Act proceedings.

6. Judges, general masters, assistant state attorneys, and assistant public defenders should be adequately trained and educated on general mental health and elder issues, including community resources and issues identified in this report, ***prior*** to being assigned to Baker Act proceedings.

7. Judges, general masters, public defenders, and state attorneys should have a working knowledge of community mental health resources and visit the less restrictive alternatives available within their community.

8. Judges, general masters, state attorneys, and public defenders should be educated on the financial relationships and incentives that may exist among mental health providers and the situations in which conflict of interest or abuses may occur.

9. Continuing educational programs on elder, mental health, and disability laws and issues should be made available to all Florida judges and lawyers on an on-going basis.

10. The court should treat petitions for writ of habeas corpus as emergency matters and expeditiously resolve these issues and ensure that the petitioner receives notice of the disposition.

11. The trial courts presently allowing county judges to preside over mental health proceedings, including Chapter 394, should review their practices to ensure that those practices comply with current Florida law.

12. Clerks of court and judges should implement a system whereby the clerk's office checks felony, misdemeanor, injunction, abuse, neglect, exploitation, and divorce records to determine if there are any cases pending within the jurisdiction for the respondent or petitioner. If there are any pending cases, the relevant files should be presented to the judge together with the ex parte petition.

13. The bar should be educated as to their responsibilities in handling involuntary placement proceedings.

14. When involuntary placement hearings are held in receiving facilities, steps should be taken to increase the probability that patients understand that a formal court hearing is taking place:

    • the proceedings should not be conducted by video;
    • courtroom formalities should be observed; and
    • the presiding officer should wear a robe.

15. While the five-day issue is being clarified by the Legislature, the Chief Justice of the Florida Supreme Court should contact every chief judge and probate judge and encourage them to ensure that involuntary placement hearings are conducted within at least five working days of the petition being filed, unless a continuance is requested by the patient with consent of counsel, and granted. In order to comply with the statute, in most jurisdictions hearings would have to be held at least twice a week.

16. The chief judge of every judicial circuit should immediately implement procedures to ensure that involuntary placement hearings are conducted within five working days, unless a continuance is granted. In order to comply with the statute, most circuits will need to hold hearings at least twice a week.

17. The Probate Section of the Florida Conference of Circuit Judges should immediately address the five-day issue (for conducting involuntary placement hearings) with its members.

18. The Probate Rules Committee and the Civil Procedure Rules Committee of The Florida Bar should determine whether probate or civil rules apply to Chapter 394 proceedings. Then the appropriate rules committee should consider whether to propose rules to clarify the procedures in regard to involuntary placement hearings.

19. If a petition for the appointment of a guardian advocate is filed, the court should conduct a hearing and make a finding as to the patient's capacity to consent to treatment at the earliest possible time.

20. At the time the court considers a motion for continuance, the court should conduct a hearing and make a finding as to the capacity to consent to treatment if there is a pending request. If the court finds that the capacity to consent to treatment is lacking, a guardian advocate should be appointed at the time the involuntary placement hearing is continued.

21. The courts should comply with section 394.467(5), Florida Statutes, and ensure that continuances are granted only when they are requested by the patient with consent of counsel.

22. Judges and general masters should ensure that the evaluation of less restrictive treatment alternatives (section 394.467(1)(b)) are given equal weight under the law with the criteria found in section 394.467(1)(a).

23. The Florida Bar Probate Rules Committee and The Florida Bar Civil Procedure Rules Committee should consider amending the rules of procedure to allow parties to waive the waiting period for entry of a court order in Chapter 394 proceedings when no exceptions will be filed, or alternatively allow for procedures similar to those used for hearing officers in family law cases (Rule 12.491).

24. The Subcommittee strongly recommends against allowing guardians to voluntarily place a ward in a mental health facility without judicial review.

25. Judges, general masters, state attorneys, and public defenders should receive training on "dumping" and vigilantly guard against that or other abuses of the Baker Act in situations involving elder residents of nursing homes or assisted living facilities. If dumping or abuse is suspected, it should be immediately reported to the Agency for Health Care Administration and the Long-Term Care Ombudsman.

26. The Florida Bar Commission on the Legal Needs of Children should study the legal needs of children under the Baker Act.

27. Each judicial circuit, which has not already done so, should review and consider adapting and adopting the model forms prepared by the Department of Children and Families.

Public Defenders

1. Each public defender should ensure that experienced and trained attorneys are assigned to involuntary placement cases.

2. To ensure quality representation of patients, each public defender should place a high priority on representing patients in involuntary placement proceedings and ensure that each case to which that office is appointed is adequately prepared prior to hearing. The

Florida Legislature should provide adequate resources to enable public defenders to provide quality representation for all patients in involuntary placement proceedings.

3. Every attorney representing a patient in involuntary placement proceedings must vigorously represent the patient's expressed desires. Every attorney representing patients in involuntary placement proceedings must be bound to the same legal and ethical obligations of any lawyer representing a client.

4. The Florida Public Defenders Association should develop a model curriculum or training videotape on involuntary examination and placement procedures, and associated issues.

5. State attorneys and public defenders should be provided with training on jail diversion programs for individuals with mental illnesses.

State Attorneys

1. Each state attorney should ensure that experienced and trained attorneys are assigned to involuntary placement cases.

2. Each state attorney should place a high priority on involuntary placement proceedings and properly prepare the cases on behalf of the state. The Florida Legislature should provide adequate resources to enable state attorneys to provide quality representation for the state in involuntary placement.

3. Each state attorney's office should independently evaluate and confirm the allegations set forth in the petition for involuntary placement. If the information is found to be correct, the state attorney should vigorously prosecute the petition. If the allegations are not substantiated, the state attorney should withdraw the petition.

4. Assistant state attorneys representing the state in involuntary placement proceedings must be bound to the same legal and ethical obligations of assistant state attorneys prosecuting other cases.

5. The state attorney's office must be represented at and actively participate in every hearing. The court should require the presence of the state attorney's office at every involuntary placement hearing. If a representative of the state attorney's office is not present at the hearing, the court should halt the proceeding while the state attorney is summoned.

6. At involuntary placement hearings, judges and general masters should require the state attorneys to comply with the statutory requirement to prove that all less restrictive alternatives have been investigated and found to be inappropriate.

7. The Florida Association of Prosecuting Attorneys should develop a model curriculum and/or training videotape on involuntary examination and placement procedures and associated issues.

8. The Florida Association of Prosecuting Attorneys and The Florida Bar should ensure that continuing legal education programs on elder, mental health, and disability laws and issues are made available on an on-going basis.

9. The bar should be educated as to attorneys' roles and responsibilities in handling involuntary placement proceedings.

10. State attorneys and public defenders should be provided with training on jail diversion programs for individuals with mental illnesses.

Division of Administrative Hearings

The Division of Administrative Hearings should ensure that hearings on petitions for continued involuntary placement are conducted prior to the expiration of the original placement order.

Department of Children & Families

1. The Florida Legislature, the Department of Children and Families, and other policy makers should adequately fund quality community supports and services for persons with mental illnesses.

2. The Florida Legislature should fund positions within the Department of Children and Families for the purpose of exploring less restrictive alternatives to involuntary placement and require the Department to report to the court on same.

3. The Florida Legislature should direct the Department of Children and Families to create a pamphlet that explains the purpose and statutory requirements of the ex parte process. The Department should provide copies of the pamphlet to the clerks of court for distribution to everyone seeking to file an ex parte petition. The Department should make the pamphlet available in large print and other accessible formats as required by the Americans with Disabilities Act, as well as in English, Spanish, Creole, and other common languages reflective of Florida's population.

4. The Florida Statutes should be revised to mandate that the rights pamphlet prepared by the Department of Children and Families be distributed to every mental health patient–both voluntary and involuntary–upon admission. The pamphlet should be available in large print and other accessible formats as required by the Americans with Disabilities Act, as well as English, Spanish, Creole, and other common languages reflective of Florida's population.

5. The Department of Children and Families, Department of Elder Affairs, appropriate sections of The Florida Bar, and mental health activists should collaborate on the production of a videotape that explains the rights of individuals with psychiatric disabilities.

6. The Department of Children and Families, The Department of Elder Affairs, appropriate sections of The Florida Bar, the medical community, and mental health activists should publicize the availability of mental health advance directives, to allow individuals to maximize self-determination.

7. The Department of Children and Families, The Department of Elder Affairs, local bar associations, and mental health activists should conduct community workshops to educate qualified individuals about mental health issues and the opportunity to volunteer as a guardian advocate.

8. The Florida Department of Law Enforcement and the Department of Children and Families should jointly initiate a comprehensive training program for law enforcement officers, incorporating a minimum:

    - A videotaped orientation to the Baker Act for statewide use, which emphasizes the criteria for initiating an involuntary examination; and
    - Crisis intervention training for appropriate interaction with persons with mental illnesses.

Human Rights Advocacy Committees (Later known as Florida Local Advocacy Councils and defunded by the Florida Legislature in 2010 despite being cited in numerous places in the Baker Act)

1. The Florida Legislature should consider authorizing and funding the Statewide Human Rights Advocacy Committee and the local Human Rights Advocacy Committees to meet with patients and make them aware of their rights.

2. The Florida Legislature should consider authorizing and adequately funding the Statewide Human Rights Advocacy Committee and local Human Rights Advocacy Committees to assess the ability of all voluntary patients to give express and informed consent to treatment.

3. The Florida Legislature should extend standing to file petitions for writ of habeas corpus to the Statewide Human Rights Advocacy Committee and the local Human Rights Advocacy Committees, to further protect the rights of persons who are voluntarily and involuntarily hospitalized.

Agency for Health Care Administration

1. The Florida Legislature should adequately fund the Agency for Health Care Administration and require the Agency to actively monitor and vigorously enforce regulations related to community facilities, such as assisted living and other facilities, to improve the quality of care and services for residents.

2. The Florida Legislature should provide the Agency for Health Care Administration with adequate funds and staff, and direct the Agency to vigorously enforce regulations in regard to violations by mental health facilities and professionals.

3. The Florida Legislature should require facilities to provide all petitions and orders for involuntary placement to the Agency for Health Care Administration within one working day.

4. The Florida Legislature should review the statutes and regulations to ensure that community facilities are adequately regulated. The Florida Legislature should also require community facilities that house people who require mental health treatment to facilitate those persons' access to such treatment by qualified professionals.

5. The Florida Legislature should direct the Department of Children and Families, the Agency for Health Care Administration, the Long-Term Care Ombudsman, or other appropriate entity to study whether nursing homes and other facilities are "dumping"

residents because of a lack of funding to treat conditions not covered by governmental programs and private insurance, as well as for fraudulent financial gain.

6. Forms related to involuntary examination and placement, including disposition, should be collected, monitored, and analyzed by the Agency for Health Care Administration on an on-going basis in order to detect and address abuses in a timely fashion. All forms should include the patient's date of birth, race, gender, and other demographic information, so that the impact of Chapter 394 on elders, children, racial minorities, and other population groups can be collected and analyzed. The results of this statewide data collection and analysis should be reported to the Florida Legislature, Department of Children and Families, and the State Courts System on an annual basis. Adequate funding should be provided by the Legislature to permit such data collection, research, and analysis.

Miscellaneous Appropriations:

1. The Florida Legislature should make funding available to jurisdictions that are willing to coordinate an interdisciplinary exploration of innovative alternatives designed to reduce the traumatic effect of involuntary examinations. Such pilot projects should be monitored and evaluated by independent entities, to determine their effectiveness.

2. The Florida Legislature should review and correct any funding inequities that are created when residents of one county are involuntarily placed in another county (relates to costs of hearings, independent expert examinations, etc.).

3. The Florida Legislature should fund a guardian advocate system that provides each geographical area with a readily available pool of guardian advocates who have training in mental health issues and psychotropic pharmacology, to serve on behalf of individuals with psychiatric disabilities for whom no family or friends are willing or able to serve.

Recommended Changes to 394

1. The Florida Legislature should review rights and protections afforded to individuals with mental illnesses under Chapter 394 and ensure that they are no less than the rights and protections afforded to nursing home residents under Chapter 400.

2. The Florida Legislature should consider revising the statutes to specify that violation of a mental health patient's rights constitutes "abuse" within the meaning of the law.

3. The Florida Legislature should consider whether the definition of mental illness should be amended to exclude dementia, Alzheimer's disease, and traumatic brain injury.

4. The Florida Legislature should consider expanding the list of professionals in 394.4625(1)(c) (independent assessment of residents in facilities licensed under chapter 400 seeking voluntary admission to a receiving facility) to prohibit the involvement of any professional who has a financial interest in the outcome of the assessment.

5. The Florida Legislature should consider the feasibility and appropriateness of extending the protections of section 394.4625(1)(c), Florida Statutes (independent assessment of residents in facilities licensed under chapter 400), to involuntary as well as voluntary examination situations.

6. The Florida Legislature should amend the statutes to expressly permit the use of less-restrictive alternatives to involuntary in-patient examinations.

7. The Florida Legislature should consider amending Chapter 394 to allow county courts to issue *ex parte* orders for involuntary examination, but maintain exclusive circuit court jurisdiction over involuntary placements.

8. The Florida Legislature should consider improvements to the *ex parte* provisions of section 394.463, Florida Statutes, including but not limited to:

   • requiring and funding a pre-screening process;

   • requiring a hearing prior to the issuance of an *ex parte* order; and

   • clarifying the time frame within which the behavior in question must be observed.

9. The Florida Legislature should consider amending Chapter 394 in regard to petitions for *ex parte* orders, to require a factual recitation of the circumstances that support the finding that the criteria for involuntary examination have been met.

10. The Florida Legislature should amend the statutes to clarify that the 72-hour involuntary examination period is not extended over weekends or holidays, unless a petition for involuntary placement will be filed on the next working day.

11. The Florida Legislature should amend the statutes to clarify whether the five-day requirement includes or excludes weekends and holidays. If the Legislature determines that involuntary placement hearings must be held within five consecutive days, adequate additional funding must be provided to the courts, clerks, state attorneys, and public defenders to enable them to conduct meaningful, as well as timely, proceedings.

12. The Florida Legislature should consider amending section 394.467(5), Florida Statutes (continuance of involuntary placement hearings), as indicated hereinafter in this report.

13. The Florida Legislature should direct and fund an interdisciplinary study on whether state attorneys should be authorized to have access to clinical records, facility staff, and other pertinent information.

14. The Florida Legislature should direct and fund an interdisciplinary study on the continued involuntary placement process.

15. The Florida Legislature should consider amending the statutes to provide an explicit right for independent examinations in continued involuntary placement proceedings.

16. The Florida Legislature should amend the statutes to clarify the duties, responsibilities, and authority of patient representatives.

17. The Florida Legislature should direct the Statewide Public Guardian to recommend a process and responsible entity to initiate a guardianship evaluation for persons who are mentally incapacitated and need intervention but who do not meet the statutory criteria of the Baker Act.

18. The Florida Legislature should consider providing limited liability protection for family members, friends, and individuals who serve as guardian advocates on a volunteer basis. Community workshops should be conducted to educate qualified individuals about mental health issues and the opportunity to volunteer as a guardian advocate.

19. The Florida Legislature should consider amending Chapter 394 to permit Chapter 744 guardians and Chapter 393 guardian advocates to participate in alternative placement decisions and receive adequate notice of the decision-making process.

20. The Florida Legislature should direct and fund a comprehensive interdisciplinary study on the legal needs of children under the Baker Act, including but not limited to:

    - whether children under the age of 18 should have the right to voluntarily consent to in-patient mental health treatment, without the consent of their guardian.

    - whether the Human Rights Advocacy Committees or another independent entity should have the authority to make contact with a child confined to a mental health facility, to confirm the voluntariness of the child's consent.

    - whether a child's right to petition for a writ of habeas corpus pursuant to Chapter 394 is adequately protected and whether legal counsel should be provided.

    - whether judicial review of placement of children in mental health facilities should be required, to ensure the appropriateness of involuntary placements and the voluntariness of voluntary admissions.

General

Family members and persons who are designated as mental health surrogates should participate in guardian advocate training prior to the time their service is needed, to avoid unnecessary delay in the provision of treatment.

APPENDIX II:

Compendium of Appellate Cases, Attorney General Opinions, and Other Legal References

Outline of Topics

I. Evidence Supporting Criteria for Involuntary Inpatient Placement
   - A. In General
   - B. Outpatient Commitment
   - C. Waiver of Patient's Presence at Placement Hearing
   - D. Notice to and Participation of State Attorney at Involuntary Placement Hearings
   - E. Duty of State Attorney and Role of Counsel for Receiving Facility in Involuntary Placement Hearings
   - F. Deadline for Filing Petitions and Notices
   - G. Appeal Not Moot
   - H. Jurisdiction of Courts
   - I. Testimony

II. Clinical Records and Confidentiality

III. Public Records Law

IV. Payment of Involuntary Placement Bills

V. Transportation of Baker Act Patients

VI. Law Enforcement
   - A. Warrantless Entry — Exigent Circumstances
   - B. Detention and Custody
   - C. Use of Force
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VII. Responsibilities of and Lawsuits Against Doctors and Receiving Facilities
   - A. Duty to Warn
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VIII. Guardianship and Adult Protective Services

IX. Baker Act and Minors

X. Baker Act and Criminal Defendants

XI. Marchman Act

I. Evidence Supporting Criteria for Involuntary Inpatient Placement

A. In General

***Zinermon v. Burch*, 494 U.S. 113, 110 S.Ct. 97, 108 L.Ed.2d 1005 (1990).** Burch, while allegedly medicated and disoriented, signed forms for voluntary admission to a state mental hospital. After his release he sued physicians, administrators, and staff of the hospital, among others, for depriving him of his liberty without due process of law, alleging that "they violated state law by admitting him as a voluntary patient when they knew or should have known that he was incompetent to give informed consent to his admission, and that their failure to initiate Florida's involuntary placement procedure denied him constitutionally guaranteed procedural safeguards." The U.S. District Court for the Northern District of Florida granted the defendants' motion to dismiss because "a deprivation of a constitutionally protected property interest caused by a state employee's random, unauthorized conduct does not give rise to a § 1983 procedural due process claim unless the State fails to provide a postdeprivation remedy," and Burch appealed. The U.S. Circuit Court of Appeals affirmed, but after rehearing en banc reversed and remanded. The Supreme Court affirmed the reversal of the motion to dismiss, stating: "The characteristics of mental illness . . . create special problems regarding informed consent. Even if the State usually might be justified in taking at face value a person's request for admission to a hospital for medical treatment, it may not be justified in doing so, without further inquiry, as to a mentally ill person's request for admission and treatment at a mental hospital." Further, the defendants could not

> escape § 1983 liability by characterizing their conduct as a "random, unauthorized" violation of Florida law which the State was not in a position to predict or avert, so that all the process Burch could possibly be due is a postdeprivation damages remedy. Burch, according to the allegations of his complaint, was deprived of a substantial liberty interest without either valid consent or an involuntary placement hearing, by the very state officials charged with the power to deprive mental patients of their liberty and the duty to implement procedural safeguards. Such a deprivation is foreseeable, due to the nature of mental illness, and will occur, if at all, at a predictable point in the admission process.

***O'Connor v. Donaldson*, 422 U.S. 563, 95 S.Ct. 2486, 45 L.Ed.2d 396 (1975).** The Court held that a state "cannot constitutionally confine, without more, a nondangerous individual who is capable of surviving safely in freedom by himself

or with the help of willing and responsible family members and friends," and there is "no constitutional basis for confining [mentally ill] persons involuntarily if they are dangerous to no one and can live safely in freedom."

***Standard Jury Instructions-Criminal Cases (99-2)*, 777 So. 2d 366 (Fla. 2000).** "Clear and convincing evidence" is defined as "evidence that is precise, explicit, lacking in confusion, and of such weight that it produces in your mind a firm belief or conviction, without hesitation, about the matter in issue."

***In re Beverly*, 342 So. 2d 481 (Fla. 1977).** The Florida Supreme Court stated that the Baker Act, authorizing involuntary commitment of mentally ill persons, "has withstood the attack of vagueness and overbreadth. We hold the statute to be constitutional on its face." But it reversed the order for involuntary hospitalization, noting, among other things, that the state and the examining physician had sought an order for involuntary hospitalization of the appellant for up to six months even though the examining physician stated that the appellant "would be ready to leave the hospital in one month." Further, one psychiatrist did not conclude that the appellant "was likely to injure himself or others and that he was in need of care but unable to make a responsible application on his own behalf." And "the evidence is not clear and convincing that appellant would likely injure himself or others if allowed to remain at liberty. Appellant is mentally ill and in need of care or treatment, but it does not appear by clear and convincing evidence that he is dangerous or that he lacks sufficient capacity to make a responsible application on his own behalf."

***Lischka v. State*, 901 So. 2d 1025 (Fla. 1st DCA 2005).** The state filed a confession of error, and the appellate court reversed the order of involuntary commitment, stating:

> Although we are concerned about the significant problems that can occur when mental health patients refuse to take their prescribed medication, the statute and case law require reversal. . . . It is well-settled that the need for treatment and medication and the refusal to take medication despite a deteriorating mental condition, standing alone, do not justify involuntary commitment under the Baker Act. . . . Rather, there must also be clear and convincing evidence that without treatment, the patient would pose a real and present threat of substantial harm to himself, or a substantial likelihood that in the near future he will inflict serious bodily harm on himself or another, as evidenced by recent behavior.

***A.E. v. State*, 83 So. 3d 1000 (Fla. 3d DCA 2012).** The appellate court affirmed an involuntary civil commitment order, finding competent substantial evidence to support it. The appellant, who was arrested and charged with aggravated battery, had been found incompetent due to schizophrenia and paranoia "and has remained incompetent with no substantial probability that she will become competent to stand trial in the foreseeable future. [She] has a long history of mental illness, perceptual disturbances, substance abuse, numerous hospitalizations, and non-compliance with treatment and medication." Further, the trial court noted that the appellant "has poor insight as to her condition and mental health needs, she had to be placed on suicidal precautions approximately two weeks prior to the hearing, and numerous attempts to place her in the community have failed."

***Rosicka v. State*, 898 So. 2d 1098 (Fla. 1st DCA 2005).** The trial court entered an order for involuntary placement, finding that the appellant had a history of multiple suicidal gestures. But the appellate court reversed, stating that "review of court record does not reveal any evidence to support that determination [or] any competent substantial evidence that the appellant posed a threat to herself through neglect."

***Craig v. State*, 804 So. 2d 532 (Fla. 3d DCA 2002).** The appellant was arrested for stalking a news reporter and was ordered to involuntary placement for treatment. The appellate court affirmed the order, stating: "A threat can be express or implied. . . . In determining whether there has been a threat, the court must look at the totality of the circumstances, including not only the words and deeds of the patient, but diagnoses and expert opinions of the mental health professionals." The appellate court also stated: "Under the statutory standard, there must be a showing of a 'substantial likelihood that in the near future he or she [the patient] will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or **threatening** such harm,'" and that "serious bodily harm would include any harm that would necessitate medical treatment. Because of potential for death or serious injury in kidnapping cases, a threat of kidnapping or false imprisonment would satisfy the statute."

***Boller v. State*, 775 So. 2d 408 (Fla. 1st DCA 2000).** The appellate court held that testimony that the patient refused to take her psychotropic medication, had slapped a hospital staff member, and believed others were trying to kill her, and the expert psychiatrist's conclusory testimony "that it was 'more likely than not' that [the patient] might inflict serious bodily harm on herself or another person," was not "clear and convincing evidence that she pose[d] a present threat of substantial harm" to justify involuntary commitment. "[T]estimony that a person may have threatened someone in the past does not amount to clear and convincing evidence

that she is a current danger to others."

***Singletary v. State*, 765 So. 2d 180 (Fla. 1st DCA 2000).** The appellate court held that the state failed to prove by clear and convincing evidence that a Baker Act patient met the criteria for involuntary placement. Testimony that the patient "may have threatened others at some point in the past" did not amount to clear and convincing evidence that she was a danger to others. In addition, testimony that she "would likely have to be rehospitalized, if she did not take her medication" was insufficient to prove "a real and present threat of substantial harm to . . . her well-being." Further, "the state did not present clear and convincing evidence that less restrictive treatment alternatives were unavailable," since the patient's mother testified that she wanted to have her daughter live with her in a better environment and that "she would ensure that her daughter continued to take her medication, and promised to initiate involuntary commitment proceedings if she did not."

***Blue v. State*, 764 So. 2d 697 (Fla. 1st DCA 2000)**. The appellate court held that evidence that a Baker Act patient was unstable and threatening to others, that her emotional outbursts scared her family, and that she was "generally very argumentative and hostile" did not constitute clear and convincing evidence "that there is a substantial likelihood that in the near future she will inflict serious bodily harm on herself or another person." The court reversed the order of involuntary placement and treatment and remanded.

***Berry v. State*, 751 So. 2d 764 (Fla. 1st DCA 2000).**The court reversed the trial court's order of involuntary placement for treatment, stating that "the record does not clearly and convincingly establish the nature, extent, and likelihood of any future harm. . . . While the appellant might derive some benefit from further treatment in a structured living arrangement, this does not justify a Baker Act commitment."

***Lyon v. State*, 724 So. 2d 1241 (Fla. 1st DCA 1999).** The appellate court reversed the trial court order of involuntary commitment that was based on a doctor's opinion that if the schizophrenic woman did not take her medication, "she w[ould] be almost incoherent in her speech, not able to take care of herself, she'll require supervision, she'll require structure." The appellate court held that the trial court's finding was not based on clear and convincing evidence; there was no specific showing that any self-neglect posed a real and present threat of substantial harm to the appellant's well-being.

***Adams v. State*, 713 So. 2d 1063 (Fla. 1st DCA 1998).** The court reversed the trial court's order of involuntary placement for treatment, holding that a Baker Act

commitment was not justified by clear and convincing evidence where the order referred to

> a purported witness who did not testify, and describes the factual basis of the ruling by merely quoting from the petition for involuntary placement. Furthermore, while the court also made oral findings at the conclusion of the hearing, a need for treatment and medication does not in itself justify a Baker Act commitment. . . . Rather, there must be clear and convincing evidence that without treatment the appellant would pose a real and present threat of substantial harm to his own well-being, or a substantial likelihood that in the near future he would inflict serious bodily harm on himself or another, as evidenced by recent behavior.

***Archer v. State*, 681 So. 2d 296 (Fla. 1st DCA 1996).** The appellate court reversed an order for involuntary placement, finding that there was no clear and convincing evidence that the patient "was 'incapable of surviving alone,' or that she was 'likely to suffer from neglect or refuse to care for" [her]self if released. The testifying psychologist acknowledged that the patient had not threatened to hurt herself or anyone else. Further, the patient also testified that if she were released she would take her medication.

***Wade v. Northeast Florida State Hosp.*, 655 So. 2d 125 (Fla. 1st DCA 1995).** The court reversed an order for continued involuntary placement, holding that "these conclusory recitations" regarding "the appellant's potential for aggression, and the possibility of substantial harm to his well-being . . . are not fully substantiated by the facts in evidence."

***Bradley v. Akins*, 650 So. 2d 1069 (Fla. 2d DCA 1995).** The administrator of a hospital challenged a final administrative order denying his request for continued involuntary placement of the appellee. The appellate court reversed, holding that the administrator "showed by clear and convincing evidence that [the appellee] continued to meet the criteria for continued involuntary placement." The appellee had killed his girlfriend in1986, "based on the delusion that she had taken his money. He was judged incompetent to proceed to trial and was committed to psychiatric care at Florida State Hospital, where he spent six years." He was transferred to another hospital pursuant to an order finding that he "remained incompetent to proceed to trial and was unlikely to regain competency in the foreseeable future." At the continued involuntary placement hearing, the administrator's sole witness was a doctor who testified that the appellant "would not be capable of surviving off the grounds of the hospital either alone or with the

help of willing family or friends, that without treatment he would suffer from neglect and refuse to care for himself, and that he was a danger to himself and others" based on recent threats he had made.

***Hedrick v. Florida Hospital Medical Center*, 633 So. 2d 1153 (Fla. 5th DCA 1994).** The court held that a Baker Act patient's "potential for the exercise of 'poor judgment'" was insufficient to satisfy the statutory test for involuntary examination. The psychiatrist's testimony lacked a factual basis to show a present threat of substantial harm to the patient's well-being.

***Salter v. State*, 618 So. 2d 352 (Fla. 1st DCA 1992).** A person was involuntarily committed to a state hospital pursuant court order. A psychiatrist testified that the person "refused to cooperate with any treatment recommended," but he did not state what treatment or medication was recommended or necessary. He testified that the person "was in danger of self-neglect or some violent act and needed to be involuntarily placed for further care and supervision . . . , but he did not state the nature of the self-neglect." The court held that the psychiatrist's testimony was insufficient to support involuntary commitment.

***Welk v. State*, 542 So. 2d 1343 (Fla. 1st DCA 1989).** The appellate court reversed the trial court order for involuntary placement at a state hospital, finding "the evidence legally insufficient to support the necessary finding that appellant poses a real and present threat of substantial harm to herself or others." The court stated:

> As stated by both expert witnesses, the ideal situation would be a facility in the local community to provide minumum [sic] supervision less than that required in a mental hospital. But a declaration of incompetency and involuntary incarceration in a mental institution is not the appropriate solution to this problem. The strict test for involuntary commitment imposed by the statute is intended to prevent the incarceration in mental institutions of people who are in need only of alternative means for minimum care and maintenance.

***Everett v. State*, 524 So. 2d 1091 (Fla. 1st DCA 1988).** The appellate court reversed an order of involuntary placement "because the state failed to present evidence that, because of her mental illness, appellant refused voluntary placement for treatment, or was unable to determine whether placement was necessary." The only evidence "was that appellant was hospitalized 'on multiple occasions' as a result of her failure to take medication prescribed for her condition." The record didn't indicate "whether the hospitalizations were voluntary or involuntary, initiated by appellant or someone else." Further, the appeal took so long that the

appellant had already been ordered to "continued" involuntary placement upon expiration of the original court order. The appellate court held that the original placement order was not superseded by the order of continued involuntary placement and stated: "If a circuit judge's order of initial involuntary placement is erroneous, subsequent administrative orders of continued involuntary placement, predicated as they are on the initial order, do not render challenges to that order moot." The appellate court urged those who challenge involuntary placement orders "to seek expedited appellate review, or to promptly challenge the order in a habeas corpus petition to the circuit court."

***Schexnayder v. State*, 495 So. 2d 850 (Fla. 1st DCA 1986).** The trial court entered an order for involuntary commitment of the appellant, who "forgets to take her medication, without which she becomes disoriented, nervous, and agitated, and ultimately in need of hospitalization." The appellate court reversed the order, noting: "Appellant has a place to live, financial resources . . . , insight into her mental illness, knowledge of the necessity for medication, and a history of self-admissions to hospitals. . . . The mere conclusion that a person is in need of care or treatment . . . is insufficient."

***Asman v. State*, 268 So. 2d 464 (Fla. 4th DCA 1985).** The appellate court affirmed the trial court's order for involuntary placement, which stated that the appellant met the criteria and referred to two expert opinions. The court stated: "While it is unfortunate that the individual's present loss of control over his life is based on a split decision, the majority of the panel are of the opinion, after review of the record, which admittedly in large part is the transcript of an inferior tape, that the statutory criteria have all been met. . . . [I]t is not our province to substitute our judgment for the trier who observed the witnesses as well as appellant."

***Neff v. State*, 356 So. 2d 901 (Fla. 1st DCA 1978).** Even though the appellant was mentally ill and there was testimony that he was unable to recognize his illness, the order of involuntary commitment was reversed because there was no evidence that he "was incapable of caring for himself in freedom."

B. Outpatient Commitment

***C.N. v. State*, 433 So. 2d 661 (Fla. 3d DCA 1983).** The circuit court had ordered that C.N. "obtain outpatient psychiatric treatment as the 'least restrictive means of intervention'" and retained jurisdiction in case she failed to do so. When C.N. did not continue outpatient treatment, the court entered a contempt judgment against her. The appellate court reversed, noting that for contempt there must be a willful disregard or disobedience of a court order, and in this case all three physicians who

were witnesses at the contempt hearing testified that C.N. had "a 'basic personality problem' related to the psychiatric disorder which gives her 'difficulty in following directions.' The evidence presented did not support a finding of contemptuous intent, an element of criminal contempt." Further, the appellate court stated:

> There is no statutory authority for the court to retain jurisdiction for the purpose of modifying an action taken on an earlier petition. The imposition of a more restrictive intervention, *i.e.*, involuntary placement, requires, at the minimum, a new petition for involuntary hospitalization, a notice of hearing and a hearing on the petition. For a court to order involuntary hospitalization, it is not sufficient that the patient merely failed to follow a plan for outpatient treatment. There must be clear and convincing proof that an individual is dangerous to herself or others before the state may deprive her of her freedom on the basis of mental illness alone.

***G.T. v. Stone*, 622 A.2d 491 (Vt. 1993).** G.T. was released from a Vermont state hospital on conditional discharge. The discharge was revoked, and G.T. brought a declaratory judgment action challenging the constitutionality of Vermont's statute governing conditional discharges. The Supreme Court of Vermont reversed and remanded, holding that "a postrevocation hearing under [18 V.S.A.]§ 8008(e) is insufficient to meet Vermont's due process standards, and that a prerevocation hearing is required except in an emergency, whether or not requested by the patient."

The following appellate cases around the country regarding involuntary outpatient commitment laws may be of interest:

- **Standards used**

  ***Matter of Maricopa County Cause No. MH-90-00566*, 840 P.2d 1042 (Ariz. Ct. App. 1992).** L.R. was committed to a state hospital for inpatient treatment followed by supervised outpatient treatment. The appellate court rejected his argument that the statute defining "persistently or acutely disabled" in relation to the provision defining "mentally disorder" was unconstitutionally vague and overbroad. It also held the evidence was sufficient "to support the [trial] court's conclusion that he was persistently or acutely disabled."

  ***Hermann v. Arkansas*, 1998 WL 118116 (Ark. Ct. App. 1998).** The appellate court reversed a commitment order (for a combination of inpatient

and outpatient) on "danger to self or others" grounds. The state failed to prove Hermann was dangerous, although he had refused his medication and was acting erratically.

***In re Johnson*, 691 A.2d 628 (D.C. Ct. App. 1997).** A voluntary outpatient can be committed involuntarily for outpatient treatment if he or she meets the statutory requirements.

***In re J.P.*, 574 N.W.2d 340 (Iowa 1998).** The evidence was insufficient to support that a depressed woman who stopped taking her medication and took her children to a battered women's shelter was "seriously mentally impaired" and in need of treatment. The order requiring involuntary outpatient commitment was reversed.

***In re LaBelle*, 728 P.2d 138 (Wash. 1986).** The appellate court upheld a commitment for a mix of inpatient and outpatient treatment. The statutory standard of "grave disability" was not unconstitutionally vague or overbroad.

***In Matter of William S.*, 570 N.W.2d 253 (Wis. Ct. App. 1997).** **(unpublished disposition).** The appellate court affirmed an outpatient commitment order because the trial court's finding of dangerousness wasn't "clearly erroneous." Two doctors, who disagreed about the degree of possible danger but agreed with the treatment order, had testified.

- **Revocation of Outpatient Status**

***Matter of Plummer*, 608 A.2d 741 (D.C. Ct. App. 1992).** A patient whose outpatient status was revoked but who was later released on indefinite convalescent leave status has "the same due process rights as a patient who is originally committed as an outpatient."

***Matter of Stokes*, 546 A.2d 356 (D.C. Ct. App. 1988).** Absent a finding of dangerousness, the revocation of outpatient status for noncompliance (medication) violates D.C.'s commitment law.

***In re James*, 507 A.2d 155 (D.C. Ct. App. 1986).** Before revoking outpatient status, "the trial court must make an explicit finding that inpatient treatment is the least restrictive alternative."

***In re Richardson*, 481 A.2d 473 (D.C. Ct. App. 1984).** "[A] trial court may authorize an outpatient's summary rehospitalization in certain

circumstances, provided the patient is detained only temporarily and the Hospital complies with the affidavit and notice requirements." The procedures used for summary rehospitalization don't violate due process.

***Matter of Mills*, 467 A.2d 971 (D.C. Ct. App. 1983).** The court was not required to apply a "clear and convincing" standard of evidence in a proceeding redetermining that a committed outpatient was mentally ill and dangerous, resulting in his indefinite hospitalization.

***Application of True*, 645 P.2d 891 (Idaho 1982).** The minimum requirements for revocation of outpatient status are "prompt written notice" and "a revocation hearing before a neutral hearing body to be held as soon as is reasonably possible following the patient's rehospitalization."

***In re K.B.*, 562 N.W.2d 208 (Mich. Ct. App. 1997).** K.B. spent 30 days in a hospital and then was outpatient committed. Her outpatient status was revoked, without notice or a hearing, for medication noncompliance. The court held that no due process violation occurred: "The various measures to ensure that the individual's rights are protected in the initial treatment determination, combined with the continued right of the individual to appeal during treatment, afford satisfactory protection. . . . In addition, the brief duration of the treatment period minimizes the risk of any erroneous deprivation of liberty resulting from changed circumstances."

***Matter of Commitment of B.H.*, 514 A.2d 85 (N.J. Super. Ct. Law Div. 1986).** "This summary revocation of B.H.'s conditional discharge by recommitment, although done under emergent conditions, constitutes a violation of her due process rights since it was not done by court review."

***State v. Bryant*, 871 P.2d 129 (Or. Ct. App. 1993).** Due process does not require "the state to prove that the person remains mentally ill at the time of the [outpatient commitment status] revocation proceeding."

***In re Cross*, 662 P.2d 828 (Wash. 1983).** The trial court "had no authority, absent a finding that [the gravely disabled person] had not adhered to the conditions attached to her less restrictive treatment or initiation of a second original commitment proceeding, to order [her] returned to inpatient status." Even if it had such authority, the patient was not given adequate notice of the grounds on which her return to inpatient status was sought.

***In re P.S.*, 702 A.2d 98 (Vt. 1997).** An order of nonhospitalization may be revoked without "a showing of dangerousness." It is sufficient if the state

proves the patient is "in need of further treatment" (the statute allows use of a "patient in need of further treatment" standard, under which the effect of discontinuing treatment is relevant).

***G.T. v. Stone*, 622 A.2d 491 (Vt. 1992).** "[D]ue process requires a judicial hearing prior to recommitment, whether or not requested by the patient, unless immediate recommitment is required because the person poses an imminent danger of harm to himself or another."

***In re G.K.*, 514 A.2d 1031 (Vt. 1986).** Orders for involuntary treatment of indeterminate duration violate due process, "absent provision for state-initiated periodic review."

- **Other**

***Randolph v. Cervantes*, 950 F.Supp. 771 (S.D. Miss. 1996).** While residing at a state-associated mental health care facility, the plaintiff injected her eyes with a roommate's insulin and lost her vision. She brought a civil rights lawsuit against the facility and an employee, which the trial court dismissed. The appellate court affirmed, holding that the court order for outpatient treatment was "insufficient to give rise to a special relationship . . . which would have imposed an affirmative duty on the part of the State to provide for her safety." The state does not have a duty "to protect an individual against private violence."

***Matter of Utley*, 565 N.E.2d 1152 (Ind. Ct. App. 1991).** Although rendered moot, it was error for the trial court to find the person in contempt for failure to comply with an outpatient commitment order without determining "whether his conduct was willful or a manifestation of his mental illness."

***In Interest of T.J.*, 482 N.W.2d 850 (S.D. 1992).** An indefinite treatment order is subject to periodic review even if it is for outpatient treatment.

C. Waiver of Patient's Presence at Placement Hearing

***Mouliom v. Northeast Florida State Hosp.*, 128 So. 3d 979 (Fla. 1st DCA 2014).** A hearing for continued involuntary inpatient placement was held by an ALJ, and the assistant public defender representing the appellant waived her presence. The ALJ entered an order continuing placement for another six months, which the appellant contended was fundamental error. The appellate court agreed and reversed the order, stating: "Even though [her] attorney affirmatively waived her presence at the hearing, we are not precluded from considering the issue raised in

this appeal because 'a denial of the due process right to be present at an involuntary commitment hearing is fundamental error which may be raised on appeal even if not preserved below.'" The right is not limited to initial commitment hearings. "The patient also has a fundamental right to be present at the periodic hearings held by an ALJ . . . to consider whether to continue the patient's commitment. The patient can waive the right to be present at the hearing, but for such a waiver to be valid, the ALJ 'must certify through proper inquiry that the waiver is knowing, intelligent, and voluntary.'" While the record showed that the patient was aware of the hearing and voluntarily chose not to attend, there was no indication that she "knew of her right to be present at the hearing or the purpose of the hearing. Without such knowledge, [she] could not have knowingly and intelligently waived her right to be present." Also, "the ALJ did not make any inquiry into [her] mental state on the morning of the hearing and whether she had the ability to comprehend the right that she was waiving."

***Register v. State*, 946 So. 2d 50 (Fla. 1st DCA 2006).** "[A] patient has a fundamental right to be present at a commitment proceeding [and] a court must certify through proper inquiry that the waiver is knowing, intelligent, and voluntary."

***Ibur v. State*, 765 So. 2d 275 (Fla. 1st DCA 2000).** The court held that a hearing officer committed reversible error by not permitting a Baker Act patient to testify at his hearing for involuntary hospitalization, stating: "Because involuntary commitment is a substantial deprivation of liberty at which fundamental due process protections must attach, the patient cannot be denied the right to be present, to be represented by counsel, and to be heard."

***Williams v. State*, 692 So. 2d 257 (Fla. 1st DCA 1997).** The appellate court reversed an order for involuntary commitment and remanded, holding that the record did not show that the appellant had waived his right to be present. While an individual may waive the right "to be personally present and be constructively present through counsel, the court must certify through proper inquiry that the waiver is knowing, intelligent and voluntary."

***Joehnk v. State*, 689 So. 2d 1179 (Fla. 1st DCA 1997).** The appellate court reversed an order for involuntary commitment and remanded, holding that the appellant's lawyer informing the trial court that the appellant did not wish to appear at an involuntary commitment hearing was an insufficient waiver of his fundamental right to be present. While an individual may waive the right "to be personally present and be constructively present through counsel, the court must certify through proper inquiry that the waiver is knowing, intelligent and

voluntary."

D. Notice to and Participation of State Attorney at Involuntary Placement Hearings

***Wickland v. State*, 642 So. 2d 670 (Fla. 1st DCA 1994).** The appellate court held that the trial court failed to comply with the requirements of the Baker Act when it did not serve notice of an involuntary placement hearing on the state attorney's office, the state attorney did not appear at the hearing, the state's psychiatrist did not assert personal knowledge of the underlying facts of the case, and the trial court's order of involuntary placement quoted verbatim from the petition.

***Jones v. State*, 611 So. 2d 577 (Fla. 1st DCA 1992).** The appellate court reversed the trial court's order for involuntary placement because the former patient's due process rights were violated:

> The state attorney's office was not represented at the hearing, and there is nothing in the record to indicate that notice was served on the state. We are cognizant that in proper circumstances, the absence of a representative for the state in a Baker Act proceeding may be deemed harmless. . . . However, in the instant case, it appears the absence of the state was a contributing factor in the due process deficiencies attendant upon the proceeding. Appellant's treating psychiatrist was the only witness. He testified in a loose, narrative fashion, marked by generalities and speculation concerning appellant's potential for violence. The psychiatrist's opinions seemingly were based upon reports received from other unidentified persons, which hearsay went unchallenged.

***Jordan v. State*, 597 So. 2d 352 (Fla. 1st DCA 1992).** The appellate court affirmed the trial court's orders for involuntary placement. Although no state attorney was present at the hearings and the trial judge examined the witnesses, any error was harmless because "the trial judge conducted the proceeding in an impartial and neutral manner and accorded appellants all of the constitutional and statutory rights to which they are entitled."

E. Duty of State Attorney and Role of Counsel for Receiving Facility in Involuntary Placement Hearings

***In re [V.S.]*, No. 95-577-IN 003 (Fla. 6th Cir. Ct. Feb. 13, 1995).** With regard to the participation of the attorney for a receiving facility in a Baker Act involuntary placement hearing, the court held that

> the facility has every right to employ legal counsel to represent their legal interests in any proceeding where the facility's legal rights, liabilities or corporate interests are implicated.
>
> Since future actions of the facility, either in providing ordered treatment, or arranging for discharge of the patient, are predicated on the outcome of the hearing, the facility is entitled to have counsel present during the adjudicatory process. Counsel for the facility, although present at the hearing, may not interpose evidentiary objections or participate in questioning witnesses. This is the assigned role of the state attorney. While the facility may be a party in interest for the purpose of placing the controversy before the court, they do not have a legally protectable interest in the outcome of an adjudication of the need for involuntary mental health treatment. The statute permits the facility administrator to throw out the first ball, but the constitutional rights of the patient require that the state attorney pitch the game.

Op. Att'y Gen. Fla. 74-53 (1974), Duties of state attorney in habeas proceedings. "Absent express statutory authority, the state attorney is not responsible for representing the administrator of a private treatment facility, which has a contract to take patients in need of hospitalization pursuant to [the Baker Act] in a habeas corpus proceeding involving a petition for involuntary hospitalization in which the state is not a party."

F. Deadline for Filing Petitions and Notices

***Pullen v. State*, 802 So. 2d 1113 (Fla. 2001).** Pullen appealed an order for her continued involuntary civil commitment. Her public defender filed an *Anders* brief, "stating that he could discern no reversible error in the proceedings below. Despite being given the opportunity to file her own pro se brief, Pullen did not do so. The State filed a motion to dismiss the appeal, arguing that the *Anders* procedure does not apply to civil commitment proceedings. The First District Court of Appeal agreed and dismissed Pullen's appeal." But the supreme court reversed, noted that "[i]n a criminal context, a 'no-merit' letter and withdrawal, such as the procedure used in the instant case, would clearly not be sufficient," and held that "the *Anders* procedure should apply to involuntary civil commitments." But it stated further that it was

> concerned that it may be a hollow remedy for those appellants who pursue an *Anders* appeal. At oral argument, the parties recognized that

> under the present time frame the appeals process often exceeds the six-month commitment period. . . . In fact, this delay would also occur in cases where counsel files an arguably meritorious appeal of a civil commitment order under the Baker Act.
>
> In light of this time frame, we request the Appellate Rules Committee to consider the adoption of expedited procedures for the appeal of civil commitment orders under the Baker Act. Procedures that the committee should consider include, but are not limited to, an expedited time frame for the filing of the notice of appeal, a shortened time for the serving of briefs, and a provision requiring the appointment of a guardian ad litem."

***D.M.H. v. Pietilla*, 33 So. 3d 800 (Fla. 5th DCA 2010).** The appellate court held that rule 1.090, Florida Rules of Civil Procedure (now rule 2.514(a), Florida Rules of Judicial Administration), governs the computation of time prescribed for an involuntary inpatient placement hearing under section 394.467(6)(a)1., Florida Statutes. That rule provides that Saturdays, Sundays, and legal holidays are excluded when the time period is less than seven days. Therefore, the appellate court affirmed the trial court's denial of the patient's petition for a writ of habeas corpus that was based on the failure to hold a hearing within five calendar days.

***Johnson v. Johnson*, 585 So. 2d 1188 (Fla. 2d DCA 1991)**. A master entered findings and recommendations awarding sole custody of the parties' minor child to the father. The next day the trial court issued an order adopting those findings and recommendations, which deprived the mother of the right to serve exceptions to the master's report within 10 days of service on her under rule 1.490, Florida Rules of Civil Procedure. The appellate court therefore vacated the order and remanded.

G. Appeal Not Moot

***Godwin v. State*, 593 So. 2d 211 (Fla. 1992).** The Supreme Court of Florida held that an appeal from a civil commitment order under the Baker Act does not become moot solely because the person subject to the order has already been released. The court considered the "collateral legal consequences" of involuntary commitment; i.e., unpaid fees for patient services constituting a lien on property. It also mentioned other consequences that, while not rising to the level of collateral legal consequences, are significant, such as societal stigma, restrictions on privileges and opportunities (e.g., restriction on driver licenses, the right to vote, and the right to carry a concealed weapon).

H. Jurisdiction of Courts

***W.M. v. State*, 992 So. 2d 383 (Fla. 5th DCA 2008).** The trial court ordered the patient to be involuntarily committed for three weeks. The patient didn't respond to treatment, so the hospital administrator sought continued treatment, and the court ordered six more months of treatment. The patient appealed, arguing that the court had no jurisdiction to order the continued treatment. The appellate court affirmed, holding that although continued involuntary placement hearings are administrative, "the circuit court retains concurrent jurisdiction over the involuntary commitment proceedings. . . . [T]he Legislature's intent was that the administrative hearing requirement applies after a patient is committed to a long-term treatment period at a treatment facility" instead of a community-based receiving facility. Because the initial order was for short-term treatment, the court properly exercised jurisdiction to order further treatment. "However, once long-term treatment is ordered, a petition for continued treatment must be addressed in an administrative hearing."

***Liebman v. State*, 555 So. 2d 1242 (Fla. 4th DCA 1989).** "[A] determination that a person is incompetent . . . is clearly within the constitutionally described jurisdiction of a circuit court and is of a judicial nature." However, a hearing officer can determine continued incompetency after a circuit court has made the initial determination.

I. Testimony

***U.S. v. Chase*, 340 F.3d 978 (9th Cir. 2003).** The appellate court held that psychiatrists can't testify against patients who make dangerous or threatening confessions during therapy, but affirmed the defendant's conviction because the admission of the psychiatrist's testimony in this case was harmless. The court ruled that although psychiatrists are sometimes required to report certain threats to authorities, prosecutors can't use testimony from psychotherapists to help convict their patients. The court concluded that "the gain from refusing to recognize a dangerous-patient exception to the psychotherapist-patient testimonial privilege in federal criminal trials outweighs the gain from recognizing the exception." It stated that "although incarceration is one way to eliminate a threat of imminent harm, in many cases treatment is a longer-lasting and more effective solution. A criminal conviction with the help of a psychotherapist's testimony is almost sure to spell the end of any patient's willingness to undergo further treatment for mental health problems." The court noted that its ruling doesn't extend to proceedings in civil court over whether the patient should be committed to a hospital.

***Linn v. Fossum*, 946 So. 2d 1032 (Fla. 2006).** The Florida Supreme Court

resolved a conflict between the First and Fourth district courts of appeal, holding an expert may not "testify on direct examination that the expert relied on consultations with colleagues or other experts in forming his or her opinion. . . . [S]uch testimony is inadmissible because it impermissibly permits the testifying experts to bolster their opinions and creates the danger that [they] will serve as conduits for the opinions of others who are not subject to cross-examination." The court emphasized that its opinion "in no way precludes experts from relying on facts or data that are not independently admissible in evidence '[i]f the facts or data are a type reasonably relied upon by experts in the subject.'"

***Rogers v. State*, 40 So. 3d 888 (Fla. 5th DCA 2010).** The trial court permitted the state to have the arresting officer testify from China via satellite, finding that "the State interest and necessities of the case warranted the use of the satellite procedure." The defendant appealed, arguing that his constitutional right to confront a witness was violated. But the appellate court affirmed, stating that his rights of confrontation had been protected: "The methodology utilized allowed the witness to be fully cross examined by the defense, and the jury was fully able to observe the demeanor of the witness as he testified." The appellate court also held that "the oath element, backed up by the possibility of the imposition of the penalties of perjury, was met."

***Mitchell v. State*, 98 So. 3d 694 (Fla. 2d DCA 2012).** After being convicted of being a sexually violent predator, Mitchell was ordered to civil commitment. The trial court denied his petition for release from commitment, relying on the state's medical expert witness's testimony that it was not safe for Mitchell to be at large, although Mitchell's medical expert testified to the contrary. The appellate court affirmed, stating: "The trial court's determination of the weight and credibility of competing expert opinions in chapter 394 proceedings will not be overturned unless clearly erroneous."

II. Clinical Records and Confidentiality

***Jaffee v. Redmond*, 518 U.S. 1, 116 S.Ct. 1923, 135 L.Ed.2d 337 (1996).** "[C]onfidential communications between a licensed psychotherapist and her patients in the course of diagnosis or treatment are protected from compelled disclosure." The Court stated:

> Effective psychotherapy depends upon an atmosphere of confidence and trust, and therefore the mere possibility of disclosure of confidential communications may impede development of the relationship necessary for successful treatment. The privilege also

> serves the public interest, since the mental health of the Nation's citizenry, no less than its physical health, is a public good of transcendent importance. In contrast, the likely evidentiary benefit that would result from the denial of the privilege is modest. That it is appropriate for the federal courts to recognize a psychotherapist privilege is confirmed by the fact that all 50 States and the District of Columbia have enacted into law some form of the privilege."

The Court explained the rationale for extending the privilege to "confidential communications made to licensed social workers in the course of psychotherapy." The Court rejected the use of in camera inspections as a means to balance the competing interests of the criminal defendant and the witness, saying that "[m]aking the promise of confidentiality contingent upon a trial judge's later devaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege."

***Opis Management Resources, LLC v. Secretary, Florida Agency for Health Care Admin.*, 713 F.3d 1291 (11th Cir. 2013).** Section 400.145, Florida Statutes, "which provides for the release of medical records of deceased residents of nursing homes to certain specified individuals," is preempted by the confidentiality provisions and regulations of the federal HIPAA Act. Therefore, nursing facilities properly declined to provide requested records of deceased residents to spouses and attorneys-in-fact who had not been appointed personal representatives of the residents' estates. The HIPAA privacy rule prohibits "covered entities" from disclosing "protected health information" except in specified circumstances. Sections 164.502(a)(1)(i) and (g)(1) of 45 C.F.R. allow disclosure to a "personal representative." The court refused to interpret the term "personal representative" to include a spouse as provided in section 400.145, Florida Statutes. Therefore, for disclosure of the medical records of a deceased nursing home resident, an estate would have to be opened and a personal representative will have to be appointed.

***Caraballo v. State*, 39 So. 3d 1234 (Fla. 2010).** The defendant was convicted of first degree murder, among other crimes, and sentenced to death. The appellate court affirmed the convictions but vacated the sentence and remanded for a new penalty phase. It held that the trial court erred in permitting the mental health expert who had conducted the defendant's competency evaluation to testify, over defense objections, during the penalty phase. His testimony was introduced by the state to show that the expert opined at the time of the evaluation that the defendant was being untruthful and was malingering. The trial court abused its discretion by permitting this testimony as rule 3.211, Florida Rule of Criminal Procedure, clearly protects its confidentiality, and the error was not harmless.

***State v. Roberson*, 884 So. 2d 976 (Fla. 5th DCA 2004).** The defendant sought production of the mental health records of his alleged victim (a juvenile). The trial court ordered an in camera inspection of the records to determine whether disclosure was warranted. The state sought review and the appellate court quashed the order, stating that while the records of the alleged victim's Baker Act proceedings were subject to in camera inspection and possible disclosure, her other mental health records were not: "[N]either the Evidence Code, nor any applicable constitutional principle allows the invasion of a victim's privileged communications with her psychotherapist."

***Cedars Healthcare Group, Ltd. v. Freeman*, 829 So. 2d 390 (Fla. 3d DCA 2002).** Freeman sued Cedars Healthcare Group, alleging she was assaulted by at least two male patients while she was a patient there. The trial court granted her motion for production of photographs of all male patients who were in the ward during a specified three-day period. The appellate court quashed the order granting her motion, stating that she did not show a compelling need for the evidence "that outweighs the constitutional privacy rights of these non-party psychiatric patients."

***Community Psychiatric Centers of Florida, Inc. v. Michael Bevelacqua*, 673 So. 2d 948 (Fla. 4th DCA 1996).** The trial court granted the plaintiff's discovery request for the names and addresses of certain former patients of the defendant psychiatric hospital who witnessed a personal injury incident, and the identity of a patient who had been involved in a similar incident. The hospital sought review, and the appellate court quashed the trial court order, stating that clinical records are confidential unless waived by "express and informed consent"; there is no "waiver by silence." Further, the patient's need for the information did not outweigh "the possible harm of disclosure to the patients."

***State v. Famiglietti*, 817 So. 2d 901 (Fla. 3d DCA 2002).** A defendant in a criminal case cannot "invade the victim's privileged communications with her psychotherapist [even] if the defendant can establish a reasonable probability that the privileged matters contain material information necessary to his defense." The court disagreed with *State v. Pinder*, 678 So. 2d 410 (Fla. 4th DCA 1996), in which the Fourth District Court of Appeal held otherwise. It also noted that "the more recent decision of the United States Supreme Court in *Jaffee* rejects the idea of applying a balancing test to the psychotherapist-patient privilege."

***Trainor v. State*, 768 So. 2d 1123 (Fla. 2d DCA 2000).** The trial court excluded from evidence the records relating to the victim's hospitalization two years earlier under the Baker Act and "the victim's other mental health records associated with the hospitalization." The defendant appealed, but the appellate court affirmed,

finding no evidence that the victim's mental health records indicated that his mental condition "affected his propensity to tell the truth" or that he suffered from a mental condition at the time of the incident or trial that "affected his ability to observe, remember, and accurately recount matters about which he testified."

***Butterworth v. X Hosp.*, 763 So. 2d 467 (Fla. 4th DCA 2000).** In its investigation of Medicaid fraud, the Attorney General's Office served subpoenas on a hospital. The hospital produced the requested business records but did not produce the mental health treatment records of adolescent Medicaid patients, some of which contained information regarding substance abuse treatment. The Attorney General's Office agreed that substance abuse records required a court order, but argued that it was entitled to the mental health treatment records without a court order. The circuit court issued an order "requiring court approval of investigative subpoenas for Medicaid patient records involving adolescent mental health treatment," holding that the Attorney General must show good cause for the release of the records. The Attorney General sought certiorari review, which the appellate court denied, agreeing with the circuit court.
NOTE: The court had applied the 1997 version of section 394.4615, Florida Statutes, but the statute was amended in 2000 to specifically provide: "Clinical records relating to a Medicaid recipient shall be furnished to the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request." § 394.4615(6), Fla. Stat.

***Katlein v. State*, 731 So. 2d 87 (Fla. 4th DCA 1999).** The court set out a mechanism for determining when it is appropriate for a court to order the release of Baker Act records. The party seeking the records must first make a threshold showing that the privileged records "'are likely to contain relevant evidence.' . . . The defendant must advance a good faith factual basis which is not 'merely a desperate grasping at a straw.' . . . In other words, no fishing expeditions." If the showing is made, "the court will do an in camera inspection." Then if the court concludes that the records do contain relevant information, it should allow the parties access to them "in order to determine whether disclosure of the information to the trier of fact is 'required to ensure the defendant a fair trial.'" The burden is on the party seeking disclosure to demonstrate that disclosure is required.

Op. Att'y Gen. Fla. 08-20 (2008), Patient Records -- Emergency Medical Services.

> Section 401.30(4), Florida Statutes, makes specific provision for records of emergency calls: "Records of emergency calls which contain patient examination or treatment information are confidential

> and exempt from the provisions of s. 119.07(1) and may not be disclosed without the consent of the person to whom they pertain, but appropriate limited disclosure may be made without such consent. . . .
>
> This subsection does not prohibit providing information to *any law enforcement agency* or any other regulatory agency responsible for the regulation or supervision of emergency medical services and personnel.
>
> While the . . . subsection recognizes the sensitive nature of medical records, the statute authorizes access to specified individuals and entities without the patient's consent. Section 401.30(4), Florida Statutes, clearly provides that the subsection, which makes emergency call records containing patient examination or treatment information confidential and exempt from disclosure without the patient's consent, does not prohibit a licensee from providing information to *any* law enforcement agency.
>
> Accordingly, I am of the opinion that section 401.30(4), Florida Statutes, permits an emergency medical services transportation licensee to release records of emergency calls which include the patient's name, address, and pertinent medical information to a local law enforcement agency that does not provide regulatory or supervisory responsibility over the emergency medical services licensee.

See also:

***State v. Johnson*, 814 So. 2d 390 (Fla. 2002)**

***Acosta v. Richter*, 671 So. 2d 149 (Fla. 1996)**

***Estate of Stephens ex rel. Clark v. Galen Health Care Inc.*, 911 So. 2d 277 (Fla. 2d DCA 2005)**

***Lemieux v. Tandem Health Care of Florida Inc.*, 862 So. 2d (Fla. 2d DCA 2003)**

***O'Neill v O'Neill*, 823 So. 2d 837 (Fla. 5th DCA 2002)**

***Attorney ad Litem for D.K. v. Parents of D.K.*, 780 So. 2d 301 (Fla. 4th DCA 2001)**

***Ussery v. State*, 654 So. 2d 561 (Fla. 4th DCA 1995)**

***Hunter v. State*, 639 So. 2d 72 (Fla. 5th DCA 1994)**

III. Public Records

***Tribune Co. v. D.M.L*, 566 So. 2d 1333 (Fla. 2d DCA 1990).** The court held that a Baker Act hearing is a closed hearing which the media and the public cannot attend. The hearings contain the clinical record of the patient, which is not a public record and which is deemed confidential pursuant to then-section 394.459(9), Florida Statutes (now see section 394.4615). The public policy for having a closed Baker Act hearing is "to avoid substantial injury" to the patient's liberty interest and individual dignity.

Op. Att'y Gen. Fla. 97-67 (1997), clerk's authority to maintain confidentiality of confidential information contained in the official records.

> It is the clerk's responsibility . . . to devise a method to ensure the integrity of the Official Records while also maintaining the confidential status of information contained therein. . . . Nothing in the Public Records Law or the statutes governing the duties of the clerk authorizes the clerk to alter or destroy Official Records. However, the statute does impose a duty on the clerk to prevent the release of confidential material that may be contained in the Official Records. . . . [T]here is nothing that precludes the clerk from altering reproductions of the Official Records to protect confidential information. The manner in which this is to be accomplished rests within the sound discretion of the clerk.

Op. Att'y Gen. Fla. 93-51 (1993), regarding whether law enforcement records under the Baker Act are public records. A law enforcement officer's "event or incident report prepared after a specific crime has been committed which contains information given during the initial reporting of the crime, and which is filed with the law enforcement agency as a record of that event, is not confidential [and is a public record subject to inspection and copying pursuant to ch. 119, F.S." However, the "written report detailing the circumstances under which the person was taken into custody" is made a part of the patient's clinical record and is confidential and exempt from the Public Records Law.

Op. Att'y Gen. Fla. 91-10 (1991), regarding the inspection and copying requirements of Baker Act and Marchman Act records in the possession of the clerk of court. Baker Act patients' clinical records produced pursuant to then-section 394.459(9), Florida Statutes (now see section 394.4615), are specifically

made confidential and are exempt from being inspected and copied by the public as provided for in chapter 119, Florida Statutes. "Generally, when materials are filed with the clerk of court, such records are open to the public. In AGO 89-94, this office concluded that in the absence of a specific statutory provision or court rule making a record confidential or dictating the manner of its release and absent a court order closing a particular court record, probate records filed with the clerk of court are subject to Ch. 119, F.S."

Op. Att'y Gen. Fla. 86-101 (1986), regarding whether the statutorily required reports of a law enforcement officer under the Baker Act are exempt from disclosure. A law enforcement agency prepares an "event form," an "incident report–narrative form," and a "report of law enforcement officer" form when a person is taken into custody under the Baker Act. Only the latter "report of law enforcement officer" form, "which is statutorily required to be included in the clinical record of a patient, is confidential and statutorily declared not to be a public record. The event forms or incident reports, "which appear to be analogous to crime and arrest reports," are public records.

IV. Payment of Involuntary Placement Bills

Op. Att'y Gen. 07-11 (2007), regarding hospital authorities and immigrants without legal status.

> The intent of the . . . Hospital Authority's enabling legislation appears to be to provide medical services to those indigents who live within the district. [Therefore] the term "residents of the district" . . . was intended by the Legislature as a pure residence requirement, and not as a requirement for domicile, legal residence, or citizenship. Thus, the enabling legislation for the authority would appear to permit the authority to provide services to otherwise qualified indigent illegal aliens living within the district. Inasmuch as Chapter 04-421, Laws of Florida, does not distinguish between the types of indigent residents, it appears that the hospital authority should provide healthcare access to these aliens on the same basis as other indigent residents.

The opinion quoted case law that held: "Any place of abode or dwelling place constitutes a 'residence,' however temporary it may be, while the term 'domicile' relates rather to the legal residence of a person, or his home in contemplation of law. As a result one may be a resident of one jurisdiction although having a domicile in another."

Op. Att'y Gen. Fla. 93-49 (1993), regarding who is responsible for the payment of an involuntary Baker Act placement. A county is not primarily responsible for the payment of hospital costs. However, it may be liable for hospital costs if a person "is arrested for a felony involving violence to another person, is arrested for a felony involving violence against another person, is taken to a receiving facility and specified sources for reimbursement are not available." Depending on the Baker Act patient's ability to pay, the patient is primarily responsible for the payment of any hospital bill for involuntary placement under the Baker Act. However, if the patient is indigent, the state "is obligated to provide treatment at a receiving or treatment facility . . . without cost to the county."

Op. Att'y Gen. Fla. 74-271 (1974), Involuntary Hospitalization in Private Psychiatric Facility.

> A circuit court judge may order a patient involuntarily hospitalized at a private psychiatric facility not under contract with the State . . . provided the patient meets the statutory criteria for involuntary hospitalization, the facility has been approved by [DCF], and the cost of treatment is to be borne by the patient, if he is competent, or by his guardian if the patient is incompetent.
>
> When state funds are to be expended for involuntary hospitalization of a patient in a private psychiatric facility, such facility must be under a contract with the state.

V. Transportation of Baker Act Patients

***Administrator, Retreat Hosp. v. Johnson In and For Broward County*, 660 So. 2d 333 (Fla. 4th DCA 1995).** Four patients were certified by a hospital for involuntary placement and were transported to the hospital's facility by private individuals. The patients' public defender filed habeas corpus petitions, alleging that the patients had been transported by someone other than law enforcement, which violated the Baker Act. The trial court ordered that the sheriff devise a plan for transportation services in compliance with the law and that another hearing be held within 90 days to review the plan, and also ordered that "[a]ny person initiating a certificate or other document which is used to initiate an involuntary examination pursuant to either §§ 394.463(2) and (3), F.S. shall file with the clerk of courts within 24 hours of its execution the original certificate or other original document." At the hearing the hospital moved to strike all pleadings and vacate the order "for lack of subject matter jurisdiction, arguing that the trial court was conducting an improper regulatory and advisory inquiry without subject matter

jurisdiction because the matters were now moot as a result of the patients' release and because the writs had been dismissed." The trial court denied the motion and rendered another order, which the hospital also claimed was outside the court's authority and it sought a writ of prohibition. The appellate court disagreed with the hospital on certain issues, stating that "the trial court had jurisdiction to conduct a judicial inquiry into the means by which the patients had been transported to the facility for involuntary examination if in violation of the statutory mandate and to issue appropriate orders to correct abuses of the provisions alleged to be violated," and the jurisdiction did not end just because the patients had been released. The appellate court also disagreed with the hospital that the special assistant public defender did not have standing to file the habeas petitions. But it granted the writ of prohibition, stating: "[W]hen the trial court, in its . . . order indicated its intent to consider additions to the statutory requirements for hospitalizing Baker Act patients by requiring a trial court order before hospitalization would be permissible, it was engaging in a process of statutory amendment beyond the scope of its powers."

***Pruessman v. Dr. John T. MacDonald Foundation*, 589 So. 2d 948 (Fla. 3d DCA 1991).** A patient was discharged from a hospital but refused to leave. The hospital administrator contacted an outside doctor to have the patient Baker Acted. The patient sued the hospital and the city, and the trial court dismissed the case. The appellate court affirmed, stating that the outside doctor was not alleged to be an agent of the hospital, "the mere request by [the hospital] for a proper Baker Act commitment does not in itself constitute a cognizable cause of action," and the city was not liable, as a matter of law, "for the act of its police officers in taking the plaintiff in custody [based on the doctor's] facially valid, executed certificate" and transporting him to a mental health facility because "the police had no discretion to refuse to do so" under the circumstances.

Op. Att'y Gen. Fla. 01-73 (2001), Mentally ill person transported to treatment facility.

> [S]ection 394.462, Florida Statutes, describes a comprehensive scheme for the transportation of persons to a receiving facility for involuntary examination and treatment when they are in the custody of a law enforcement agency. The general rule is that where statutory language is plain and definite in meaning without ambiguity, it fixes the legislative intention and statutory interpretation and construction are not needed.
>
> . . . . [I]f 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 noncriminal 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 arrested shall be processed through the criminal justice system as any other criminal suspect and is entitled to examination and treatment in the facility where he or she is held.

Op. Att'y Gen. Fla. 85-81 (1985), Transporting and Receiving Baker Act Patients. "[T]he law enforcement agency designated by the county is the only agency authorized to transport persons to the receiving facility in the absence of an agreement with an emergency medical transport service to perform this transportation" or a court order otherwise.

> The statutes do not require a county facility to have the capability to house patients for 72 hours in order to be qualified to be designated by [DCF] as a receiving facility. Where a person is being transported to a so-called "alternate receiving facility" for an involuntary examination, the transportation provisions . . . remain applicable. . . . The Sheriff's Office is liable for negligent ministerial acts committed in the transportation of patients under [the Baker Act].

Op. Att'y Gen. Fla. 78-123 (1978), Counties, patient transportation. The Baker Act "does not authorize or require counties to pay the costs of transferring *nonindigent*, nonresident mentally ill patient in treatment facilities in Florida to treatment facilities in the states of their residence."

Op. Att'y Gen. 74-108 (1974), regarding costs of transporting mental patients. "[A] municipal police department is required to transport patients to a receiving facility pursuant to an *ex parte* order of the court or a physician's certificate or when a law enforcement officer makes an independent judgment that a person is in need of emergency examination and treatment." The Baker Act doesn't require any patient or guardian or representative to pay for transportation to a receiving facility. Instead, when "a law enforcement officer is required to transport patients

to a receiving facility, the costs incurred are simply a part of the budgeted operating expenses of the municipal police department."

VI. Law Enforcement

A. Warrantless Entry — Exigent Circumstances

***Michigan v. Fisher*, 558 U.S. 45, 130 S.Ct. 546, 175 L.Ed.2d 410 (2009).** Officers had been called to the residence because the decedent was "going crazy. They "found a household in considerable chaos" and saw blood on a pickup truck in the driveway and on a door of the house and could see Fisher through a window, screaming and throwing things. The front door was blocked by a couch and the back door was locked. The officers knocked, but Fisher did not answer. They saw he had cut his hand and asked him whether he needed medical attention. He ignored their questions and "demanded, with accompanying profanity, that the officers go to get a search warrant." When an officer pushed the front door open and started going into the house, he saw Fisher pointing a gun at him and withdrew. Fisher was charged with assault with a dangerous weapon and possession of a firearm during the commission of a felony.

Fisher filed a motion to suppress the officer's statement about him pointing a gun, which the state trial court granted, holding that the officer violated the Fourth Amendment of the U.S. Constitution when he entered the house. The state appellate court affirmed. But the U.S. Supreme Court reversed, holding that the search was proper under the "emergency aid" exception to the warrant requirement, under which officers "may enter a home without a warrant to render emergency assistance to an injured occupant or to protect an occupant from imminent injury."

***Brigham City, Utah v. Stuart*, 547 U.S. 398, 126 S.Ct. 1943, 164 L.Ed.2d 650 (2006).** Officers responding to a call about a loud party saw juveniles drinking in the yard and "saw through a screen door and windows an altercation in the kitchen between four adults and a juvenile, who punched one of the adults, causing him to spit blood in a sink. An officer opened the door and announced the officers' presence," but no one noticed. So the officer went into the kitchen and again called out, and the fight stopped. The officers arrested the participants and charged them with various misdemeanors. The trial court granted the defendants' motion to suppress, the state appellate court affirmed, and the state supreme court affirmed as well, finding that the officers had violated the Fourth Amendment protection against unreasonable search and seizure: "The injury caused by the juvenile's

punch was insufficient to trigger the so-called 'emergency aid doctrine'" and the officers weren't seeking to help the injured adult but rather were acting in their law enforcement capacity. Further, the state supreme court held that "the entry did not fall within the exigent circumstances exception to the warrant requirement." But the U.S. Supreme Court granted certiorari and reversed, stating:

> It is a "basic principle of Fourth Amendment law that searches and seizures inside a home without a warrant are presumptively unreasonable." . . . Nevertheless, because the ultimate touchstone of the Fourth Amendment is "reasonableness," the warrant requirement is subject to certain exceptions. . . . We have held, for example, that law enforcement officers may make a warrantless entry onto private property to fight a fire and investigate its cause, . . . to prevent the imminent destruction of evidence, . . . or to engage in "hot pursuit" of a fleeing suspect. . . . "[W]arrants are generally required to search a person's home or his person unless 'the exigencies of the situation' make the needs of law enforcement so compelling that the warrantless search is objectively reasonable under the Fourth Amendment." . . .
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> One exigency obviating the requirement of a warrant is the need to assist persons who are seriously injured or threatened with such injury. . . . Accordingly, law enforcement officers may enter a home without a warrant to render emergency assistance to an injured occupant or to protect an occupant from imminent injury. . . .

The Court reiterated that the officers' subjective motivations were not dispositive; an officer's action is reasonable under the Fourth Amendment if the circumstances, viewed objectively, justified the action. It also stated that the Fourth Amendment requires a "knock and announce" and "once the announcement was made the officers were free to enter. They did not have to wait until further danger was done. "The role of a peace officer includes preventing violence and restoring order, not simply rendering first aid to casualties."

***Seibert v. State*, 923 So. 2d 460 (Fla. 2006).** After Seibert locked out his roommate and said he was going to kill himself, the roommate called 911. Police officers responded, and Seibert opened the door a few inches, told them he was okay, and said they could leave. They entered anyway, saw a severed foot through a partly open bathroom door, and arrested Seibert for murder. He was convicted and sentenced to death and appealed, claiming, among other things, that "the trial court erred in denying his motion to suppress evidence discovered and statements made as a result of the nonconsensual, warrantless entry and search by the police of his

apartment." The Florida Supreme Court affirmed, stating that the roommate's 911 call about suicide established the necessary exigent circumstance because the officers had an objectively reasonable belief that Seibert's life was in danger. The court also cited "Seibert's strange behavior in not answering the door for four or five minutes after the officers first knocked, after which he immediately slammed the door."

The court also held that the officers' search after entry was constitutional, stating that "[t]he officers' quick look around the apartment was not an extensive search because they did not open any containers or even enter any other rooms. There has been no evidence that any pretense existed on the part of the police in this case. It was objectively reasonable for them to glance around to ensure that the apartment and Seibert were secure. Moreover, insufficient time had elapsed for the officers to determine that the exigency had passed."

***Riggs v. State*, 918 So. 2d 274 (Fla. 2005).** In the middle of the night, deputies were summoned to an apartment complex where a four-year-old girl had been seen wandering, naked and alone. The child was disoriented and "had no idea where she had wandered out of," so the deputies decided to search each apartment for her caretakers. They noticed that every door on the second floor was closed except one, and they thought the child might have come out of that apartment. They pounded on the door at least three dozen times, identifying themselves as police officers, but no one in the apartment responded. Concerned that "something had happened to the child's caregiver and that maybe there was a medical concern in there," the deputies entered the apartment. In the third room they looked in, they found Riggs and the child's babysitter. Riggs was arrested and filed a motion to suppress the evidence, which the trial court granted. The Second District Court of Appeal reversed, holding that "[t]he officers believed it was their duty to see that the child's caregiver was not incapacitated and justifiably entered the residence." The Florida Supreme Court approved the decision and disapproved the conflicting opinion of *Eason v. State*, 546 So. 2d 57 (Fla. 1st DCA 1989). It stated that the child "did not lead the deputies in any particular direction. A search based on a feared medical emergency, however, does not require certainty. The Fourth Amendment, which protects against unreasonable searches, requires only that the police reasonably believe that an emergency exists."

***Zakrzewski v. State*, 866 So. 2d 688 (Fla. 2004).** After Zakrzewski failed to report for class, his Air Force Sergeant called his home, hospitals, the Sheriff's Office, and the police. Unable to locate him, the sergeant went to his home, where he saw a broken window and accumulated mail and asked the Sheriff's Office to send a deputy. The deputy told dispatch that he "was going to enter the house through the

broken window to check on the welfare and see if there had been any kind of burglary inside." In the home the deputy found the dead bodies of Zakrzewski's wife and two children, and eventually Zakrzewski was tried for murder and sentenced to death. In a motion for postconviction relief he claimed, among other things, ineffective assistance of counsel for failure to move to suppress evidence. But the Supreme Court affirmed the trial court's denial of relief on that claim, stating that the deputy "did not enter Zakrzewski's home with the intent to seize evidence or make an arrest," and that in any case Zakrzewski had not shown that his attorney's failure to file a motion to suppress caused him prejudice; i.e., that he would not have pled guilty but for counsel's errors.

***Ortiz v. State*, 24 So. 3d 596 (Fla. 5th DCA 2009).** One evening a school called the Sheriff's Office to report that the parents of a six-year-old child had not picked him up. A deputy picked the child up and took him home, and knocked on the door, but got no response. The child led the officer into the garage, and the deputy could then see that a light was on in the house. The child invited the deputy to come into the house, and before entering the deputy announced his presence, but no one responded. The deputy and the child looked around but didn't find the parents, so the child led the deputy to the parents' bedroom, which was locked, and no one responded to the deputy knocking and announcing his presence again. Believing there might be an medical emergency "or worse," the deputy unlocked the door and looked under the bed and in closets "for a body," and saw bags of cocaine in the adjoining bathroom. When Ortiz entered the room, the deputy arrested him on drug charges. Ortiz filed a motion to suppress, arguing that "exigent circumstances did not justify a warrantless entry into his home, and specifically, the locked bedroom," and that "the six-year-old child did not have the authority to consent to the warrantless entry into the house." The trial court denied the motion, and the appellate court affirmed, stating that the deputy could have reasonably concluded that something was wrong. The appellate court noted that such cases require a balancing of two important values:

> our desire to have police officers perform the community caretaking function particularly in perceived emergent circumstances, and the warrant requirement to underpin a search. . . . [T]he benefit obtained by allowing officers to act without a warrant in perceived emergency situations must trump the marginal curtailment of the warrant requirement. This case does not present a new exception, nor does it diminish the respect for the sanctity of the home. Rather, it simply adheres to the holding of our supreme court in *Riggs,* and applies a recognized exception to the warrant requirement.

***Eastes v. State*, 960 So. 2d 873 (Fla. 5th DCA 2007).** Police were called to Eastes' apartment after a "[d]isturbance call, possible suicide." When they arrived, they saw Eastes in his doorway, with blood running down his arms. An officer could see broken glass on the apartment floor and "furniture in a state of disarray," along with other damage. The officer followed Eastes into his apartment, concluded he was "very intoxicated," and decided to take him to a mental health facility. The officer explained to Eastes that he was not under arrest, but Eastes began swinging his arms and hit the officer. He was taken to an ER and then to the police department, and was not taken to the Baker Act receiving facility because it wouldn't accept an arrested person. The officer did request in his police report that Eastes "be sent to the jail's 'physician unit'" because it "had mental health staff to treat suicidal individuals."

Eastes was charged with battery of a law enforcement officer, resisting an officer with violence, and resisting an officer without violence (for refusing to cooperate during booking). He filed a motion to suppress, which the trial court denied. The appellate court affirmed, stating: "The Fourth Amendment does not bar a police officer from making a warrantless entry into a residence when the officer reasonably believes that a person within is in need of immediate aid. . . . It was immaterial whether an actual emergency existed. The test is whether the officer reasonably believed an emergency existed at the time of the warrantless entry." Eastes also argued that the trial court erred in denying his motion for judgment of acquittal, claiming "the evidence was insufficient to establish that he met the criteria for an involuntary examination, and therefore, the officers were not engaged in the lawful execution of a legal duty." But the appellate court rejected that argument, stating:

> The Florida Mental Health Act authorizes a law enforcement officer to take a person who appears to meet the criteria for involuntary examination into custody. . . . Here, the evidence supports a determination that Eastes met the criteria for an involuntary examination. His behavior, his physical condition, and the condition of his apartment suggested a substantial likelihood that, without care or treatment, Eastes would cause serious injury to himself in the near future. The evidence further supported a conclusion that Eastes was possibly suicidal and unable to determine for himself whether an exam was necessary. Under these circumstances, the officers were justified in placing him in protective custody for involuntary examination.

B. Detention and Custody

***Graham v. Connor*, 490 U.S. 386, 109 S.Ct. 1865, 104 L.Ed.2d 443 (1989).**
Graham, a diabetic, noticed he was having an insulin reaction and asked a friend to drive him to a store to get orange juice. When Graham saw how many people were in the checkout line, he left the store and asked his friend to take him to another friend's house. A police officer saw Graham "hastily enter and leave the store" and, suspicious, followed him and stopped the car he was in. The officer ordered Graham and his friend to "wait while he found out what, if anything, had happened" at the convenience store, and when the officer went to his car to call for backup, Graham exited the car he was in, ran around it twice, and passed out on the curb. An officer rolled him over and cuffed him, ignoring the friend's "pleas to get him some sugar." Once Graham regained consciousness, the officers ignored his request to check his wallet for his diabetic decal, and when a friend brought some orange juice the officers would not let Graham have it. After getting a report that nothing had happened at the convenience store, the officers drove Graham home and released him. He later brought an action under 42 U.S.C. § 1983 based on injuries he allegedly sustained during the investigatory stop, alleging that the excessive force they used caused him to sustain "a broken foot, cuts on his wrists, a bruised forehead, and an injured shoulder; he also claims to have developed a loud ringing in his right ear."

The federal trial court granted the defendants' motion for a directed verdict, "applying a four-factor test for determining when excessive use of force gives rise to a § 1983 cause of action, which inquires, *inter alia*, whether the force was applied in a good faith effort to maintain and restore discipline or maliciously and sadistically for the very purpose of causing harm." The appellate court affirmed, "rejecting Graham's argument that it was error to require him to prove that the allegedly excessive force was applied maliciously and sadistically to cause harm, and holding that a reasonable jury . . . could not find that the force applied was constitutionally excessive." But the U.S. Supreme Court vacated and remanded the case, holding that the Court of Appeals erred in applying the four-part *Johnson v. Glick* test ("which requires consideration of whether the individual officers acted in 'good faith' or 'maliciously and sadistically for the very purpose of causing harm'"), rather than the reasonableness test, and stating:

> Determining whether the force used to effect a particular seizure is "reasonable" under the Fourth Amendment requires a careful balancing of " 'the nature and quality of the intrusion on the individual's Fourth Amendment interests' " against the countervailing governmental interests at stake. . . . Our Fourth Amendment jurisprudence has long recognized that the right to make an arrest or

> investigatory stop necessarily carries with it the right to use some degree of physical coercion or threat thereof to effect it. . . . [The proper application [of the test of reasonableness] requires careful attention to the facts and circumstances of each particular case, including the severity of the crime at issue, whether the suspect poses an immediate threat to the safety of the officers or others, and whether he is actively resisting arrest or attempting to evade arrest by flight. . . .
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> The "reasonableness" of a particular use of force must be judged from the perspective of a reasonable officer on the scene, rather than with the 20/20 vision of hindsight. . . . The Fourth Amendment is not violated by an arrest based on probable cause, even though the wrong person is arrested, . . . nor by the mistaken execution of a valid search warrant on the wrong premises. . . . With respect to a claim of excessive force, the same standard of reasonableness at the moment applies: "Not every push or shove, even if it may later seem unnecessary in the peace of a judge's chambers," *Johnson v. Glick*, 481 F.2d, at 1033, violates the Fourth Amendment. The calculus of reasonableness must embody allowance for the fact that police officers are often forced to make split-second judgments—in circumstances that are tense, uncertain, and rapidly evolving—about the amount of force that is necessary in a particular situation.
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> As in other Fourth Amendment contexts, however, the "reasonableness" inquiry in an excessive force case is an objective one: the question is whether the officers' actions are "objectively reasonable" in light of the facts and circumstances confronting them, without regard to their underlying intent or motivation. . . . An officer's evil intentions will not make a Fourth Amendment violation out of an objectively reasonable use of force; nor will an officer's good intentions make an objectively unreasonable use of force constitutional.

As to the federal civil rights violation count, the federal district court found that the civil commitment was constitutionally permissible under the facts, and therefore "there can be no policy or custom that officially sanctioned or ordered a constitutional violation." The court declined to retain jurisdiction over the state law claims.

***Thomas v. State*, 748 So. 2d 363 (Fla. 5th DCA 2000).** On their way to investigate

a call about a fight, officers saw Thomas walking 2½ blocks from the fight location, with blood on his face, chest, and arms. They questioned him, but he was "loud, incoherent, and flailing his arms around." He said he had weapons, so the deputies patted him down and found cocaine, and they arrested him. He filed a motion to suppress, which the trial court denied, stating that the stop and search were lawful "as a result of law enforcement exercising other activities other than criminal law enforcement." He appealed, but the appellate court affirmed, stating that the initial detention was justified by the Baker Act.

Op. Att'y Gen. Fla. 99-68 (1999), regarding who may take a person who appears to meet the criteria for involuntary examination into custody: state law enforcement, federal law enforcement, or both. The opinion advised a federal Veterans Affairs police officer that federal law enforcement officers are not law enforcement officers for purposes of the Baker Act, and they "possess no authority under the act to initiate the involuntary examination of a person or to transport such person [to a receiving facility] as law enforcement officers." The Baker Act provisions imposing certain transportation responsibilities on law enforcement officers "are not applicable to a federal veterans affairs police officer" unless, under the Florida Mutual Aid Act, state and local law enforcement agencies in Florida have entered into a mutual aid agreement with a federal law enforcement agency.

Op. Att'y Gen. Fla. 92-46 (1992), regarding the duties of law enforcement personnel. "Section 401.445(1), Florida Statutes, provides protection from recovery in any action brought for examining or treating a patient without his or her informed consent and extends such protection to 'any person acting under the direct medical supervision of a physician.'" But this does "not apply to law enforcement personnel acting under the direction of an emergency medical technician or paramedic" in restraining a patient who is refusing medical treatment. However, if a law enforcement officer is "personally receiving 'medical direction' from a physician [through two-way voice communication], he or she would be protected by the provisions of the statute."

Op. Att'y Gen. Fla. 85-86 (1985), Definition of minor criminal behavior.

> Words in statutes should be given the meaning accorded to them in common usage unless a different connotation is expressed in or necessarily implied from the context of the statute in which they appear. . . . As no definition of "minor" or "minor criminal behavior" has been provided in [the Baker Act] from which guidance may be obtained, the term must be construed in its plain and ordinary sense.

> . . . The language of [the Baker Act] distinguishes minor criminal behavior or noncriminal behavior from behavior which constitutes a felony.

However, in the absence of a legislative or judicial determination otherwise, the phrase "minor criminal behavior" "refers to criminal behavior which is not dangerous or not as serious as other criminal behavior" and "is not limited to crimes chargeable as misdemeanors but may include felonies which do not involve violence against another person."

Op. Att'y Gen. Fla. 74-39 (1974), Mental Health--Treatment of Federal Prisoner at Receiving Facility--Law Enforcement Officers--U.S. Marshals not Peace Officers under State Law. A federal prisoner held in a county jail pursuant to contract tried to kill himself. Fearing liability, the jail had marshals remove the prisoner, and they took him to a receiving facility for emergency admission. In response to the inquiries of the marshal's office, the attorney general opined that section 394.463, Florida Statutes, does "not exclude the admission of a federal prisoner to a receiving facility. Neither a United States marshal nor his deputy is a law enforcement officer within the meaning of s. 394.463. The State of Florida is not responsible for the cost incurred when a federal prisoner is admitted to a receiving facility pursuant to s. 394.463. A United States marshal is not a peace officer under Florida law." The opinion stated that 28 U.S.C.A. § 570 (see current 28 U.S.C.A. § 564),which provided that "[a] United States marshal and his deputies, in executing the laws of the United States within a State, may exercise the same powers which a sheriff of the State may exercise in executing the laws thereof," refers to when the marshal is executing the laws of the United States "and does not purport to authorize a marshal to execute the laws of a state."

C. Use of Force

***Valle v. City of Houston*, 613 F.3d 536 (5th Cir. 2010).** The plaintiffs' son, who suffered from depression and anxiety, was shot and killed by police officers who responded to a call at the family home. The plaintiffs sued the city, seeking relief under 42 U.S.C. § 1983, alleging excessive force. The district court granted the city's motion for summary judgment, and the appellate court affirmed. Although the court found "the actions and decisions of the officers involved in this unfortunate shooting to be very troubling, . . . the Valles did not present sufficient evidence to show that *the highly predicable consequence* of sending non-[Crisis Intervention Team] officers in response to their call for help would result in the shooting of their son."

***Oliver v. Fiorino*, 586 F.3d 898 (11th Cir. 2009).** The plaintiff's decedent died after being tased by police officers at least eight times in a two-minute period. The plaintiffs brought a 42 U.S.C. § 1983 claim alleging excessive force. The officers filed a motion for summary judgement based on qualified immunity. The trial court denied the motion, and the appellate court affirmed, stating that the officers were not entitled to qualified immunity:

> The facts, when viewed in a light most favorable to [the plaintiff], show that [the decedent] was neither accused nor suspected of a crime at the time of the incident, that Officer Fiorino tasered [him] at least eight and as many as eleven or twelve times with each shock lasting at least five seconds, that the officers made no attempt to handcuff or arrest [him] at any time during or after any Taser shock cycle, that the officer continued to administer Taser shocks to [the decedent] while he was lying on the hot pavement, immobilized and clenched up, and, finally, that these Taser shocks resulted in extreme pain and ultimately caused [his] death.

The appellate court agreed with the trial court "that the force employed was so utterly disproportionate to the level of force reasonably necessary that any reasonable officer would have recognized that his actions were unlawful."

***Furtado v. Yun Chung Law*, 51 So. 3d 1269 (Fla. 4th DCA 2011).** A man contacted the Sheriff's Office because his wife "was in a 'persistent severe delusional and agitated state,' had a 'long history of severe depression,' and had been 'walking around the house with knives.'" The Baker Act certificate stated that the wife "'essentially included everyone in her delusions system including her husband and [the psychiatrist]' and was 'probably holding knives at the moment.'" Three deputies responded, two with unholstered weapons and one with a Taser. In searching the house for the wife they entered the bathroom, where she came at the lead deputy with a knife raised over her head. The back-up deputy used his Taser but apparently missed, resulting in the lead deputy firing his weapon, killing the wife. The husband sued for a civil rights action under 42 U.S.C. § 1983, wrongful death under Florida law, and a claim under the ADA. The trial court granted the defendants' motion for summary judgment, and the appellate court affirmed, holding that exigent circumstances existed which the deputies did not create.

D. Weapons

Legal Note 2005-4, Miami-Dade Police Legal Bureau, May 5, 2005.

> Florida Statutes Section 933.14(3) states that no pistol or firearm taken by any officer with a search warrant or without a search warrant upon a view by the officer of a breach of the peace shall be returned except pursuant to an order of a trial court judge. If a firearm was seized pursuant to a search warrant, it cannot be returned without a court order.
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> Breach of the peace is a generic term which includes disturbances of public peace or order. In the context of Section 933.14(3) [it] also includes behavior which would be a violation of law. Use of a firearm or a threat or reference to use of a firearm would constitute a breach of the peace. An incident which resulted in taking a person into custody pursuant to the Baker Act would also constitute a breach of the peace. As a general rule, when an officer impounds a firearm for safekeeping only, this is an indication that no breach of the peace occurred. With every case, review of the police report should indicate whether the incident was a breach of the peace, and if the narrative so indicates, the firearm should not be returned without a court order [see the AGO below]. If the facts are unclear, questions concerning these elements should be referred to the Police Legal Bureau.

Op. Att'y Gen. Fla. 09-04 (2009), confiscation and return of firearms by law enforcement agencies when firearm owner subject to Baker Act evaluation. "In the absence of an arrest and criminal charge against the person sent for evaluation under the Baker Act, the Sheriff . . . may not retain firearms confiscated" at the time of the event. "Baker Act proceedings are not criminal proceedings." The Attorney General suggested the sheriff seek legislation to address the problem.

VII. Responsibilities of and Lawsuits Against Doctors and Receiving Facilities

A. In General

***Chirillo v. Granicz*, 199 So. 3d 246 (Fla. 2016).** The plaintiff Granicz's wife, the decedent, who had a history of depression, called her primary care doctor's office, reporting that she was under mental strain and having gastrointestinal problems. Her physician, Dr. Chirillo, changed her antidepressant medication and referred her to a gastroenterologist. His staff told the decedent she could pick up samples of the medication and a prescription, but they did not schedule an appointment with Dr. Chirillo. The decedent picked up the samples and prescription but hanged herself and was found the next day. Granicz filed a medical malpractice lawsuit against

Dr. Chirillo, alleging that he breached a duty of care that resulted in the suicide. The trial court granted Chirillo's motion for summary judgment, finding that he "did not have a duty to prevent the unforeseeable suicide." But the appellate court disagreed and reversed, and the Supreme Court approved the appellate decision, stating that while the decedent was an outpatient of Chirillo's and therefore "there was no duty to prevent her suicide, . . . the nonexistence of one specific type of duty does not mean that Dr. Chirillo owed the decedent no duty at all. . . . Although the inpatient duty to prevent suicide does not apply here, there still existed a statutory duty . . . to treat the decedent in accordance with the standard of care. We find that the Second District properly evaluated the . . . case based on the statutory duty owed to the decedent and also properly classified the foreseeability of the decedent's suicide as a matter of fact for the jury to decide in determining proximate cause."

***Moses v. Providence Hosp. and Medical Centers, Inc.*, 561 F.3d 573 (6th Cir. 2009).** A woman took her husband, who had severe psychiatric symptoms and had "demonstrated threatening behavior, which made her fearful for her safety," to a hospital ER for severe psychiatric symptoms. A psychiatrist examined him several times during his stay at the hospital and determined that he "was not 'medically stable from a psychiatric standpoint,'" and should be transferred to the hospital's psychiatric unit for reassessment. The psychiatrist's order notes stated that the psychiatric unit would accept the patient "if [his] insurance will accept criteria." But the patient was released instead of transferred, and ten days later he murdered his wife. The plaintiff (the personal representative of the deceased wife's estate) sued the hospital and the psychiatrist under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd, and for common law negligence. The defendants filed a motion for summary judgment. The trial court declined to exercise jurisdiction over the negligence claims and granted the motion for summary judgment as to the EMTALA claim, stating that EMTALA

> was not designed or intended to establish guidelines for patient care or to provide a suit for medical negligence or malpractice. Under the clear and unambiguous language of the statute, the Plaintiff's claim must be dismissed. The hospital admitted [the patient] and did not turn him away, as was required. . . . The patient was undisputedly completely screened, as the statute requires, even if on the basis of a wrong diagnosis; and he was thereafter admitted to the Defendant hospital, and no emergency medical condition was recognized on the screening.

The appellate court affirmed as to the psychiatrist but reversed as to the hospital,

reiterating that "EMTALA requires hospitals to do more for patients with emergency medical conditions than just admit them." It "requires more than the admission and further testing of a patient; it requires that actual care, or treatment, be provided as well," and the hospital did not satisfy the requirements under EMTALA by merely screening the patient "and admitting him to conduct further testing."

The defendants argued that a rule promulgated by Centers for Medicare and Medicaid Services (CMS), the agency responsible for implementing EMTALA,

> effectively ends a hospital's EMTALA obligations upon admitting an individual as an inpatient. . . . According to the CMS regulation, "[i]f a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual."

But the appellate court stated:

> Although "[a]n agency's construction of a statutory scheme that it is entrusted to administer is entitled to a degree of deference .... we must ... 'reject administrative constructions which are contrary to clear congressional intent.' " . . . The CMS rule appears contrary to EMTALA's plain language, which requires a hospital to "provide ... for such further medical examination *and such treatment* as may be required to stabilize the medical condition." . . . Although "treatment" is undefined in the statute, it is nevertheless unambiguous, because it is unreasonable to believe that "treatment as may be required to stabilize" could mean simply admitting the patient and nothing further. Moreover, the statute requires the patient to be "stabilized" upon release; "[i]f an individual at a hospital has an emergency medical condition which has not been stabilized ... the hospital may not transfer the individual unless" the patient requests a transfer in writing or a physician or qualified medical person certifies that the risks of further treatment outweigh the benefits. . . . Therefore, a hospital may not release a patient with an emergency medical condition *without first determining that the patient has actually stabilized*, even if the hospital properly admitted the patient. Such a requirement would be unnecessary if a hospital only needed to admit

> the patient in order to satisfy EMTALA.

The court also discussed what constitutes an "emergency medical condition" and held, without "guidance from the legislative history," that a mental health emergency could qualify.

***Moody v. Lawnwood Medical Center, Inc.*, 125 So. 3d 246 (Fla. 4th DCA 2013).** A child was injured in an playground accident, and her pediatrician diagnosed a fractured hip and sent her to Lawnwood, where he had staff privileges. The orthopedist on call concluded that the child did not have a hip fracture, and the pediatrician discharged her. Her condition worsened, and her mother took her to another hospital, where she was diagnosed with a fractured hip, septic arthritis, septic shock, heart failure, MRSA, and infections throughout her body. Her parents sued the pediatrician, the pediatrician's clinic, the orthopedist, the orthopedist's practice, and Lawnwood, but signed releases as to all defendants but Lawnwood. The trial court granted Lawnwood's motion for summary judgment, holding that the plaintiffs' release of the two doctors released the hospital for vicarious liability for the doctors' negligence. But the appellate court reversed, noting that the releases specifically stated that the hospital was not released and that all claims against the hospital were preserved. In addition, there was an issue of fact as to whether the hospital had a non-delegable duty to provide competent care to the plaintiffs' child; i.e., whether the mother had read and signed, "or otherwise acquiesced to," provisions in the hospital admission form "purportedly discharging Lawnwood from liability for the acts of independent contractor physicians."

***Tuten v. Fariborzian*, 84 So. 3d 1063 (Fla. 1st DCA 2012).** The plaintiff Tuten's husband had been treated as an outpatient and as a voluntary inpatient, and after his second suicide attempt the facility administrator filed a petition for involuntary placement, supported by the psychiatrist. Before the involuntary placement hearing, the husband requested release. The psychiatrist certified that the husband was competent to provide consent, and the husband was released. The next day he shot Tuten and fatally shot himself. Tuten brought a wrongful death/negligence action against the psychiatrist and the mental health facility. The court dismissed it, "noting that no amendment to the complaint could state a cause of action." Tuten appealed, arguing that under the Baker Act the facility and psychiatrist had a duty to keep her husband in the facility until the trial court ruled on the petition for involuntary placement. She also argued that they owed her husband a duty of care that was breached when he was released. But the appellate court affirmed, holding that the Baker Act does not

> expressly provide that, once a petition for involuntary placement has

> been filed, it cannot be withdrawn. In fact, a plain reading of section 394.469 would indicate that a petition could be withdrawn prior to a ruling. Also, the grant by a court of a petition for involuntary placement requires proof that a patient meets the criteria outlined in section 394.467(1)(a) and (b), and the criteria must be established by clear and convincing evidence. Since [the psychiatrist] concluded that, in his professional opinion, [the patient] could determine for himself whether commitment was necessary, there was no proof [the facility or the psychiatrist] could offer in continuing support of a petition for involuntary placement.

And because, for involuntary placement, the court must find that all available less restrictive treatment alternatives are inappropriate, "**[i]f a patient improves and is able to function in an 'available less restrictive environment' then the State has no alternative but to place the patient in that environment.** To do otherwise, would violate the constitutional rights of the patient as well as the plain requirements of the Baker Act."

The appellate court also noted that Florida law "does not impose a duty upon a psychiatrist to hospitalize or otherwise involuntarily detain a patient." It rejected the argument that the facility and psychiatrist had a common law duty to keep the husband committed against his will despite the psychiatrist's opinion that he was competent to make his own decision: "Because the 'internal workings of the human mind remain largely mysterious,' to impose a general duty on a psychiatrist would require such doctors to have the gift of 'clairvoyance.'" The court also stated: "It has been recognized that mental illness may be caused or intensified by institutionalizing mental patients. Emerging from these roots, the science and profession of psychiatry has burgeoned into a multifaceted social institution. The practice of psychiatry is no longer limited to the institutionalization of the mentally ill."

The court also reiterated that case law establishes no duty to warn even if the patient is dangerous and involuntarily committed. It noted "the unpredictability and inexactness inherent in the practice of psychiatry. Thus, because the future behavior of a psychiatric patient is unknowable, under Florida law risk of harm is not foreseeable and therefore no duty exists to lessen the risk or protect others from the type of risk which a psychiatric patient might pose."

***Estate of Smith v. Florida Dept. of Children and Families*, 34 So. 3d 181 (Fla. 1st DCA 2010).** The decedent, an employee at the Florida State Hospital in Chattahoochee forensic unit, had a fatal heart attack after intervening in a

confrontation between an inmate and a co-worker. His estate brought a wrongful death action alleging that DCF concealed and failed to disclose the criminal and violent background of the inmate and that the decedent's death was foreseeable. The trial court dismissed the lawsuit as barred by sovereign immunity, and the appellate court affirmed.

***Wax v. Tenant Health System Hospitals, Inc.*, 955 So. 2d 1 (Fla. 4th DCA 2007).** The plaintiff's husband died during surgery, and she sued the hospital and surgeon. The trial court granted the defendants' motion for summary judgment, after stopping the plaintiff's experts from testifying as to certain issues, holding that "such testimony would have been outside the designations of these expert witnesses in the pretrial disclosure, or it would have been cumulative." The appellate court disagreed and reversed, stating that

> both a statutory and a contractual basis for the hospital's duty of providing non-negligent, competent surgical anesthesia services to its patient. Under the admission consent form, we find that the patient consented to the Group's administration of anesthesia services. . . . [H]owever, we find no language at all in this form that might fairly and reasonably be construed to stand as an agreement to discharge the hospital from its primary statutory and contractual duty of providing non-negligent anesthesia services. If there were negligence in the provision of anesthesia services, then the Hospital would be liable as a matter of law.

***Sweet v. Sheehan*, 932 So. 2d 365 (Fla. 2d DCA 2006).** After sustaining "severe neurological damage as a result of a failed suicide attempt," Sweet sued his psychiatrist for medical malpractice. He alleged that after he told his psychiatrist about the attempt to overdose, his psychiatrist was negligent by "(1) failing to appropriately recognize and treat Sweet's severe depression, (2) failing to recommend to Sweet and his family that Sweet needed immediate hospitalization after his [previous] suicide attempt, (3) failing to adequately inform Sweet and his family of the risks of not being hospitalized, and (4) failing to appropriately monitor the amount of medication prescribed." The trial court granted the psychiatrist's motion for summary judgment, holding that the psychiatrist "owed no duty to Sweet and that there was no causal connection between [his] alleged negligence and Sweet's injuries." But the appellate court reversed and remanded, holding that the psychiatrist had not shown "conclusively the absence of any genuine issues of material fact." It stated that "Florida law unquestionably recognizes that physicians owe their patients a duty to 'use the ordinary skills, means and methods that are recognized as necessary and which are customarily

followed in the particular type of case according to the standard of those who are qualified by training and experience to perform similar services in the community or in a similar community.'"

***Lawlor v. Orlando*, 795 So. 2d 147 (Fla. 1st DCA 2001).** After the decedent committed suicide, his estate sued his psychotherapist for negligence. The trial court granted final summary judgment in favor of the psychotherapist, finding that "the suicide of a former patient was not sufficiently foreseeable to impose a duty under the circumstances of this case." The appellate court affirmed, holding that "[a]lthough Florida law would clearly impose a duty on a psychotherapist for failure to safeguard a patient from harming himself in a custodial setting, . . . no Florida cases extend the duty of custodial supervision and care to the outpatient relationship between a psychotherapist and a patient." However, in *Granicz v. Chirillo*, 147 So. 3d 544 (Fla. 2d DCA 2014), the Second District Court of Appeal reversed a summary judgment in favor of the physician and certified conflict with *Lawlor*. It stated:

> As did the trial court in this case, the First District [in *Lawlor*] determined that the psychotherapist did not have a legal duty to prevent the patient's suicide because the suicide was unforeseeable. . . . And the appellate court rejected the plaintiff's expert testimony setting forth the applicable standard of care, how it was breached, and how the breach proximately caused the patient's suicide. . . . For the reasons set forth above, we disagree with the *Lawlor* court's description of the psychotherapist's legal duty as a duty to prevent the patient's suicide. Instead, we agree with . . . the dissent that the psychotherapist had a "duty to provide 'appropriate psychotherapy' " and that the plaintiff's expert affidavit precluded summary judgment. . . . [The dissenting judge in *Lawlor*] correctly noted that because a legal duty existed, the issue of whether the doctor's actions proximately caused the plaintiff's suicide was to be resolved by a jury. . . . Similarly in this case, based on the record evidence, a jury question remains as to the proximate cause issue.

The Florida Supreme Court granted conflict review in *Chirillo v. Granicz*, 168 So. 3d 224 (Fla. 2014), and heard oral argument on September 2, 2015.

***Garcia v. Lifemark Hospitals of Florida*, 754 So. 2d 48, 49 (Fla. 3d DCA 2000).** The decedent was admitted to the hospital after a crash. Before the physical workup was complete, he requested release and was released against medical advice. Once home, he committed suicide. His estate sued the hospital and ER

staff, alleging that the police report "should have put the hospital on notice that the accident was a suicide attempt." The trial court dismissed the action, and the appellate court affirmed, stating:

> Doctors do not have a duty to treat each of their patients for every conceivable medical condition that they might have. For example, if a person goes to an ophthalmologist because they have an eye infection, one could hardly contend that there is a duty for the doctor to diagnose and treat that patient for hemorrhoids. Likewise, it is even more difficult to argue that this doctor has a duty to diagnose and treat that patient for obsessive compulsive disorder. Imposing such a duty takes us down the path of clairvoyance. . . because of the nature of psychiatry.

***Santa Cruz v. Northwest Dade Community Health Center, Inc.*, 590 So. 2d 444 (Fla. 3d DCA 1991).** Police took Santa Cruz to the hospital "pursuant to an ex parte court order describing him as violent and delusional." He was transferred to another hospital, from which he escaped, and returned to the first hospital about two weeks later and began outpatient treatment there. A few weeks later he shot his brother and another person, and they sued the hospital. The trial court dismissed their case for failure to state a cause of action, and the appellate court affirmed, stating: "This was a correct ruling by the trial court. There is no recognized basis for these appellants to assert a third party claim against the medical facility. They were not patients of the medical staff at Northwest Dade nor did they fit into any exception to the physician/patient requirement. Thus, it is clear there was no special relationship between Northwest Dade and the appellants which would support a claim for medical malpractice." On appeal the plaintiffs had argued that the hospital had a duty to detain or hospitalize Santa Cruz under the circumstances, but the court disagreed because Santa Cruz was not in its custody.

***Paddock v. Chacko*, 522 So. 2d 410 (Fla. 5th DCA 1988).** The plaintiff sustained injuries after her failed suicide attempt. She sued a psychiatrist whom she had seen once, four days before her suicide attempt, and who had recommended hospitalization, but the plaintiff's father did not consent and the recommendation was rejected. A jury awarded her $2,150,000, but the trial court granted the defendant's motion for judgment NOV/new trial. The plaintiff appealed, but the DCA affirmed, holding that "the existence of a legal duty was a question of law for the court and not for the jury," and "the trial court determined that the law did not impose a legal duty on a psychiatrist to involuntarily take a patient into his custody; that he was not legally obligated (nor empowered) to take control of her life away from her against her will to protect her from her self-destructive

tendencies."

There was also testimony that the increased dosage of Navane that the psychiatrist prescribed was inadequate, but there was no testimony that, even if it was, it was a proximate cause of the plaintiff's injuries.

While a facility may have liability based on "the negligent failure to safeguard and protect a psychiatric patient with suicidal tendencies," such cases involve patients who were already committed to the custody of the facility. But the appellate court "found no case that has held a doctor liable for the failure to take his patient into custody. Under the circumstances and facts of this case, we are unwilling to extend the duty of custodial supervision and care to the out-patient relationship between a psychiatrist and a patient."

Op. Att'y Gen. 93-88 (1993), Florida Volunteer Protection Act. Volunteers for nonprofit organizations who receive a stipend (other than reimbursement of actual expenses) are not covered by the Florida Volunteer Protection Act.

Op. Att'y Gen. 73-220 (1973), Responsibility of Admitting Physician in Receiving Facility. "The admitting physician in a receiving facility is responsible for the care of any person eligible to be admitted to the receiving facility and must make a good faith effort to comply with the provisions of the Florida Mental Health Act and the guidelines by the [responsible agency] in the administering of care to such eligible individuals until the receiving facility's overload is eased or a transfer of the patient to another receiving facility is accomplished."

B. Duty to Warn

***Nova University, Inc. v. Wagner*, 491 So. 2d 1116 (Fla. 1986).** Nova University ran a residential rehabilitation center for children with behavior problems. The children were not allowed to leave without permission, but two residents who "exhibited a propensity toward physical violence" ran away and killed a four-year-old and injured a six-year-old. The victims' mother sued Nova, and the trial court granted the defendants' motions for summary judgment, "finding that as a matter of law they owed no duty to the plaintiffs." The appellate court reversed, "finding that the Center stood *in loco parentis* to its residents and that the proper application of that theory precluded summary judgment for the defendants," and certified the following question: "DOES KNOWLEDGE OF A CHILD'S VIOLENCE REQUIRE A PARENT TO EXERCISE CONTROL TO AVOID INJURY TO ANOTHER CAUSED BY SUBSEQUENT VIOLENCE WHICH IS MORE SEVERE?"

The Supreme Court restated the question as: "Does a child care institution that accepts as residents delinquent, emotionally disturbed and/or ungovernable children have a duty to exercise reasonable care in its operation to avoid harm to the general public?" and answered in the affirmative, stating that the center "for a fee, undertakes to rehabilitate children with emotional and behavior problems. We do not think it too onerous a burden to place upon it the duty to exercise reasonable care in carrying out its efforts." It approved the appellate court decision.

***O'Keefe v. Orea*, 731 So. 2d 680 (Fla. 1st DCA 1998).** The plaintiff was a psychiatric nurse at Charter Hospital, which had recently admitted, as a transfer from another hospital, a schizophrenic patient who had a history of violence and making threats. While being escorted to seclusion by the plaintiff and two male staff members, the patient hit the plaintiff in the back of the head, and she "apparently suffered a moderate degree of brain damage." The plaintiff sued, among others, Mental Health Care (MHC), which had previously treated the patient, based on vicarious liability, and alleged, among other claims, that the patient's clinical case manager at MHC was negligent for failing to inform staff at Charter about the patient's "potential for violence." The trial jury awarded the plaintiff $901,415.72, assigning no negligence to the plaintiff or any of the *Fabre* defendants. But the appellate court reversed, stating that "a case manager at a community mental health facility who has provided non-custodial mental health care for a client has no duty to warn the nursing staff at a psychiatric hospital that the client may be dangerous when the client is admitted to the hospital as a result of a Baker Act proceeding initiated by a third party."

***Mental Health Care, Inc. v. Stuart*, 909 So. 2d 371 (Fla. 2d DCA 2005).** Four days after being released from the hospital, a 17-year-old patient attacked his parents, who were also patients of his psychiatrist, killing the father. The mother sued the psychiatrist and his P.A. for medical malpractice. The trial court dismissed the complaint for failure to state a cause of action, but the appellate court reversed, stating that "when the prevailing standard of care creates a duty that is obviously for the benefit of certain identified third parties and the physician knows of the existence of those third parties, then the physician's duty runs to those third parties." It also noted that the duty to warn "derives from the fiduciary relationship between [the psychiatrist] and the parents of his minor patient, as well as the physician-patient relationship between [the psychiatrist] and [the parents]."

***Green v. Ross*, 691 So. 2d 542 (Fla. 2d DCA 1997).** The appellate court affirmed the trial court order dismissing for failure to state a cause of action a complaint against a mental health worker. The appellate court agreed with and relied on *Boynton v. Burglass*, 590 So. 2d 446 (Fla. 3d DCA 1991) (see below), and rejected

the argument that "the permissive language of section 491.0147 created an affirmative duty to warn so as to support a cause of action for a failure to warn."

***Liles v. P.I.A. Medfield, Inc.*, 681 So. 2d 711 (Fla. 2d DCA 1995).** "[I]nvoluntary commitment procedures do not involve the rendering of medical care or services. Although a medical diagnosis is necessary in order to involuntarily commit a patient, the process of complying with the statute does not require medical skill or judgment." Therefore, a guardian filing suit against a hospital and doctor for false imprisonment did not have to comply with the medical malpractice presuit screening requirements and his complaint should not have been dismissed.

***Boynton v. Burglass*, 590 So. 2d 446 (Fla. 3d DCA 1991).** The court declined to adopt the rule in *Tarasoff v. Regents of University of California*, 551 P.2d 334 (Cal. 1976), that "a psychiatrist who allegedly 'knows, or should know,' that a patient of his presents a serious threat of violence to a third party has a duty to warn the intended victim." Instead it held that there is no such duty and affirmed the trial court order dismissing the complaint for failure to state a cause of action. It stated that to impose such a duty "is neither reasonable nor workable and is potentially fatal to effective patient-therapist relationships."

Op. Att'y Gen. 2006-36 (2006), regarding sovereign immunity of a nonprofit corporation. When a county health foundation "is acting primarily as an instrumentality" of the county hospital board "for purposes of section 768.28, Florida Statutes, [it] would appear to be subject to the sovereign immunity provisions of that section."

C. Malpractice vs. Ordinary Negligence

***Shands Teaching Hosp. and Clinics, Inc. v. Estate of Lawson ex rel. Lawson*, 175 So. 3d 327 (Fla. 1st DCA 2015).** Lawson had been admitted to Shands' psychiatric hospital. She took an employee's keys and escaped, and was killed by a truck on a nearby highway. Her estate sued Shands, and Shands filed a motion to dismiss, arguing that the complaint was actually for medical negligence and the estate had not complied with mandatory presuit requirements for such actions. The trial court denied the motion, but the appellate court quashed the order denying the motion, concluding that "because the claim arises from the services and care Shands was giving to a patient in a locked psychiatric unit, the complaint alleges medical negligence under section 766.106(1)(a), Florida Statutes."

***Pierrot v. Osceola Mental Health*, 106 So. 3d 491 (Fla. 5th DCA 2013).** The appellate court reversed a trial court order dismissing with prejudice a wrongful

death action for failure to comply with Florida's medical malpractice presuit requirements. The complaint alleged violations of the deceased patient's rights under the Baker Act, not medical malpractice, and therefore the plaintiff did not have to comply with the medical malpractice presuit requirement. Further, the facility was not a health care provider.

***Southern Baptist Hosp. of Florida, Inc. v. Ashe*, 948 So. 2d 889 (Fla. 1st DCA 2007).** The trial court found that the plaintiff did not need to comply with the medical malpractice presuit requirements because the "cause of action did not sound in medical malpractice, but instead in ordinary negligence." The defendant sought review, but the appellate court denied review, agreeing with the trial court. It noted that the complaint did not "challenge any medical diagnosis or decision that required professional skill or judgment."

***Doe v. HCA Health Services of Florida, Inc.*, 640 So. 2d 1177 (Fla. 2d DCA 1994).** A Baker Act patient's mother sued the receiving doctors and hospitals that treated him, "alleging false imprisonment, malicious prosecution, negligent hiring and failure to train, assault and battery, misrepresentation, and intentional infliction of emotional distress." The trial court dismissed her lawsuit for failure to comply with the medical malpractice presuit requirements, and the appellate court affirmed, stating that each of the allegations "arose out of the rendering of medical care by licensed health care providers subject to the prevailing professional standard of care, and compliance . . . was required."

VIII. Guardianship and Protective Services

***Auxier v. Jerome Golden Center for Behavioral Health*, 85 So. 3d 1164 (Fla. 4th DCA 2012).** A magistrate had discharged the public defender's office in a Baker Act case because the person who was the subject of the proceedings had a plenary guardian, and her rights had been transferred to her guardian and counsel for the guardian would represent her. The person was not present at the hearing on which the order was based and did not have independent counsel, and she was involuntarily committed. The public defender's office sought review of the order discharging it from representing her, and the Fourth District Court of Appeal granted it and quashed the discharge and commitment orders. It held that "the magistrate and the circuit court departed from the essential requirements of law [which] requires appointment of the public defender's office to represent the patient in involuntary civil commitment proceedings 'unless the person is otherwise represented by counsel.' The guardian's attorney represents the guardian, not the ward." The court "agree[d] with the First District's discussion of the role of the public defender in Baker Act proceedings" in *Handley v. Dennis*

(see below).

***Handley v. Dennis*, 642 So. 2d 115 (Fla. 1st DCA 1994).** The court defined the role of the public defender in involuntary placement proceedings:

> The Public Defender has a duty under the law to represent indigent mental patients in hearings to determine the need for continued involuntary placement. . . . In such cases, the duty of the Public Defender is a legal and professional duty that is owed to the patient as a client. The Public Defender serves as an independent advocate for the patient, not as a neutral party charged with the responsibility of determining the best interests of the patient or the needs of society.
>
> . . . . If the patient wishes to be released or transferred and if there is a basis for that request, the Public Defender has a duty to advocate the cause of the patient.

The court also stated that when there is a conflict between guardianship law and the Baker Act, "both the duty of the guardian and the power of the circuit court in the guardianship proceeding must give way to the ward's rights under the Baker Act to be released to a less restrictive environment," and "if a ward must be moved to a facility outside the circuit to accommodate a ruling in a Baker Act proceeding, the Public Guardian need only to file a motion to withdraw and transfer the guardianship case to the appropriate circuit," and the circuit judge in the circuit to which the ward has been transferred will appoint a successor guardian.

DCF General Counsel Opinion regarding which substitute decision maker controls approval of a treatment plan presented by a facility (January 28, 2000). DCF concluded that the appropriate order of deference should be the guardian advocate, legal guardian, health care surrogate, and the proxy.

> [T]he Legislature has recognized that the patient, to the extent that he is able to do so, is responsible for, and should be allowed to exercise control over, his own health care decisions. Guardian advocates, health care surrogates, health care proxies, and legal guardians should be considered as substitute consent givers only after it has been determined that the patient is unable to consent for himself, whether for reasons of mental incompetence or physical disability.
>
> * * *

> The guardian advocate is appointed when a patient has specifically been found to be incompetent to consent to treatment pursuant to . . . the Baker Act. The guardian, on the other hand, although also appointed by the court, is appointed because the principal has been adjudicated "incapacitated" as that term is defined in Chapter 744 and not as the result of having been determined "incompetent to consent to treatment."
>
> * * *
>
> There can be no question that the use of a substitute consent giver is to be undertaken only with a high degree of assurance that the patient's rights will be protected. It must be remembered, however, that it is the court which acts as the impartial protector of individual rights, civil liberties and due process. Therefore, court involvement assures to the fullest extent possible that these decisions will be accomplished within the parameters of due process and with adequate protection of the patient's individual rights.
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> * * *
>
> [B]ecause the court appoints a guardian advocate with assistance in making mental health care decisions specifically in mind, . . . the greatest deference should be given to the guardian advocate in determining who should approve the treatment plan when the patient cannot do so for himself. Thereafter the person . . . referred to as the "legal guardian", assuming that the ability to make mental health care decisions is included within the court's order appointing a person to that office, should be next in order of priority. The court involvement in appointing each of these substitute consent givers is significantly persuasive in coming to this conclusion.
>
> . . . [N]ext in order of precedence should be the mental health care surrogate and then the health care surrogate. It is these two in that order, who are most likely to make the decisions which offer the greatest protection to the patient. The proxy, who can be appointed by someone other than the patient, then falls to the rank of the least reliable of all the substitute consent givers.

IX. Baker Act and Minors

***Parham v. J. R.*, 442 U.S. 584, 99 S.Ct. 2493, 61 L.Ed.2d 101 (1979).** A class

action based on 42 U.S.C. § 1983 was brought on behalf of children being treated in a Georgia state mental hospital, which "sought a declaratory judgment that Georgia's voluntary commitment procedures for children under the age of 18 . . . violated the Due Process Clause of the Fourteenth Amendment and requested an injunction against their future enforcement." The federal district court held that the statutory procedures were unconstitutional and violated due process rights. It enjoined future commitments based on the procedures and ordered Georgia to spend whatever was "reasonably necessary" to provide appropriate nonhospital treatment for the plaintiffs, and held that due process "includes at least the right after notice to be heard before an impartial tribunal" and that "a judicial or quasi-judicial body should review voluntary commitment decisions." The state Department of Human Resources and its commissioner appealed.

The U.S. Supreme Court stated that the basic issues were "what process is constitutionally due a minor child whose parents or guardian seek state administered institutional mental health care for the child and specifically whether an adversary proceeding is required prior to or after the commitment," and it reversed and remanded. It stated:

> Although we acknowledge the fallibility of medical and psychiatric diagnosis, . . . we do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing. Even after a hearing, the nonspecialist decisionmaker must make a medical-psychiatric decision. Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real. . . .
>
> Another problem with requiring a formalized, factfinding hearing lies in the danger it poses for significant intrusion into the parent-child relationship. Pitting the parents and child as adversaries often will be at odds with the presumption that parents act in the best interests of their child. It is one thing to require a neutral physician to make a careful review of the parents' decision in order to make sure it is proper from a medical standpoint; it is a wholly different matter to employ an adversary contest to ascertain whether the parents' motivation is consistent with the child's interests.

> Moreover, it is appropriate to inquire into how such a hearing would contribute to the successful long-range treatment of the patient. Surely, there is a risk that it would exacerbate whatever tensions already exist between the child and the parents. . . .
>
> Although our review of the record in this case satisfies us that Georgia's general administrative and statutory scheme for the voluntary commitment of children is not *per se* unconstitutional, we cannot decide on this record, whether every child in appellees' class received an adequate, independent diagnosis of his emotional condition and need for confinement under the standards announced earlier in this opinion. On remand, the District Court is free to and should consider any individual claims that initial admissions did not meet the standards we have described in this opinion.
>
> In addition, we note that appellees' original complaint alleged that the State had failed to provide adequate periodic review of their need for institutional care and claimed that this was an additional due process violation. Since the District Court held that the appellees' original confinement was unconstitutional, it had no reason to consider this separate claim. Similarly, we have no basis for determining whether the review procedures of the various hospitals are adequate to provide the process called for or what process might be required if a child contests his confinement by requesting a release. These matters require factual findings not present in the District Court's opinion. We have held that the periodic reviews described in the record reduce the risk of error in the initial admission and thus they are necessary. Whether they are sufficient to justify continuing a voluntary commitment is an issue for the District Court on remand. The District Court is free to require additional evidence on this issue.

The majority opinion concluded by stating: "Georgia's medical factfinding processes are reasonable and consistent with constitutional guarantees. Accordingly, it was error to hold unconstitutional the State's procedures for admitting a child for treatment to a state mental hospital."

***In re Amendments to the Florida Rules of Juvenile Procedure*, 952 So. 2d 517 (Fla. 2007).** The Florida Supreme Court refused to adopt a rule change that would require that a guardian ad litem and attorney ad litem be appointed for children under state care when judges decide whether the children should be given psychotropic medication without parental permission. The court stated that section

39.407(3), Florida Statutes, imposes "detailed requirements" on DCF when it "seeks a medical evaluation to determine the need for psychotropic medication for a child," and "[t]he court is also authorized to order additional medical consultation and to require the department to obtain a second opinion." Statutes and rules exist "to ensure that the court's ruling on the motion for court authorization to administer the medication is based upon the most complete medical information that is available."

The court also noted that "in most cases, children in the custody and care of the department should already have representation in the form of a guardian ad litem." And the court already has discretion to appoint such representation for children in such cases.

***M.W. v. Davis*, 756 So. 2d 90 (Fla. 2000).** The Florida Supreme Court stated that all the parties "agree that section 39.407(4) requires dependency courts to comply with the procedures outlined in the Baker Act prior to placing a child who has been taken into emergency shelter into a residential mental health treatment facility" and that "a hearing before a judge is required before a child who has been adjudicated dependent may be placed by the [DCF] into a residential mental health treatment facility against the child's wishes. At issue, however, is whether that hearing must comply with the procedural requirements of the Baker Act, the factors to be considered by the dependency court, and whether evidence should be allowed."

The Fourth District Court of Appeal had certified the following question:

> IS A HEARING WHICH COMPLIES WITH THE REQUIREMENTS OF SECTIONS 39.407(4) AND 394.467(1), FLORIDA STATUTES, NECESSARY WHEN A COURT ORDERS THAT A CHILD BE PLACED IN A RESIDENTIAL FACILITY FOR MENTAL HEALTH TREATMENT, WHERE THE CHILD HAS BEEN COMMITTED TO THE LEGAL CUSTODY OF THE DEPARTMENT OF CHILDREN AND FAMILY SERVICES, AND THE DEPARTMENT IS SEEKING RESIDENTIAL TREATMENT?

The Florida Supreme Court answered in the negative. It held that the Florida Legislature intended for the Baker Act procedures to apply only to children who have been placed in emergency shelter and not to children who have been adjudicated dependent and placed in the temporary legal custody of DCF and who are in need of mental health treatment. It also cited the GAL program of the Eleventh Judicial Circuit, which "advocates that proper procedures exercised by the dependency courts will better assure the child's safety and mental health than

the procedures required by the Baker Act," which would limit the placing of a dependent child into residential psychiatric treatment only when "the child is so disturbed that the child meets the criteria of being manifestly incapable of surviving alone or dangerous."

The court further noted: "The judge was already familiar with M.W. and had reviewed his case at several hearings in the months preceding his placement," and "[a]lthough the dependency judge did not hold an evidentiary hearing before placing M.W. in [the locked facility], she did recognize the need for an evidentiary hearing and scheduled one for a date six weeks in the future. Accordingly, the procedure followed . . . satisfied minimum constitutional due process requirements."

***K.D. v. Department of Juvenile Justice*, 694 So. 2d 817 (Fla. 4th DCA 1997).** The appellate court held that section 394.467(2), Florida Statutes, is inapplicable when determining whether a delinquent juvenile is incompetent to proceed to trial on a delinquency petition and whether a delinquent juvenile should be involuntarily hospitalized by a juvenile judge. It upheld the trial court's order committing the child to DCF for placement in a residential program, holding that a determination of involuntary commitment of a juvenile pursuant to section 39.0517(2), Florida Statutes (1996) (see current section 985.19), is analogous to a determination of competency of an adult pursuant to Fla. R. Crim. P. 3.210–3.212, which — unlike section 394.467(2) — require the appointment of "experts" to examine the juvenile/defendant and not the receipt of a psychiatrist's testimony or report (which is needed to involuntarily place a patient in a treatment facility).

***Department of Health and Rehabilitative Services v. A.E.*, 667 So. 2d 429 (Fla. 2d DCA 1996).** The trial court found the 10-year-old child incompetent to proceed to trial and ordered him committed to DCF for placement in a mental health treatment facility pursuant to section 916.13, Florida Statutes. DCF appealed, the minor's counsel conceded error, and the appellate court reversed and remanded for further proceedings under sections 39.046 (now 985.224), 394.467, and 393.11, holding that the juvenile court did not have jurisdiction to order the involuntary commitment under section 916.13(2) of a child alleged to be delinquent.

***Department of Health and Rehabilitative Services v. State*, 655 So. 2d 227 (Fla. 5th DCA 1995).** The appellate court held that the juvenile court lacks the power to order the involuntary placement of minors who are alleged to be delinquent under section 916.13, Florida Statutes. It determined that section 916.13 specifically set forth "procedure for court-ordered involuntary commitment of adult offenders found incompetent to stand trial or to be sentenced" and did not apply to juvenile

delinquents. It reversed and remanded for further proceedings.

***Department of Health and Rehabilitative Services v. V.L.*, 583 So. 2d 765 (Fla. 5th DCA 1991).** The appellate court held that the circuit court had jurisdiction to place a foster child in a long-term residential treatment facility at HRS cost but could not place a limitation on how much time HRS would have in order to come up with the money. HRS can provide the placement to the child only when funds become available.

***State, Dept. of Health and Rehabilitative Services v. Brooke*, 573 So. 2d 363 (Fla. 1st DCA 1991).** Two juvenile court judges ordered the Secretary of HRS to appear at hearings regarding the status of dependent children who had been committed to HRS custody, to explain why HRS did not have sufficient funding to place the children in residential treatment facilities. The appellate court reversed the orders, noting that "budgetary decision-making is strictly within the secretary's executive discretion," and "the secretary's appearance or non-appearance could not lead to the disclosure of any facts upon which the judges would have jurisdiction to act or against which to issue an order to show cause. The judges were therefore clearly without jurisdiction to require the secretary's appearance regarding his transfer of monies or his making of budgetary decisions."

HRS also claimed that the judges' orders interfered with its "executive discretion concerning the placement of dependent children in derogation of the doctrine of separation of powers," but the appellate court stated that "simply because the trial court cannot order a child to be placed in a specific institution does not necessarily preclude the court from placing other conditions on the exercise of the Department's discretion to place the child." It was clear that in one case the judge only directed that HRS

> place the child "in *available* placement as recommended" by the [Case Review Committee]. No order for placement in a specific institution was made . . . and the language arguably is consistent with the discretionary authority granted to the Department pursuant to section 394.4781, insofar as the order may be interpreted so that the Department need not place the children as recommended by the CRC if there are neither funds nor facilities available. Thus, this particular portion of the . . . orders under review . . . do not necessarily contravene the statutory scheme. . . in derogation of the doctrine of separation of powers.

X. Baker Act and Criminal Defendants

***Thomas v. Bryant*, 614 F.3d 1288 (11th Cir. 2010).** Ten Florida State Prison inmates brought a § 1983 action against officers and employees of the Florida Department of Corrections, "alleging that the use of chemical agents on inmates with mental illness and other vulnerabilities violates the Eighth Amendment's prohibition on cruel and unusual punishment." The plaintiffs settled their claims against the individual corrections officers, and a trial was held on the claims for declaratory judgment and injunctive relief against the Secretary of DOC and the prison warden. The federal district court entered judgment in favor of two of the remaining six plaintiffs, concluding that they had "demonstrated that at times in which they were sprayed with chemical agents they were unable to conform their behavior to prison standards due to their mental illnesses such that the DOC's use of force for purposes of prison discipline amounted to cruel and unusual punishment." The district court permanently enjoined the defendants "from allowing the non-spontaneous use of chemical agents [on the two plaintiffs] without first consulting with the DOC's trained mental health staff to evaluate their mental health status." The defendants appealed, and the federal circuit court affirmed, stating: "Although it is well-established that the use of chemical agents on recalcitrant prisoners is not per se unconstitutional, . . . there are constitutional boundaries to its use. . . . We agree with the district court that 'if the DOC fails to account for an inmate's decompensation, with the result that he is gassed when he cannot control his actions due to his mental illness, then the force no longer has a necessary penological purpose and becomes brutality.'" The circuit court also agreed with the district court that

> the "lasting psychological injuries" suffered by [the plaintiff] as a result of his subjection to repeated chemical sprayings at FSP are sufficiently serious injuries to satisfy the objective harm requirement. [He] need not have suffered lasting physical injury from the sprayings to subject DOC conditions to 8th Amendment scrutiny. The case law establishes that "mental health needs are no less serious than physical needs" for purposes of the 8th Amendment. Accordingly, the court held that the policy and practice of spraying inmates with chemical agents, when fully secured in a cell and not presenting a threat of immediate harm to himself or others, and when unable to understand and comply with officers' orders due to mental illness—are extreme deprivations violating the "broad and idealistic concepts of dignity, civilized standards, humanity and decency" embodied in the 8th Amendment.

***Onwu v. State*, 692 So. 2d 881 (Fla. 1997).** A county court had found the defendant in a misdemeanor case incompetent and entered an order of commitment. The defendant filed a petition for habeas corpus, and the chief circuit judge, in his appellate capacity, directed the defendant's release, holding that "although the county court had inherent authority to determine issues of competency, it did not have the authority to commit mentally incompetent persons" to HRS. The judge then issued an administrative order that "assigned all of the county judges of the Seventeenth Judicial Circuit to act as circuit judges for the purpose of determining the competency of any person who may appear within the courts of Broward County, Florida, and thereafter entering a proper order of commitment." The county judge presiding over the defendant's criminal case found him incompetent and ordered a commitment hearing, and the defendant filed a petition for prohibition, to stop the commitment proceedings. He argued that because under section 916.106, Florida Statutes, "court" means the circuit court, only the circuit court can make the findings necessary for a forensic commitment. The Florida Supreme Court agreed and declared the administrative order invalid.

***Perkins v. State*, 84 So. 3d 336 (Fla. 2d DCA 2012).** The appellate court concluded that

> the probate court erred in ruling that the doctrine of collateral estoppel precluded it from determining whether Mr. Perkins met the criteria for civil commitment. . . . [N]o one presented any evidence at the hearing in the criminal proceeding to establish that Mr. Perkins met the civil commitment criteria. Thus the record doesn't establish that the facts supporting [his] commitment in the criminal proceedings are the same and based upon the same evidence presented in the probate proceedings.

The court also noted that it was not shown that that Perkins

> affirmatively waived his right to be present at a hearing to determine whether he met the criteria for civil commitment. . . . The defense attorney's primary goal in the . . . criminal proceeding was to obtain a dismissal of the criminal charges based upon Mr. Perkins' continued incompetence to proceed to trial. There is no support in the record for the proposition that Mr. Perkins should be bound by any determination of his mental status resulting from a hearing at which everyone stipulated to the dismissal of the criminal proceeding.

***A.E. v. State*, 83 So. 3d 1000 (Fla. 3d DCA 2012).** A.E. was charged with

aggravated battery and found incompetent, and appealed the involuntary civil commitment judgment. The appellate court affirmed, finding competent substantial evidence to support the commitment:

> A.E . . . has remained incompetent with no substantial probability that she will become competent to stand trial in the foreseeable future. A.E. suffers from schizophrenia and is paranoid. Despite taking her medications, when evaluated just prior to the hearing conducted by the trial court, A.E. was agitated, exhibited "unusual gestures," was easily distractible, had difficulty focusing, was seen responding to voices, and at times appeared disorganized, unable to express herself in a rational manner, and delusional. A.E. has a long history of mental illness, perceptual disturbances, substance abuse, numerous hospitalizations, and non-compliance with treatment and medication. The trial court additionally noted that A.E. has poor insight as to her condition and mental health needs, she had to be placed on suicidal precautions approximately two weeks prior to the hearing, and numerous attempts to place her in the community have failed.

***Johnson v. State*, 40 So. 3d 883 (Fla. 4th DCA 2010).** The 37-year-old defendant was convicted of lewd or lascivious battery based on his relationship with a 13-year-old girl. He appealed, arguing that "the trial court erred by admitting evidence that the victim twice attempted to commit suicide [and was Baker Acted] after the relationship was revealed and the defendant was arrested." The appellate court reversed and remanded for a new trial "[b]ecause any probative value of this evidence was substantially outweighed by the danger of unfair prejudice, and the error in admitting it was not harmless."

***Amador v. State*, 712 So. 2d 1179 (Fla. 3d DCA 1998).** In 1984 Amador was charged with multiple crimes, including the murder of his mother. The trial court found him incompetent to stand trial and committed him to HRS custody. Seven years later the trial court dismissed the charges without prejudice, "finding that there was no substantial probability that he would regain mental competency in the foreseeable future," and committed him again, retaining jurisdiction and ordering that he not be released without court approval. Two years after that, because of a lack of hospital space, Amador was transferred from a forensic hospital to a civil treatment facility, where he was evaluated on a six-month basis. In 1997, a hearing examiner determined that Amador no longer met the criteria for involuntary placement (which the appellate court called an "astonishing result"), and the hospital notified the state that Amador "would be 'removed from the hospital'."

The state attorney's office filed a motion for competency hearing and/or to continue its commitment or to recommit Amador to the custody of DCF, and the trial court entered an order recommitting him. The public defender filed a petition for a writ of habeas corpus on behalf of Amador, which the circuit court granted, ordering release within 30 days, to give the trial court time to act. An arrest warrant was then issued for the original criminal charges against Amador. The state and the defendant stipulated that the defendant was incompetent to proceed. Meanwhile, the Third District Court of Appeal held in *State v. Heidrick*, 707 So. 2d 1165 (Fla. 3d DCA 1998), that "once a defendant's charges have been dismissed without prejudice in light of a determination that the defendant-who has been involuntarily hospitalized-is not competent to stand trial, the committing court lacks jurisdiction to determine whether the defendant continues to meet the criteria for involuntary hospitalization." However, the opinion further stated that it "in no way prohibits the State or any other interested party from once again initiating an action to involuntarily hospitalize the defendants pursuant to the Baker Act."

Two days after *Heidrick* was decided, the state refiled the original criminal charges against Amador. He moved to dismiss "on the basis that the trial court, under *Heidrick*, lacked jurisdiction to continue involuntary hospitalization." The trial court found that Amador met the criteria to undergo an involuntary examination, ordered him to a receiving facility, lodged a capias against him, and "directed that if the receiving facility determined that he did not meet the criteria for involuntary placement, 'he shall be returned to the county jail.'" The receiving facility refused to accept Amador, even for examination, because the state had refiled the criminal charges against him, so the state nolle prossed the charges. The trial court then dismissed the criminal charges and republished its previous order, leaving the capias. Amador admitted himself voluntarily to a treatment facility and remained subject to the capeas.

Amador petitioned the Third District Court of Appeal for a writ of habeas corpus to challenge the two court orders that directed him to a receiving facility and directed that he be returned to county jail if the receiving facility determined that he did not meet the criteria for involuntary placement. The court granted the writ, quashed in part the two trial court orders, and quashed the capias, stating:

> Under *Heidrick*, once the charges against the defendant have been dismissed, the committing court lacks jurisdiction to order the continued involuntary *hospitalization* of a defendant. However, consistent with . . . *Heidrick* and section 394.463(2)(a)1, Florida Statutes, . . . the trial court has the authority to order an involuntary *examination* of the defendant under the Baker Act." The court

> remanded the case for further proceedings under section 394.463(2)(a)1, Florida Statutes.

***State v. Heidrick*, 707 So. 2d 1165 (Fla. 3d DCA 1998).** Two defendants were adjudicated incompetent to stand trial and were involuntarily hospitalized pursuant to section 916.13, Florida Statutes. Five years later the circuit courts entered orders finding that "there was no substantial probability that the defendants would regain mental competency in the foreseeable future" and that they met the criteria for involuntary placement. "Therefore, the circuit courts dismissed the defendants' charges without prejudice to the State to refile the charges should the defendants be declared competent to stand trial in the future. Further, the circuit courts committed the defendants to [HRS]." As required by rule 3.213(b), Florida Rules of Criminal Procedure, the orders instructed the facility administrator to notify the state attorney at least 30 days before the defendants' anticipated release dates.

A few years later, HRS gave the 30-day notice to the state attorney, explaining that the defendants were unlikely to achieve competency to stand trial, but that they "were no longer dangers to themselves or others and that they could live and function in a less restrictive environment." The state attorney "moved to have the committing courts determine whether the defendants should remain involuntarily hospitalized," and both courts found that they "lacked jurisdiction to make such a determination." The state filed petitions for writ of mandamus, but the appellate court denied the petitions, holding that the two circuit courts properly found that they lacked jurisdiction to determine whether the defendants continued to meet the criteria for involuntary hospitalization. The court also stated that "this decision in no way prohibits the State or any other interested party from once again initiating an action to involuntarily hospitalize the defendants pursuant to the Baker Act."

The appellate court held that the once a defendant's charges are dismissed without prejudice pursuant to rule 3.213, the state must either release the defendant or commit the defendant for involuntary hospitalization pursuant to the Baker Act rather than chapter 916.16, Florida Statutes (Mentally Deficient and Mentally Ill Defendants). It also noted that Baker Act discharge procedures are to be followed:

> [S]ection 394.469(1), Florida Statutes, . . . provides that the administrator of the facility is the one who has the power to discharge the patient. Chapter 394 does not allow the State to seek review of the administrator's decision to discharge the defendant before the court that initially committed the defendant. Therefore, contrary to the State's assertion, the discharge provision of section 916.16 is inapplicable, and pursuant to section 394.469(1), the decision to

> discharge the defendants rests solely with the administrator of the facility.

The appellate court also found that the policy purpose of the notification requirements of rule 3.213(b), Florida Rules of Criminal Procedure, "is to provide the state attorney of the committing circuit with the opportunity to decide whether he or she will refile the charges against the defendant [and] not for the purpose of providing the State with an opportunity to challenge the administrator's decision to discharge the defendant from the facility."

***Cuervo v. State*, 603 So. 2d 654 (Fla. 3d DCA 1992).** The Third District Court of Appeal held that the circuit court, which ordered the commitment of a criminal defendant to the custody of HRS, retained jurisdiction over the defendant for the purpose of determining continued hospitalization or release, and that a later decision by a circuit court to transfer a criminal defendant to HRS after five years of Baker Act hospitalization pursuant did not divest the circuit court of jurisdiction over the person. It further held that the circuit court "may amend the commitment order to require that the administrator of the H.R.S. facility comply with [the notification requirements of] Florida Rule of Criminal Procedure Rule 3.213(b)." However, in *State v. Heidrick*, 707 So. 2d 1165 (Fla. 3d DCA 1998), the Third District Court of Appeal held that *Cuervo* was incorrectly decided and receded from it on this issue.

XI. Marchman Act

***Blair v. Razilou*, 2010 WL 571980 (M.D. Fla. 2010).** Blair and her husband had been drinking one night, and on the way home her husband was pulled over and arrested for DUI. Because Blair was intoxicated, a relative who could give her a ride home was 40 minutes away, and officers at the scene were concerned that Blair "may stumble into the road and get hit by a car," Officer Razilou handcuffed her and took her to jail for involuntary civil commitment under the Marchman Act. Blair later filed a complaint against the city and Officer Razilou, alleging (1) violation of her Fourth and Fourteenth amendment rights to be free from involuntary commitment, (2) that the city failed to properly instruct its employees regarding probable cause and the Marchman Act, (3) false arrest (under state law), and (4) false imprisonment (under state law). The defendants filed a motion for summary judgment, claiming qualified immunity on the part of Officer Razilou, who was acting within his discretionary authority. The court granted the defendants' motion for summary judgment on the first two counts, finding that because Officer Razilou had "arguable probable cause to civilly commit plaintiff," he was entitled to qualified immunity. Judgment was entered only on the federal

claims; the court declined to retain jurisdiction over the state-law claims.

***Cole v. State*, 714 So. 2d 479 (Fla. 2d DCA 1998).** The circuit court convicted Cole of indirect criminal contempt for violating its order directing him to complete a substance abuse treatment program and sentenced him to 90 days in jail. He filed a petition for writ of habeas corpus and other relief. The appellate court ordered his release, quashed his conviction and sentence for indirect criminal contempt, and prohibited the circuit court from enforcing the involuntary treatment order. As grounds, the appellate court noted that the trial court failed to inform Cole of his right to counsel, Cole "was not given meaningful prior notice of the charges against him," the trial was not recorded as required by law, and the court order "included directives and prohibitions that were beyond the judicial authority granted by the Marchman Act." It stated that

> even if the proceeding had not been so fundamentally flawed, the printed directory provisions of the . . . form order would have been unenforceable because they exceeded the court's authority. Although the Act empowers the court to order a respondent's submission to involuntary substance abuse treatment, and, pursuant to section 397.697, to enter such further orders as the circumstances may require, that authority does not extend to prescribing the specific modalities of the treatment. Under the Act that authority is placed with the licensed service provider.

***S.M.F. v. Needle*, 757 So. 2d 1265 (Fla. 4th DCA 2000).** The circuit court had granted a petition for involuntary substance abuse treatment for a minor in response to a petition filed by her parent. The order was for 60 days of involuntary treatment, the maximum period permitted under law, commencing upon her admission to the facility. However, the minor ran away prior to commencing treatment and was returned to the program after the initial court order had expired. She filed a petition for a writ of habeas corpus, arguing that she was entitled to immediate release because section 397.6977, Florida Statutes, provided that "[a]t the conclusion of the 60-day period of court-ordered involuntary treatment, the client is automatically discharged unless a motion for renewal of the involuntary treatment order has been filed with the court." The appellate court held that the automatic discharge would occur "at the 'conclusion of the 60-day period of court-ordered involuntary treatment,' not merely sixty-days after the entry of the order for treatment," and that the 60-day period had not expired, because the petitioner ran away before commencing treatment. The petition for writ of habeas corpus was denied.

***Department of Health and Rehabilitative Services v. Straight, Inc.*, 497 So. 2d 692 (Fla. 1st DCA 1986).** The trial court entered a final summary judgment granting declaratory relief to a nonprofit corporation that operated a drug treatment and rehabilitation program, declaring that chapter 397, Florida Statutes, "does not prevent a parent from placing a minor child in a drug treatment program without obtaining either the child's consent or judicial review of the child's involuntary commitment." The appellate court affirmed.

APPENDIX III:

List of FAQ Categories on DCF Website

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. Questions can be found on the State's Baker Act internet site located at http://myflfamilies.com/service-programs/mental-health/baker-act-faq.

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- EMTALA / Medical Screening
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APPENDIX IV:

List of All Mandatory and Recommended Baker Act Forms

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3002*	Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination (2-sided; 4 pages)
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3024*	Notice of Petition for Continued Involuntary Inpatient Placement
3031*	Order for Continued Involuntary Inpatient Placement or for Release
3032*	Petition for Involuntary Inpatient Placement (2-sided; 3 pages)
3033*	Notification to Court of Withdrawal of Petition for Hearing on Involuntary Inpatient or Involuntary Outpatient Placement
3035*	Petition Requesting Authorization for Continued involuntary Inpatient Placement (2-sided 2 pages)
3036*	Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances
3038*	Notice of Release or Discharge
3040*	Application for Voluntary Admission of an Adult (Receiving Facility)
3042a*	General Authorization for Treatment Except Psychotropic Medications
3042b*	Specific Authorization for Psychotropic Medications
3043*	Inventory of Personal Effects
3044*	Authorization for Release of Information
3045*	Notice of Person's Admission for Involuntary Examination
3046*	Application for and Notice of Transfer to Another Receiving or Treatment Facility
3048*	Confidentiality Agreement
3049*	Restriction of Communication or Visitors
3051a*	Notice of Right of Person on Voluntary Status to Request Discharge From a Receiving Facility (2-sided; 2 pages)
3051b*	Notice of Right of Person on Voluntary Status to Request Discharge From a Treatment Facility (2-sided; 2 pages)
3052a**	Report of Law Enforcement Officer Initiating Involuntary Examination (MANDATORY)
3052b**	Certificate of Professional Initiating Involuntary Examination (2-sided; 2 pages)
3057*	Authorization for Electroconvulsive Treatment
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3089*	Transfer Evaluation (To a State Mental Health Treatment Facility) (MANDATORY)
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3097*	Application for Voluntary Admission –Minors
3098*	Application for Voluntary Admission (State Treatment Facility)
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.
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3116*	Findings and Recommended Order Restoring Person's Competence to Consent to Treatment and Discharging the Guardian Advocate
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3160*	Notice to Court of Modification to Treatment Plan for Involuntary Outpatient Placement and/or Petition Requesting Approval of Material Modifications to Plan
3170*	Petition for Termination of Involuntary Outpatient Placement Order
3180*	Petition Requesting Authorization for Continued Involuntary Outpatient Placement (2-sided; 2 pages)
3185*	Notice to Court of Waiver of Continued Involuntary Outpatient Placement Hearing and Request for an Order

7000*	State Mental Health Facility Admission Form (2-sided; 6 pages)
7001*	State Mental Health Facility Discharge Form (2-sided; 12 pages)
7002*	Physician to Physician Transfer Form

*Recommended **Mandatory