

Minors

(See also Involuntary Examination)

(See also bakeracttraining.org for course on Consent for Minors)

Minority Defined

Q. How is a minor defined?

A minor is any person under 18 years old who has not been married and has not had a court remove the disability of nonage. However, most references in the Baker Act are to persons “under the age of 18). Therefore, one must consider a person age 0-17 as a minor for the purposes of the Baker Act and lack the legal capacity to provide consent for admission or treatment. A minor must provide assent (agreement) to be voluntary.

Q. 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 divorce, guardianship belongs to the parent or parents with custody. 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. (Florida laws governing dissolution of marriage and parental responsibility have changed some of the language dealing with divorce and custody).

Informed Consent & Consent to Treatment

Q. We have a psychiatrist that is board-certified for treatment of Adult, Child and Adolescent patients. He has been treating a 17 year old patient that is resistant to pharmacological management. He approached me and asked if he could perform outpatient ECT on the patient. The parents are willing to consent for the treatment. The hospital is licensed for pediatric medical patients (not psychiatric) to perform anesthesia-assisted procedures. 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 provisions are as follows:

394.459(3, FS) 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, FS Electroconvulsive and psychosurgical procedures.

(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. However, it might be best if you verify that your hospital or HCA doesn’t have some policy/procedure governing this issue.

Q. We had a 17 year old present to the ER for detox who said she didn’t know how to contact her parents. She was with an adult partner. I know that for outpatient, the age is under 16 for informed consent SA Treatment – would that also apply for medical detox of a minor under 18?

You are correct that a person under the age of 18 can consent to voluntary substance abuse services

397.601 Voluntary admissions.

(1) A person who wishes to enter treatment for substance abuse may apply to a service provider for voluntary admission.

(2) Within the financial and space capabilities of the service provider, a person must be admitted to treatment when sufficient evidence exists that the person is impaired by substance abuse and the medical and behavioral conditions of the person are not beyond the safe management capabilities of the service provider.

(3) The service provider must emphasize admission to the service component that represents the least restrictive setting that is appropriate to the person’s treatment needs.

(4)(a) 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.

(b) Except for purposes of law enforcement activities in connection with protective custody, the disability of minority is not removed if there is an involuntary

admission for substance abuse services, in which case parental participation may be required as the court finds appropriate.

Such services must be provided by a licensed service provider. This is defined as:

397.311 Definitions.

As used in this chapter, except part VIII, the term:

(33)“Service provider” or “provider” means a public agency, a private for-profit or not-for-profit agency, a person who is a private practitioner, **or a hospital licensed under this chapter or exempt from licensure under this chapter.**

397.405 Exemptions from licensure.

The following are exempt from the licensing provisions of this chapter:

- (1) A hospital or hospital-based component licensed under chapter 395.
- (5) A physician or physician assistant licensed under chapter 458 or chapter 459.
- (6) A psychologist licensed under chapter 490.
- (7) A social worker, marriage and family therapist, or mental health counselor licensed under chapter 491.
- (11)A facility licensed under s. 394.875 as a crisis stabilization unit.

The exemptions from licensure in this section do not apply to any service provider that receives an appropriation, grant, or contract from the state to operate as a service provider as defined in this chapter or to any substance abuse program regulated pursuant to s. 397.406. Furthermore, this chapter may not be construed to limit the practice of a physician or physician assistant licensed under chapter 458 or chapter 459, a psychologist licensed under chapter 490, a psychotherapist licensed under chapter 491, or an advanced registered nurse practitioner licensed under part I of chapter 464, who provides substance abuse treatment, so long as the physician, physician assistant, psychologist, psychotherapist, or advanced registered nurse practitioner does not represent to the public that he or she is a licensed service provider and does not provide services to individuals pursuant to part V of this chapter. Failure to comply with any requirement necessary to maintain an exempt status under this section is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

Your hospital ED is an authorized service provider exempt from licensure under the Marchman Act for substance abuse services. However, if the service is for medical treatment and not for substance abuse treatment, a minor generally doesn't have any authority to provide consent for his/her own treatment, unless a court has emancipated the minor from the parents. Other laws govern provision examination and treatment of persons with emergency medical conditions and in circumstances in which a minor's legal guardian isn't available. All of these circumstances are in covered in Appendix 1-10 of the 2011 Baker Act Handbook.

Q. 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 that 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, FS) in which a guardian advocate was appointed to make such treatment decisions. This is not the case where the parents refuse consent.

Q. Can you tell me if Florida Statutes address whether or not a social worker in a school setting can counsel a child without written/signed parent or guardian consent? My school district has always operated on seeing a child once only w/o consent and from there, requiring signed authorization for continued counseling.

The Baker Act has long allowed minors age 12 or older to seek crisis intervention services and treatment without the consent of a guardian. This should be for crisis oriented services and can't exceed more than two visits during any one week period. The statutory provisions are below. You may want to be sure that education statutes aren't in conflict with the Baker Act for what can be done in schools. When two laws are in conflict with each other, the more specific statute prevails over the general statute.

DOE provided the following information: There is no Florida Education Statute that requires parental consent for students to be able to access support services in schools. However, parental "involvement" (at least-notice) is crucial when on-going support services are needed for any student. Counseling services and social work services should be available to every student. Parent involvement is a definite part of RtI in the early and ongoing process and support services may be a piece of the recommendations in order to inform class room interventions. At any time, if those services are required to determine eligibility for ESE, consent is required. Particularly in crisis situations, these services should be immediately available.

Q. We had a caregiver bring in a 14 year old girl for whom she has been providing care for several years. She has a power of attorney signed by a Notary We learned from this caregiver that the parents are out of the picture According to the caregiver the whereabouts of the father are unknown and the last contact she had with the mother was some time ago and the mother was in Texas, but she states she has no contact with the mother and does not know where she is. We have admitted the adolescent under a Baker Act executed by our psychiatrist which provides for the psychiatric evaluation. Our decision at this time (hopefully it is a correct one) is that after the psychiatric evaluation, if the psychiatrist determines she needs further treatment including medication, we will file a Baker Act 3032 and ask the Court to appoint the caregiver as the Guardian Advocate who could then consent for treatment if the Court granted the Petition.

You've done a good job with a very difficult situation. You were correct that the caregiver couldn't apply for the child's admission and couldn't consent to psychotropic medications on behalf of the child, even with a power of attorney (743, FS)

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. If the patient has been adjudicated incapacitated or found to be incompetent to consent to treatment, express and informed consent to treatment shall be sought instead from the patient's guardian or guardian advocate. If the patient is a minor, express and informed consent for admission or treatment shall also be requested from the patient's guardian. Express and informed consent for admission or treatment of a patient under 18 years of age shall be required from the patient's guardian, unless the minor is seeking outpatient crisis intervention services under s. 394.4784. Express and informed consent for admission or treatment given by a patient who is under 18 years of age shall not be a condition of admission when the patient's guardian gives express and informed consent for the patient's admission pursuant to s. 394.463 or s. 394.467.

Until a guardian advocate is appointed, emergency treatment orders can be authorized by a physician when imminent danger is documented. While the provisions of the Baker Act apply to this situation, you may also need to be aware of other laws that may apply, including:

743.0645 Other persons who may consent to medical care or treatment of a minor.--

(1) As used in this section, the term:

(b) "Medical care and treatment" includes ordinary and necessary medical and dental examination and treatment, including blood testing, preventive care including ordinary immunizations, tuberculin testing, and well-child care, but does not include surgery, general anesthesia, provision of psychotropic medications, or other extraordinary procedures for which a separate court order, power of attorney, or informed consent as provided by law is required, except as provided in s. 39.407(3).

(c) "Person who has the power to consent as otherwise provided by law" includes a natural or adoptive parent, legal custodian, or legal guardian.

(2) Any of the following persons, in order of priority listed, may consent to the medical care or treatment of a minor who is not committed to the Department of Children and Family Services or the Department of Juvenile Justice or in their custody under chapter 39, chapter 984, or chapter 985 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 person who possesses a power of attorney to provide medical consent for the minor. A power of attorney executed after July 1, 2001, to provide medical consent for a minor includes the power to consent to medically necessary surgical and general anesthesia services for the minor unless such services are excluded by the individual executing the power of attorney.

(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.

There shall be maintained in the treatment provider's records of the minor

documentation that a reasonable attempt was made to contact the person who has the power to consent.

A guardian advocate is not generally sought when a person of any age has a natural (parent) or court appointed guardian (744, FS). However, if the guardian is not available, there is no prohibition in the Baker Act from appointing a guardian advocate in such circumstances.

While the caregiver may be able to consent to treatment on behalf of the child on inpatient status once appointed as a guardian advocate, this will end once the child is discharged. It is essential that the caregiver petition the court to be appointed the child's guardian so such decisions can be made in the future. It is clear that the child has been abandoned by her parents and DCF may be able to assist in this process. If not, I'm sure that there is a good legal service in your area that could help in this matter.

Q. Can a licensed clinical social worker provide therapy to an adolescent without consent from the parents or guardians? Can the social worker provide therapy to the adolescent if a general medical consent is received, but not consent for psychiatric care?

The Baker Act allows for minors age 13 years and older to access outpatient diagnostic and evaluation services as well as outpatient crisis intervention, therapy, and counseling services without the consent of parent or guardian. I've included those provisions below.

However, the Baker Act has much more stringent provisions for minors on an inpatient status.

394.459(3) RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT.--
(a)1. Each patient entering treatment shall be asked to give express and informed consent for admission or treatment.... If the patient is a minor, express and informed consent for admission or treatment shall also be requested from the patient's guardian. Express and informed consent for admission or treatment of a patient under 18 years of age shall be required from the patient's guardian, unless the minor is seeking outpatient crisis intervention services under s. 394.4784....

This provision clearly requires the consent of the minor's guardian for any type of treatment on an inpatient basis. If your facility uses the model Baker Act forms for "General Authorization for Treatment Except Psychotropic Medications" and "Specific Authorization for Psychotropic Medications", there is space at the top of the 3042a form for the guardian to authorize psychiatric assessment and for "other" which might include psychotherapy.

In any case, inpatient therapy does require consent of a legal guardian. Should a parent refuse to provide express and informed consent to medically necessary treatment (can't have any element of force, duress, or coercion), you may have to consider a referral to child protective services.

394.4784 Minors; access to outpatient crisis intervention services and treatment.--For the purposes of this section, the disability of nonage is removed

for any minor age 13 years or older to access services under the following circumstances:

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

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

Voluntary Admissions

Q. Under what conditions can a minor be voluntary?

The Baker Act permits minors to be voluntary if agreeable to the admission, but only when their parent or legal guardian has applied for their admission and a judicial hearing has been conducted to confirm the voluntariness of the consent. Unless parental rights have been terminated, the natural parent continues 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 didn't 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 is no rule 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.

Q. Today we had a situation where a juvenile walked into the Crisis Unit voluntarily for evaluation. The RN's advised that they did not have the authority to Baker Act the juvenile patient and that we, the police, had to. The RN's advised us that the patient stated to them that if she goes back home she will kill herself. I asked them if the patient was an adult and made the same comments would/could they be able to Baker Act the patient. They advised yes. But when asked why they couldn't Baker Act the juvenile they simply advised that they had not authority to do so unless the person was in imminent danger. I know and understand that legally hospitals need parental permission to do things with a juvenile patient and that was lacking in this case but that still doesn't explain how staff are not authorized to Baker Act a juvenile. Because of the concerns we had, we decided to do the Baker Act. Can you please explain to me how can this be and, if it is the case, the staff cannot/or are not authorized to Baker Act a juvenile.

You are correct -- there is no difference in the initiation of an involuntary examination for minors than for adults. The only difference is in the voluntary admission and consent for treatment of a minor. RN's aren't authorized to initiate involuntary examinations for persons of any age. Only a physician, psychologist, psychiatric nurse, LCSW, LMHC and LMFT and PA are authorized, other than circuit judges and law enforcement officers. The initiating document simply permits law enforcement to take a person into custody for delivery to a receiving facility. Since the youth was already at a designated receiving facility with the authority to retain persons for examination, they could have held the minor for up to 24 hours to get an authorized professional to conduct the examination. They couldn't have treated the minor without consent of his legal guardian. The staff should have immediately tried to contact the guardian in order to get such consent. It wasn't appropriate for staff to contact law enforcement to initiate an examination of a person already in their care. If they wanted a BA-52 signed, they should have contacted an on-call legally authorized staff member to do the initiation.

Q. I have several questions about voluntary admission of minors. If a parent has requested admission of a minor, but the minor is unwilling, can we admit? What if the minor becomes unruly and refuses, but says nothing that shows imminent risk

to us so an involuntary admission is out of the question? Do we let them go as there is not evident risk? Our voluntariness hearings are done on the CCSU – but this is after the admission takes place. Should Emergency Services be handling the “Voluntariness Hearing” prior to admission?

There are two provisions of the Baker Act that apply to the questions you raise. They are:

394.459(3), F.S. RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT.-

(a)1. Each patient entering treatment shall be asked to give express and informed consent for admission or treatment... If the patient is a minor, express and informed consent for admission or treatment shall also be requested from the patient's guardian. Express and informed consent for admission or treatment of a patient under 18 years of age shall be required from the patient's guardian, unless the minor is seeking outpatient crisis intervention services under s. 394.4784...

394.4625 Voluntary admissions.--

(1) AUTHORITY TO RECEIVE PATIENTS.--

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

As to your questions:

1. If the minor is unwilling to be admitted, there isn't any choice but to release the minor or to initiate an involuntary examination. While the parent/guardian's application is required for voluntary admission, the minor's assent must also be sought. Overt danger isn't always necessary to establish the grounds for involuntary status. If the child has a mental illness, has refused or is unable to determine that the exam is needed and is likely to suffer from neglect or refuse to care for himself and this might lead to a real and present threat of substantial harm to his wellbeing, overt harm to self/others need not be present.
2. Voluntariness hearings were removed from the Florida Administrative Code in 1997 after a legislative committee deemed them to exceed DCF's authority to define a "Hearing" as other than a judicial hearing. Such a hearing would have to take place prior to, rather than after admission.

Q. I have some questions regarding the admission of minors under chapter 394. Involuntary is easy and makes sense, however voluntary admissions do not, so I would appreciate your expertise in this area. Chapter 394.4625(1)(a) states that a person under 17 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 are in agreement with admission, can we have the application 3097 signed? Do we need the psychiatrist to determine 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.

In 1997 a joint legislative committee determined that the "voluntariness hearing" described in the Baker Act Florida Administrative Rules at that time didn't conform to a "hearing" as intended in this section of the law because each other time that term was used in the law, it applied to a judicial hearing. As a result, all reference to "voluntary hearings" were deleted from the rules. The DCF General Counsel stated that only a judicial hearing would suffice to meet this legal requirement and that it had to be conducted prior to the minor's voluntary admission, despite the consent of the parents or assent of the child to the admission..

The 3097 form 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 to conduct an evaluation of voluntariness. However, this bill would have to pass the Legislature to take effect.

Q. We admitted a 15 year old girl to our CSU whose 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 comes as to whether or not the DCF or Community Based Care worker has the authority to sign the child in voluntarily or should a Petition for Involuntary Placement 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—filed a BA-3032. 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 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.

Q. When admitting a minor of any age, can they be admitted voluntary, against their will, with guardian consent? I have always been under the impression that they could not. I am being told otherwise. I would like to clear this up.

You are correct that minors cannot be legally admitted on voluntary status unless:

- the minor’s legal guardian has applied for the admission,
- the minor is in agreement to the admission (assent), and
- that a “hearing” has been conducted prior to the admission.

It is unlikely that pre-admission court hearings for voluntary admission of minors are being conducted anywhere in the state. For this reason, DCF has proposed legislative changes that would change this required court hearing. However, the legislation hasn’t passed and the “hearing” is still required.

As a result of this legal requirement, most receiving facilities admit minors on an involuntary status and if the minor and the legal guardian agree to the admission, then the minor is “transferred” to voluntary status, avoiding a voluntary “admission”. Some facilities still have staff do a “voluntariness hearing”, a provision that was removed from the Florida Administrative Code by legislative instruction in 1997. Some facilities review these voluntary admissions with the court magistrate at the time involuntary placement hearings are conducted. Other receiving facilities seem to just ignore the law entirely.

Involuntary Examinations

Q. One of the community facilities has told us that they will only take a child under 14 if the patient is Baker Acted. If the patient has insurance that would only be covered at this facility, we wouldn’t be able to transfer unless we Baker Act the patient. Is this appropriate?

Requiring that an initiation of involuntary status of a person who doesn’t meet that criteria is clearly incorrect. However, many hospitals want to ensure the person’s safety during transport and sometimes that can only be achieved when involuntary has been initiated because some medical transporters will release any voluntary person who demands such release.

Q. I work at a free-standing psychiatric hospital. As to minors (14 and above) it appears if the parents voluntarily admit their child with 3052b paperwork, there are no forms to be filed with the court (unless child is dependent). Is this correct? What discontinues the 3052b? Regarding consent to treat by a proxy, the proxy is initiated when within the first 24 hours the physician deems the patient incompetent to provide consent and is viable until a court hearing when an advocate is then appointed by the court. Correct?

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

If there is “3052b” paperwork, the child is on involuntary status and wouldn’t be voluntarily admitted by the child’s parents. If the BA-52 had been initiated prior to the child’s arrival at the facility, the law requires that law enforcement transport be provided and the BA-3100 form be completed by the officer. A parent wouldn’t present their child with the BA-52 paperwork.

While a parent’s application for voluntary admission on behalf of his/her child is required, it is also required that the child’s “assent” be obtained – agreement to the admission.

The law also requires that a judicial hearing to verify the voluntariness of the consent take place prior to the child's admission, although few if any counties in the state provides for such hearings.

If the parent doesn't file the application for voluntary admission or the child doesn't assent to the voluntary admission, the child must be continued on involuntary status and a BA-32 petition for involuntary inpatient placement must be filed with the Clerk of Court within 72 hours of the child's arrival at the facility.

Only a dependent child's parent is authorized to apply for his/her voluntary admission or to provide consent to the dependent child's treatment. If the parent can't or won't provide this consent for admission and treatment, only the court is authorized to do so.

Once a BA-52 is initiated, only a documented examination by a physician or clinical psychologist at a hospital or receiving facility documenting that the person doesn't meet criteria for involuntary placement can lead to conversion to voluntary status. At that time, an application for voluntary admission and consent to treatment can be completed by the parent of a minor. If the patient is an adult, a Certification of Competency must be documented that the patient is able to make well-reasoned, willful and knowing decisions on a consistent basis before an application for voluntary admission can be completed.

A proxy cannot provide consent to admission or treatment for a minor. With regard to an adult, a surrogate or proxy can't consent to a person's voluntary admission – the person must be held on involuntary status. When a physician documents that the patient isn't able to provide express and informed consent (well-reasoned, willful and knowing decision making), the surrogate/proxy is notified and signs the affidavit. After required information is provided to the surrogate/proxy about their duties as well as full disclosure about the treatment to be provided and the surrogate/proxy speaks with the patient and the physician, consent for treatment can be accepted. A petition for involuntary inpatient placement and appointment of a guardian advocate is then filed with the court within the time period provided by law. The Guardian Advocate will then, once appointed by the court, take the place of the surrogate/proxy for psychiatric decision-making.

Q. When two physicians have determined a minor to be incompetent for admission, does a petition for involuntary placement need to be sent in to the court or does the petitioner have the right to choose not to send it?

All minors are considered "incompetent to consent" by virtue of age. They can only be voluntary if the parent/guardian has applied for the child's admission and a court has conducted a hearing to verify the voluntariness of the consent.

Chapter 394.4625(1)(a), F.S. governs voluntary admissions. The "hearing" referred to in this section for minors has been determined to be judicial, rather than administrative. Another Baker Act provision is 394.459(3)(a) that governs right to express and informed patient consent. This section requires that each person (including minors) be asked to give express and informed consent for admission and treatment. If a minor, that consent must also be requested and obtained from the person's guardian.

If a minor objects to or is unable to fully understand the implications of inpatient care, a petition for involuntary placement must be filed with the court. There is no provision for a

waiver of filing/hearing in the law. Involuntary examination 394.463(1) and Involuntary Placement [394.467 (1), FS] provisions of the Baker Act make no distinction between minors and adults. If they meet the criteria listed in the law, a petition must be filed with the court.

Q. 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 and bi-lateral 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 has authority to initiate an ex parte order under the Baker Act – federal courts have no such authority, in addition to certified law enforcement officers and authorized mental health professionals. In fact, federal law enforcement officers can't initiate involuntary examinations per the Florida Attorney General – only law enforcement officers who are certified under state law. 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 others on legal or illegal bases. The DCF Assistant General Counsel concurred with the above response.

Q. Our Risk Managers (attorneys) indicated there is a gap in the Baker Act law. They instructed us that a child can be involuntarily examined (52), but cannot be involuntarily placed (32). 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?

Minors are frequently involuntarily placed by courts throughout the state. Minors cannot be ordered to involuntary outpatient placement -- this may have caused some confusion. The criteria for voluntary admission, as well as involuntary examination and placement are:

394.4625 Voluntary admissions.--

(1) AUTHORITY TO RECEIVE PATIENTS.--

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

394.463 Involuntary examination.--

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

(a)1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or
2. The person is unable to determine for himself or herself whether examination is necessary; and

(b)1. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or

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

394.467 Involuntary inpatient placement.--

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

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

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

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

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

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

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

394.459(3) RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT.--

(a)1. Each patient entering treatment shall be asked to give express and informed consent for admission or treatment. If the patient has been adjudicated incapacitated or found to be incompetent to consent to treatment, express and informed consent to treatment shall be sought instead from the patient's guardian or guardian advocate. If the patient is a minor, express and informed consent for admission or treatment shall also be requested from the patient's guardian. Express and informed consent for admission or treatment of a patient under 18 years of age shall be required from the patient's guardian, unless the minor is seeking outpatient crisis intervention services under s. 394.4784. Express and informed consent for admission or treatment given by a patient who is under 18 years of age shall not be a condition of admission when the patient's guardian gives express and informed consent for the patient's admission pursuant to s. 394.463 or s. 394.467.

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 394.467.
- 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, FS.

Q. In order to Baker Act a child or adolescent, do you need or must you have 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, a law enforcement officer, or an authorized mental health professional who has reason to believe the involuntary examination criteria is met. In no case under chapter 394.463 governing involuntary examination is a difference made between adults and minors noted – no parental consent is mentioned.

Q. A 16 year old male with suicidal behaviors and positive for illicit drugs was brought to our ER. The doctor initiated an involuntary examination but the patient's father, as the custodial parent, wanted to take him home without being seen by a psychiatrist; he preferred an appointment with a psychologist of his preference. Does the custodial parent (guardian) reserve the right to take the minor home against a doctor's opinion for inpatient evaluation?

The consent of a minor's guardian is required for voluntary status, but not for involuntary status. If a court, law enforcement officer, or authorized mental health professional have reason to believe the minor meets the criteria for involuntary examination, the minor must be taken to a receiving facility for an examination. The Administrator has the power to release/discharge a person only if the criteria for involuntary placement aren't met. Of course, for a receiving facility to keep a person longer than the 72 hours permitted for examination, a petition for involuntary placement must be timely filed with the court.

Q. Shouldn't the nearest Baker Act receiving facility accept an adolescent brought in by police for an involuntary evaluation even if they do not have an adolescent unit?

Receiving facilities are required to accept any person brought by law enforcement for involuntary examination. This is found in chapter 394.462(1)(j), FS "The nearest receiving facility must accept persons brought by law enforcement officers for involuntary examination". This is especially critical when the receiving facility is a licensed hospital because it is then governed by the federal EMTALA law that requires it to accept any person brought to its emergency department and to conduct a medical screening and stabilization before releasing or transferring the person. Failure to follow that federal law has serious consequences.

The community can incorporate into a proposed Transportation Exception Plan a provision that law enforcement officers transporting minors can bypass the nearest receiving facility and be taken to a receiving facility that has licensed pediatric psychiatric beds. However, if the minor is brought to another receiving facility in error, it must accept the minor and transfer the child to a more appropriate facility.

Q. 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 394.459,(3)(a)1 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 (394.463) by a physician or psychologist to determine if he/she meets criteria for involuntary placement (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.

Transportation & Transfers

Q. When transporting a juvenile for an involuntary examination we, law enforcement, have to transport to the nearest receiving facility unless there is a Transportation Exception Plan. I would rather transport a juvenile to a receiving facility that is properly equipped to handle the juvenile, rather than transport a juvenile, who is in crisis, to an adult center and have them wait there for further transportation. As it stands the closest facility (approximately 10 minutes away) does not have the facilities for juveniles. A different facility approximately 15 - 20 minutes away and is a juvenile receiving facility. Who defines the Transportation Exception Plan and is it something that a local agency can write?

The good news is that a Transportation Exception Plan for law enforcement to take minors to the nearest facility licensed with pediatric psychiatry beds has been approved by your Board of County Commissioners and the DCF Secretary. This will allow you to

by-pass the nearest receiving facility to deliver the minor to a receiving facility that has specialized programming for youth.

Q. A parent (legal guardian) has refused to allow her adolescent who is held for involuntary examination in a hospital ED to go to the closest receiving facility that treats adolescents; no other facilities have capacity. At what point does it become necessary to send the adolescent to that closest receiving facility, without consent of the parent?

There is no difference in the federal EMTALA law and the state Baker Act between how adults and minors are treated with regard to transfers. Clearly, the minor's guardian has the right to request a transfer on behalf of the minor. However, this request doesn't obligate another facility to accept the transfer.

If the sending facility is a designated receiving facility with licensed psychiatric beds for minors, it can only transfer after the consent of the guardian and the destination facility. If the guardian refused to consent to the transfer and your hospital has the capability and capacity to meet the child's needs, it must retain the child. If the sending ED is not a part of a Baker Act receiving facility, the ED physician can certify the necessity of the transfer and the child can be transferred without the consent of the guardian.

Q. If the minor is medically clear and no appropriate beds (for a minor) are available, the 12 hr time period has elapsed, what happens to the Baker Act? Is our facility obligated to discharge the patient? Does the Baker Act just end or do we continue to hold the patient and wait for an appropriate bed to become available? It is my understanding that if we don't admit the patient to our unit or find an appropriate bed within the 12 hour period, this is a direct violation and the Baker Act is discontinued.

Your hospital is a designated receiving facility; therefore the 12 hour provision isn't applicable. It is only applicable when a hospital where a person has been taken for examination/treatment of an emergency medical condition isn't designated as a receiving facility and therefore doesn't have the capability or capacity to meet the person's needs. Since your entire hospital is part of the receiving facility, the clock you need to be concerned with is the 72-hour clock.

If you don't have licensed beds for minors, you should begin the process of seeking an appropriate facility to which you can transfer the minor. The Baker Act does permit the admission of a minor to an adult unit under certain circumstances, as follows:

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

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

by the attending physician or a designee or on-call physician each day and documented in the case record.

While the above admission isn't ideal, any alternative is better than releasing a person of any age who is actively harmful to self or others due to an acute mental illness. Continue to document your efforts to locate another facility more appropriate for the patient.

Q. If a minor patient is Baker Acted to a hospital which has no psychiatric facility and the nearest receiving facility that accepts minors is at capacity, does the receiving facility legally have to accept the child (on an overflow)?

A receiving facility only has to accept a transfer if it has the capability (psychiatric care for the age of the patient) and capacity (available beds). If the hospital accepts transfers of paying patients over its capacity, it must also do so for non-paying patients. Otherwise, it can refuse the transfer and the child would be sent to the next closest facility that could meet the child's needs.

Q. Does the initiating hospital have to hold the child until a receiving facility accepts?

Yes. The transfer must take place within 12 hours after the child has been medically stabilized. An appropriate transfer can only take place when the destination hospital has agreed to the transfer.

Q. Can the child be transferred to another county and can that BA receiving facility deny admission if they do not accept the child's insurance (in this case straight Medicaid)?

Yes, the child can be transferred to another county if that is the nearest receiving facility with pediatric capability and capacity. While the initiating hospital should make every effort to send a patient to a receiving facility that accepts the person's insurance (or to a public receiving facility if the child is uninsured), no hospital can refuse a referral based on the person's inability to pay. This constitutes "reverse dumping" under EMTALA and must be reported to AHCA for investigation.

Q. May a Baker Act receiving facility transfer a Baker Act patient with a Medicaid HMO/Medicaid PSN/Medicaid FFS without the patient's or legal guardian's consent? May a Baker Act Receiving Facility transfer a Baker Act patient with a commercial plan without the patient's or legal guardian's consent?

No. The federal EMTALA law governs this issue and where the federal law is in conflict with the State's Baker Act law, the federal law prevails. A hospital with the capability and capacity to care for a person's needs cannot transfer a person with an emergency medical condition (even an emergency psychiatric condition) on a pre-admission basis without the consent of that person or his/her legal representative because of the person's inability to pay. No contract between a Managed Care Organization (MCO) can

excuse a hospital from its EMTALA obligations. MCO's cannot deny a hospital permission to treat its enrollees -- it can only refuse to pay. Even if the plan requires prior authorization, a Medicare or Medicaid MCO can't require prior authority for provision of emergency care.

Q. Regarding transfer agreements between two Baker Act facilities, I have been told that I must obtain a letter of agreement with another Baker Act facility to accept patients under the age of 14 that are brought to my facility under the Baker Act (if I do not offer child services and provided that we determine the patient is medically stable before being transferred). Do you know if this letter of agreement can be with a Baker Act facility in another county?

It would be in the best interest of the child and family to have the agreement with a nearby facility for the purpose of continuity of care and aftercare planning. Further, chapter 395 Florida's hospital licensing statute requires medically necessary transfers be made to the geographically closest hospital with the service capability and capacity, as follows:

395.1041 Access to emergency services and care.--
(3) (e) Except as otherwise provided by law, all **medically necessary transfers shall be made to the geographically closest hospital with the service capability,** unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

You have two licensed free-standing hospitals in your surrounding area that are licensed for children. There are also two CSU's for children closer than the hospital you propose. Any hospital, including free-standing Class 3 psychiatric hospitals are subject to the federal EMTALA law and must follow federal and state requirements for an appropriate transfer – for sending and accepting persons with psychiatric emergencies. Ability to pay for care for an unstabilized emergency cannot be considered as a condition for acceptance. Non-hospital receiving facilities are not subject to EMTALA or chapter 395. If the geographically closest hospital-based facilities don't have capability to serve minors, an agreement with an out-of-county receiving facility with such capability would appear to be acceptable.

Q. I am the Risk Manager at a residential treatment center and Baker Act receiving facility for children and adolescents, licensed as a specialty hospital. If a patient is admitted as a Baker Act (BA52) to a hospital ER for overdosing on medication, goes into a coma and comes out of the coma 7 days later, The hospital did not initiate an extension (BA32). The hospital then transfers the patient to our care. Did the Baker Act end at the 72 hour mark, requiring a BA32 (14 days) to be initiated? Does a BA52 end while a patient is unconscious? If the 72 hours period is still in effect, can we legally re-initiate a Baker Act because the first one expired after 72 hours? If the patient / guardian arrives here does not want to voluntarily sign in and is not stating they are suicidal or homicidal, what do we do? Do we

appeal for a BA32? Would the age of the patient matter? Does the Marchman Act play a role in this scenario?

- 1. Did the Baker Act end at the 72 hour mark, requiring a BA32 (14 days) to be initiated?** No. The 72-hour clock for involuntary examination stopped as soon as the physician at the ED documented an emergency medical condition. The clock starts again once the doctor determines that the person's medical condition has stabilized or that an emergency medical condition doesn't exist. In your scenario, the 72-hour clock wasn't even ticking for at least 7 days while the person was in a coma. It is possible that the emergency medical condition may have even extended beyond that time, depending on the documentation from the physician. The statute reads as follows:

394.463(2) Involuntary Examination

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

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

1. The patient must be examined by a designated receiving facility and released; or
2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

- 2. Does a BA52 end while a patient is not conscious?**

See the above response. The BA-52 is still valid until after the medical emergency is over.

- 3. If the 72 hours period is still in effect, can we legally re-initiate a Baker Act because the first one expired after 72 hours?**

You cannot re-initiate a new BA 52. It is the patient's right to not be held for longer than 72 hours for psychiatric examination, not the facility's right to have a full 72 hours to conduct the examination. It is understood that the psychiatric examination cannot take place while an emergency medical condition exists; however, any time that elapses other than for the medical emergency is deducted from what is available for the psychiatric exam.

4. If the patient/guardian arrives here does not want to voluntarily sign in and is not stating they are suicidal or homicidal, what do we do?

If the patient is on a voluntary status and doesn't meet criteria for involuntary placement, he/she must be released. However, the criteria extends beyond just vocalizing suicidal or homicidal ideations. The criteria is as follows:

394.463 Involuntary examination.--

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

(a)1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or

2. The person is unable to determine for himself or herself whether examination is necessary; and

(b)1. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or

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

As you can see from the above, refusal to undergo the exam is not always necessary – it can be due to inability to make well-reasoned, willful, and knowing decisions. It can be due to passive self-neglect as well as overt danger. Even if overt danger, there must be reason to believe that there is substantial likelihood (based on recent behavior) that he person will cause serious bodily harm.

5. Do we appeal for a BA32?

It is unclear what you mean by "appeal for a BA 32". If the person meets the criteria for involuntary placement (as differentiated from involuntary examination), a receiving facility may file the petition in a timely manner with the clerk of court.

6. Would the age of the patient matter?

The age of the patient doesn't matter for involuntary examination and involuntary placement. However, the age does matter for voluntary admission. A voluntary admission of a person age 17 or younger is based on an application by the child's parent or legal guardian (not just a caretaker or DCF) as well as the

assent (agreement) by the child. The law also requires a hearing prior to the voluntary admission of a minor.

7. Does the Marchman Act play a role in this scenario?

The Marchman Act wouldn't apply in the scenario you presented unless the basis of the overdose was solely due to substance abuse impairment as defined in chapter 397 instead of a mental illness as defined in chapter 394.

Involuntary Placement

Q. Is there a requirement for a natural parent to attend the Baker Act hearing of an adolescent, over the age of 13? The magistrate found a minor to meet the criteria for involuntary hospitalization and treatment with psychotropic medications. The parents have joint custody and the father encourages his daughter's noncompliance with her medications.

The Baker Act doesn't address the presence of parents/guardians at the involuntary placement hearings. However, it seems unusual that a parent who lives locally whose child meets such acute criteria wouldn't insist on being a part of the process and to encourage the child's compliance with medically recommended treatment. If a parent denies necessary medical treatment to his/her child, a report to DCF might be considered. No treatment can be provided to the minor, regardless of age, without the consent of a guardian or the court, short of imminent danger.

Decision making by divorced parents is governed by chapter 61, FS -- this law has just been dramatically amended by the 2008 Legislature. It eliminates terms such as "custody" and replaces them with terms such as "parenting plan", "time sharing schedule", "shared parental responsibility", and "sole parental responsibility". In any case, with shared parental responsibility (previously called shared custody), both parents retain access to information and records as well as decision-making about their child. If they disagree, they need to go back to family court for resolution to the parenting plan that contains information about consent issues.

Separation of Minors from Adults

Q. Is it permissible to house minors age 14 and older on the same unit as adults? We have a distinct area of 10 beds, although it is not separated by locked doors, where adolescents can stay at times. 394.4785 speaks to part of this but I am unclear if the intent is that adolescents and adults are SHARING a room on the unit, not as in our case, just sharing the unit space. We would not ever have the adolescents and adults sharing rooms.

Chapter 394.4785(1), FS permits children and adolescents to be admitted to licensed hospitals on voluntary status and on involuntary placement status. You may have noticed that this section doesn't mention admission of minors to hospitals or CSU's for involuntary examination, which is of course a necessary step for an involuntary placement petition to be filed. This seems to be an error in the statute that may be addressed in future revisions to the Baker Act.

However, s.394.4785(2), FS prohibits placing children under the age of 14 in rooms with adults or sharing common space with adults. It does permit persons 14 and older to actually share a room with an adult if the physician documents on a daily basis that the placement is necessary for safety or medical reasons. Your inquiry states that you wouldn't have minors and adults sharing the same rooms. However, there is no prohibition in the law against persons age 14 or above from sharing common space with adults on a psychiatric unit. Your staff may provide continuous observations to absolutely ensure that the adolescents and adults are never left unattended. The liability in such cases may be high.

You may need to consult with AHCA since a separate CON/license is needed for pediatric psychiatric beds from those licensed for adults. If an occasional 16 or 17 year old was housed on common areas with adults, that might not be necessary. However, when a unit is established, staffed and program designed specifically for minors, it may be a different issue.

Juvenile Delinquency (s.985.115, FS)

Q. The LCSW at our Juvenile Detention Center initiated a Baker Act for a youth in DJJ custody. The facility contacted the mobile crisis unit, per protocol, who stated they would be out to assess later that evening. The CSU called JDC and stated the youth met Baker Act criteria, however, if DJJ did not provide an officer to stay with the youth she would not be accepted. This was related to aggressiveness during a previous Baker Act. Is DJJ required to provide an officer to stay with the youth during Baker Act? Also, is it acceptable for the Crisis Unit to not assess the youth at all (either at their facility or the DJJ facility) after the Baker Act was initiated by a licensed professional?

There is no requirement in the Baker Act for a referral agent to provide a sitter or law enforcement officer as a condition of a receiving facility accepting a person for involuntary examination.

394.462 Transportation.

(1)TRANSPORTATION TO A RECEIVING FACILITY.—

(j)The nearest receiving facility **must accept** persons brought by law enforcement officers for involuntary examination.

While a person with minor criminal charges must be taken to a receiving facility instead of to jail, the law makes some difference for those who have been arrested for a felony. If the child has actually been arrested for a felony (not just a "delinquent act") and has been "processed" at the JDC, it is totally appropriate for the child to then be sent to the receiving facility for examination and/or treatment. Only if the facility documents that it is unable to provide adequate security can it deny admission, but remains legally responsible for providing mental health examination and treatment to the child where he or she is held.

394.462 Transportation.

(1)TRANSPORTATION TO A RECEIVING FACILITY.—

(f)When any law enforcement officer has custody of a person based on either noncriminal or minor criminal behavior that meets the statutory guidelines for involuntary examination under this part, the law enforcement officer shall transport the person to the nearest receiving facility for examination.

(g)When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under this part, such person shall first be processed in the same manner as any other criminal suspect. The law enforcement agency shall thereafter immediately notify the nearest public receiving facility, which shall be responsible for promptly arranging for the examination and treatment of the person. A receiving facility is not required to admit a person charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide mental health examination and treatment to the person where he or she is held.

This would mean the full range of treatment services provided at a CSSU would have to be delivered at the JDC. Suggesting that behavior from a previous admission is sufficient to deny admission without an accompanying officer is not appropriate. Receiving facilities are established to care for persons of all ages who because of mental illness are “dangerous to self or others”. Those persons may be aggressive and staff are trained to de-escalate such individuals.

Q. Do law enforcement officers have to take minors with “felony” charges and who have had an involuntary examination under the Baker Act initiated to the Juvenile Assessment Center or to a designated receiving facility?

It is the responsibility of DJJ to provide housing for the child, while it is the responsibility of the CCSU according to 394 to provide crisis evaluation and treatment as needed. DCF central office has been working with DJJ to sort out the process of transition and providing services to children in DJJ custody. According to the Baker Act, CCSU’s have the right not to admit a child with felony charges to their facility if they feel they cannot provide adequate security. In the event they do not accept DJJ children, then CCSUs by law must then provide services where the child is held.

Q. Can a public receiving facility bill a DJJ-contracted facility for an indigent (non-Medicaid) child who receives involuntary examination initiated by the DJJ facility professional staff? I feel that the answer is no, but I don't know what authority to cite.

DJJ has no responsibility to pay for the cost of involuntary examination or placement of a youth in a public or private receiving facility. The following AG opinions deal with payment of Involuntary Placement Bills

Attorney General Opinion 93-49 Regarding Who is Responsible for the Payment of an Involuntary Baker Act Placement, 1993 WL 384795 (Fla. A.G.) Attorney General Robert A. Butterworth advised the Board of County Commissioners for Lafayette County, FL that the county is not primarily responsible for the payment of hospital costs, however, a county may be liable for hospital costs in the event a person is arrested for a felony involving violence

to another person, and the arrested person is indigent. Depending upon the Baker Act patient's ability to pay, the patient is responsible for the payment of any hospital bill for involuntary placement under the Baker Act, however, if the patient is indigent, the Department of Health and Rehabilitative Services (HRS) is obligated to provide treatment at a receiving facility and HRS provides treatment for indigent Baker Act patients without any cost to the county.

Attorney General Opinion 74-271 Regarding Involuntary Hospitalization in Psychiatric Facility. A circuit court judge may order a patient involuntarily hospitalized at a private psychiatric facility not under contract with the State provided that 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.

The above summaries place responsibility on the patient to pay for care. If neither the patient nor an insurer can pay, DCF provides this care through a public receiving facility under contract with the department. The Baker Act only mentions recovery of cost of care for arrested persons as follows:

394.462 Transportation.--

(1) TRANSPORTATION TO A RECEIVING FACILITY.--

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

Chapter 901, FS governs arrests. The above section reads as follows;

901.35 Financial responsibility for medical expenses.--

(1) Notwithstanding any other provision of law, the responsibility for paying the expenses of medical care, treatment, hospitalization, and transportation for any person ill, wounded, or otherwise injured during or at the time of arrest for any violation of a state law or a county or municipal ordinance is the **responsibility of the person** receiving such care, treatment, hospitalization, and transportation. The provider of such services shall seek reimbursement for the expenses incurred in providing medical care, treatment, hospitalization, and transportation from the following sources in the following order:

(a) From an insurance company, health care corporation, or other source, if the prisoner is covered by an insurance policy or subscribes to a health care corporation or other source for those expenses.

(b) From the person receiving the medical care, treatment, hospitalization, or transportation.

(c) From a financial settlement for the medical care, treatment, hospitalization, or transportation payable or accruing to the injured party.

(2) Upon a showing that reimbursement from the sources listed in subsection (1) is not available, the costs of medical care, treatment, hospitalization, and transportation shall be paid:

- (a) From the general fund of the county in which the person was arrested, if the arrest was for violation of a state law or county ordinance; or
- (b) From the municipal general fund, if the arrest was for violation of a municipal ordinance.

The responsibility for payment of such medical costs shall exist until such time as an arrested person is released from the custody of the arresting agency.

- (3) An arrested person who has health insurance, subscribes to a health care corporation, or receives health care benefits from any other source shall assign such benefits to the health care provider.

Nowhere above is DJJ assigned responsibility. Chapter 985, FS governing juvenile justice provides for access to medical care for youth in DJJ custody as follows:

985.18 Medical, psychiatric, psychological, substance abuse, and educational examination and treatment.--

(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, by a district school board educational needs assessment team, or, if a developmental disability is suspected or alleged, by a developmental disabilities diagnostic and evaluation team with the Agency for Persons with Disabilities. **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) Whenever a child has been found to have committed a delinquent act, or before such finding with the consent of any parent or legal custodian of the child, the court may order the child to be treated by a physician. The court may also order the child to **receive mental health, substance abuse, or retardation 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, whichever is applicable, shall be used.** After a child has been adjudicated delinquent, if an educational needs assessment by the district school board or the Department of Children and Family Services has been previously conducted, the court shall order the report of such needs assessment included in the child's court record in lieu of a new assessment. For purposes of this section, an educational needs assessment includes, but is not limited to, reports of intelligence and achievement tests, screening for learning disabilities and other handicaps, and screening for the need for alternative education.

(3) When any child is detained pending a hearing, the person in charge of the detention center or facility or his or her designated representative may authorize a triage examination as a preliminary screening device to determine if the child is in need of medical care or isolation or provide or cause to be provided such medical or surgical services as may be deemed necessary by a physician.

(4) Whenever a child found to have committed a delinquent act is placed by order of the court within the care and custody or under the supervision of the Department of Juvenile Justice and it appears to the court that there is no parent, guardian, or person standing in loco parentis who is capable of authorizing or willing to authorize medical, surgical, dental, or other remedial care or treatment for the child, the court may, after due notice to the parent, guardian, or person standing in loco parentis, if any, order that a representative of the Department of

Juvenile Justice may authorize such medical, surgical, dental, or other remedial care for the child by licensed practitioners as may from time to time appear necessary.

(5) Upon specific appropriation, the department may obtain comprehensive evaluations, including, but not limited to, medical, academic, psychological, behavioral, sociological, and vocational needs of a youth with multiple arrests for all level criminal acts or a youth committed to a minimum-risk or low-risk commitment program.

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

(7) Nothing in this section shall be deemed to eliminate 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.

Subsection (5) above seems to suggest that DJJ would have to have a specific legislative appropriation to pay for such care.

Q. I have a question about transportation of juveniles. One of my deputies responded to the Juvenile Detention Center and was asked to transport a kid that was court ordered to serve 20 days. While he was there someone from DJJ initiated a Baker Act. All of the papers were signed and they wanted us to transport him to the receiving center. He was in their care, control and custody. I told DJJ to transport him just like they would if the kid had a Dr.'s appt or other court ordered event. The DJJ supervisor said that the SO does it all the time but agreed that DJJ would do it this time. The deputy said he knew of other times we did transport but only when the kid's sentence was complete. Can you comment on both situations of when he is mid sentence or completed sentence? What if the deputy response to a disturbance and there is no staff there to initiate a Baker Act. If the kid meets the criteria for Baker Act could or should we remove him from a secure facility?

The criminal/delinquency law and the Baker Act can be used simultaneously, unless there something in the criminal law that directly contradicts the Baker Act. In this case, law enforcement continues to have responsibility to provide the transport of a person from any setting except a hospital (because of the federal EMTALA law) of a person under involuntary examination status to the nearest receiving facility. The following are some legal citations that might help:

985.115 Release or delivery from custody.--

(2) Unless otherwise ordered by the court under s. 985.255 or s. 985.26, and unless there is a need to hold the child, a person taking a child into custody shall attempt to release the child as follows:

(d) If the child is believed to be mentally ill as defined in s. 394.463(1), to a law enforcement officer who shall take the child to a designated public receiving facility as defined in s. 394.455 for examination under s. 394.463.

985.18 Medical, psychiatric, psychological, substance abuse, and educational examination and treatment.--

(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, by a district school board educational needs assessment team, or, if a developmental disability is suspected or alleged, by a developmental disabilities diagnostic and evaluation team with the Agency for Persons with Disabilities. 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.

394.462 Transportation.--

(1) TRANSPORTATION TO A RECEIVING FACILITY.--

(a) Each county shall designate a single law enforcement agency within the county, or portions thereof, to take a person into custody upon the entry of an ex parte order or the execution of a certificate for involuntary examination by an authorized professional and to transport that person to the nearest receiving facility for examination. The designated law enforcement agency may decline to transport the person to a receiving facility only if:.. *[there are exceptions listed, but none of them are related to juvenile justice]*

394.463(2) INVOLUNTARY EXAMINATION.--

(a) An involuntary examination may be initiated by any one of the following means:

3. A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer shall take the person named in the certificate into custody and deliver him or her to the nearest receiving facility for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report and certificate shall be made a part of the patient's clinical record. Any receiving facility accepting the patient based on this certificate must send a copy of the certificate to the Agency for Health Care Administration on the next working day.

There are also two appellate cases – one says only law enforcement can transport persons on involuntary examination status and the other says that because such transport is non-discretionary, the officer is immune from any civil or criminal liability.

Q. A local receiving facility recently stated that it didn't have to accept minors on a Baker Act if they were from JDC. Is this correct?

The issue of minors with felony charges has come up as a result of the following section of the law:

394.462 Transportation.--

(1) Transportation to a Receiving Facility.--

(f) When any law enforcement officer has custody of a person based on either noncriminal or minor criminal behavior that meets the statutory guidelines for involuntary examination under this part, the law enforcement officer shall transport the person to the nearest receiving facility for examination.

(g) When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under this part, such person shall first be processed in the same manner as any other criminal suspect. The law enforcement agency shall thereafter immediately notify the nearest public receiving facility, which shall be responsible for promptly arranging for the examination and treatment of the person. A receiving facility is not required to admit a person charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide mental health examination and treatment to the person where he or she is held.

While the above section was originally intended to apply only to adults, the language is not limited to adults. Further, chapter 985 governing juvenile delinquency generally refers to "delinquent acts" instead of "felonies". Many communities believe the JAC and/or JDC must process the child first, even though he/she may be threatening suicide. Most DJJ facilities won't accept a child who is suicidal. This catches law enforcement and the child between the two systems. However, any minor should have the benefit/protection of the civil mental health system, regardless of his/her charges.

Q. Law enforcement agencies in our area refuse to initiate or even transport a child for an involuntary examination under the Baker Act if the child was committed to a DJJ program. The law enforcement agency states that since the child is in a DJJ program under a court order, the officer had no authority to remove the child from the placement without further order of the court. Can a juvenile who has been committed to a DJJ program undergo an involuntary examination under the civil Baker Act?

The DJJ statute clearly allows any child committed to such a program to be transferred to a mental health or substance abuse program for a period of up to 90 days. The specific provision is as follows:

985.418 Transfer to other treatment services.--Any child committed to the department may be transferred to retardation, mental health, or substance abuse treatment facilities for diagnosis and evaluation pursuant to chapter 393, chapter 394, or chapter 397, whichever is applicable, for a period not to exceed 90 days.

Q. We are trying to address issues about disabled (autistic, schizophrenic, etc.) children who create a disruption and are taken into custody on school property, often for battery on a school employee, which is a felony. The goal is to try to get school administration and law enforcement to deal with these children in a way that recognizes the children's limitations and hopefully avoids arrest and transportation to DJJ / jail facilities. Do you have any suggestions?

This issue you raise is a serious one. Some school districts have had disproportionately high rates of arrest among students as a first line of defense in a "0-Tolerance" policy implementation. Even when criminal charges are brought, chapter 985 provides the following:

985.115 Release or delivery from custody.--

(1) A child taken into custody shall be released from custody as soon as is reasonably possible.

(2) Unless otherwise ordered by the court under s. 985.255 or s. 985.26, and unless there is a need to hold the child, a person taking a child into custody shall attempt to release the child as follows:

(d) If the child is believed to be mentally ill as defined in s. 394.463(1), to a law enforcement officer who shall take the child to a designated public receiving facility as defined in s. 394.455 for examination under s. 394.463.

(e) If the child appears to be intoxicated and has threatened, attempted, or inflicted physical harm on himself or herself or another, or is incapacitated by substance abuse, to a law enforcement officer who shall deliver the child to a hospital, addictions receiving facility, or treatment resource.

However, the Baker Act has some conflicting language:

394.462 Transportation.--

(1) Transportation To A Receiving Facility.--

(f) When any law enforcement officer has custody of a person based on either noncriminal or minor criminal behavior that meets the statutory guidelines for involuntary examination under this part, the law enforcement officer shall transport the person to the nearest receiving facility for examination.

(g) When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under this part, such person shall first be processed in the same manner as any other criminal suspect. The law enforcement agency shall thereafter immediately notify the nearest public receiving facility, which shall be responsible for promptly arranging for the examination and treatment of the person. A receiving facility is not required to admit a person charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide mental health examination and treatment to the person where he or she is held.

This has placed law enforcement officers in an awkward situation where the Juvenile Assessment Center (CAC) won't accept a child with acute mental health or substance abuse issues, but the receiving facility or Juvenile Addiction Receiving Facility (JARF) won't accept a child with felony charges. There have been complaints around the state about officers stuck driving between JAC and JARF programs, neither willing to accept the child.

When arrests are used, an apparent discriminatory pattern sometimes emerges. Then schools turn to the next method of removing youth from a campus -- the Baker Act. These schools often insist on school resource officers initiating the involuntary examination and some districts even prohibit school-based licensed mental health personnel from doing the initiation. Failure to have behavioral health professionals involved in these situations often results in an excess of unnecessary Baker Acts being done -- often for the wrong reasons.

These students are usually released from the Baker Act receiving facility in 1-3 days and returned to the classroom. All it accomplishes some times is placing a stigma against the child. However, when schools recommend parents take these children for voluntary examination and treatment, many never follow through.

Receiving Facilities

Q. Our free-standing psychiatric hospital is licensed only for adults. However, I've always been under the impression that either a CSU or psychiatric hospital could admit a child 14 as long as the doctor felt it would be appropriate for the child to be on a unit with adults? If not, could we refuse to accept a minor?

A **non-hospital CSU** is permitted to let a child **under 14** share common areas of the unit with adults when under direct visual observation by staff, but not to share a room. If **14 or over**, the child can share a room only when the physician daily documents medical or safety reasons. Chapter 65E-12 governing CSU's (not hospitals) has the following language:

Section 65E-12.106, FAC Common Minimum Program Standards.

(22) Children. Every program which serves persons under 18 years of age shall define, in local program standards, the services and supervision to be provided to the children. Minors under the age of 14 years shall not 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 shall be reviewed and documented on a daily basis.

Hospitals have a little different and more stringent provision in the Baker Act. Minors under 14 cannot share common areas with adults or a room. However, if 14 or over, they can share a room if the physician documents daily that the co-location with an adult is necessary for medical or safety reasons.

Now, with regard to the federal **EMTALA law**, all hospitals accepting unscheduled admissions are subject to EMTALA as a free-standing psychiatric hospital if it accepts persons on an unscheduled "emergency" basis. Emergency psychiatric conditions and emergency substance abuse conditions are defined by CMS as emergency medical conditions, even if no other physical problems are identified. Therefore, all provisions of EMTALA apply. We know that as a designated receiving facility free-standing

psychiatric hospitals do indeed accept persons with emergency conditions on an unscheduled basis.

Such free-standing psychiatric hospitals must perform on all persons brought onto the premises of the hospital a screening examination within the capability of the facility to provide. If the hospital determines on the basis of the examination that it doesn't have the capacity (space) or capability (programming) to meet the emergency needs of the person, it can seek a transfer of the person to another hospital that has the capability and capacity and that provides prior approval for the transfer. This transfer may be on the basis of the individual's medical condition, the age of the individual (minors for which it isn't licensed, etc. If the transfer is on the basis of "capacity or capability", it may be possible to perform a transfer without the consent of the individual – only requiring the certification of a physician. However, it cannot request a transfer without the consent of the individual (or legal representative) undergoing an emergency solely on the basis of inability to pay as this has no relevance to the hospital's capacity or capability.

CSU's licensed under Chapter 394, Part IV, FS are not hospitals and are **not subject to EMTALA**. Some public receiving facilities are hospitals – not CSUs and, if licensed as hospitals, they are subject to EMTALA. Some hospitals are public receiving facilities if they have a contract with DCF for Baker Act appropriated funds. Such hospitals are subject to EMTALA. The term public/private only relates to whether Baker Act appropriated funds are provided under contract with DCF. Hospital are licensed under chapter 395 and CSU's are licensed under Chapter 394. EMTALA only applies to hospitals that accept persons under emergency conditions.

Q. We are a Baker Act facility for adults - no acute beds for minors. Last Friday the police dropped off a 12 years old and then we spent hours trying to transfer him to another facility in the area who serves that population. My question is: Do we have to accept that patient or can we tell the police that they need to take him to the next Baker Act facility a few miles away that treats acute minors? I ask this because there is absolutely no place at our facility for that patient to go once dropped off.

The issue you raise is one that DCF HQ and Circuit staff along with AHCA staff spent a great deal of time discussing about a year or so ago. As a licensed hospital that accepts individuals for emergency psychiatric conditions, you are subject to the federal EMTALA law. You must accept and provide the required medical screening examination within the capability of your free-standing hospital to provide. If the minor can't be released because you've confirmed the presence of an emergency medical condition (psychiatric and substance abuse emergencies are EMC's) and you can't admit because you're not licensed for minors, you have to transfer the minor to "A Designated Receiving Facility".

The facility to which you transfer doesn't need to be the nearest. It was resolved earlier that you would transfer such minors to your sister facility in another county if you couldn't arrange a transfer to local facility serving minors.

Besides the federal EMTALA law, the state's Baker Act requires the nearest receiving facility to accept any person brought by law enforcement for involuntary examination. A Transportation Exception Plan should be devised for your area of the state to permit law enforcement officers to deliver all minors directly to facility licensed and funded for minors. Such a Plan requires approval by the affected Boards of County Commissioners

and the Secretary of DCF. It permits but doesn't require law enforcement to follow the exception, but without the TEP, the officer has no legal choice but to deliver a person of any age on involuntary status to the nearest facility and for your hospital to "accept" (but not necessarily admit) the individual.

Q. Our hospital is licensed for acute adult beds and child residential beds. Lately local law enforcement has dropped off an adolescent for acute admission. We are not licensed for this level of care and have a very difficult time transferring these patients to an acute facility. My question: As a Baker Act receiving facility must we accept these patients from law enforcement or are we able to instruct law enforcement to take the patient to a nearby facility that is licensed as a Child and Adolescent Hospital? Currently we are admitting these patients and placing them on the adult unit on a 1:1 level of observation.

This issue is related to your obligations under the federal EMTALA law as well as the state's Baker Act. EMTALA generally requires all licensed hospitals to accept any person and to conduct a "medical screening examination" to determine if the person has an emergency medical condition. If so, all aspects of EMTALA apply regarding transfer requirements. CMS defines an emergency medical condition to include emergency psychiatric and substance abuse conditions, even absent any other medical issues. Age of the patient isn't a factor in acceptance. However, once you document you don't have the capacity or capability to manage the person's emergency, you can seek a transfer to a willing hospital that does have the capacity and capability. Not being licensed to provide inpatient care for minors would be a "capability" limitation in justifying the necessity of a transfer.

The other free standing psychiatric program in your area is also licensed as a hospital and is licensed to serve minors -- as such it has certain obligations to accept the transfer of persons for which it has the capability and capacity -- regardless of the person's ability to pay for care.

The state's Baker Act requires law enforcement to deliver a person on involuntary status to the nearest receiving facility and for "the nearest receiving facility to accept any person brought by law enforcement for involuntary examination". Once you've "accepted" the person from law enforcement, you can seek a transfer under the provisions specified in the law, as follows:

394.4685 Transfer of patients among facilities.

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

(3)TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.—

(a)A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.

(b)A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the

patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

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

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

The Baker Act provides for a “Transportation Exception Plan” permitting variance from the above transportation requirements for certain purposes – one of which could be allowing (but not requiring) law enforcement to take minors to a specified receiving facility that has the capability of addressing the needs of minors, even when not the nearest facility. Such a TEP exists in Pinellas, Broward, and Miami-Dade. TEP’s for other purposes exist in counties around the state such as for a centralized receiving facility or other permitted reasons. In any case, a TEP must be approved by the Board of County Commissioners and the DCF Secretary before implantation.

DCF Circuit Office staff would be critical to developing such a proposed plan and to help negotiate improved transfer agreements between local receiving facilities.

Q. I am the CEO of a freestanding psychiatric hospital. I have a question regarding our pending Baker Act designation. DCF has completed our unit inspection. I have been told that I must obtain a letter of agreement with a CCSU if I choose to only be a CSU. I was also told that a CSU is for all ages, but I do not understand how a CSU would then differ from a CCSU. I don’t want to admit Baker Acts under the age of 14.

You use the term CSU and CSSU for your facility. This is probably not correct since these terms are legally restricted to state-funded public receiving facilities. They have a substantial range of additional requirements contained in 65E-12, FAC that are over and above the hospital requirements in chapter 395 and the Baker Act requirements in chapter 394, FS and 65E-5, FAC. You may be using these terms in substitution for designation as a receiving facility, which may be a CSU/CSSU or a licensed hospital.

The state’s Baker Act statute [394.4785(2)] prohibits persons under the age of 14 from sharing a room or any common area with an adult. This means that you would have to seclude a child of this age in an enclosed area with 1 to 1 staff. This seclusion may not be acceptable under your federal CMS Conditions of Participation or under the Baker Act because the child hasn’t demonstrated any imminent danger to warrant the seclusion.

A CCSU is limited to serving persons under the age of 18. A CSU is legally authorized to serve persons of any age. While you may not want to accept children under the age of 14, you would have to accept them if brought to you by law enforcement for Baker Act involuntary examination. Further, as a licensed hospital subject to the federal EMTALA law, you would have to accept any person brought to you and provide a medical screening within your hospital’s capability. If determined that you cannot meet the specialized emergency needs of the child, you would have to seek an appropriate transfer. As you know, the federal EMTALA regulations are very precise as to what

constitutes an appropriate transfer and there are serious consequences for failing to meet these requirements.

You may wish to work with the DCF Circuit staff in developing a Transportation Exception Plan for your county in which children under a certain age could be diverted by law enforcement to a facility that has the capability of serving this age group. Such a plan requires approval by the Board of County Commissioners and the Secretary of DCF. Such plans are in place in several counties throughout the state. A MOU with facilities serving children under the age of 14 is a good idea. However, it might be difficult for any such facility to guarantee immediate access to a transfer. Many facilities are at full capacity and with the shortfalls in state general revenue funding; public receiving facilities cannot always meet this need.

Under EMTALA, no licensed hospital with the capability and capacity to manage a person's specialized emergency needs can delay or deny a transfer solely on the basis of inability to pay. It can only refuse a transfer based on lack of capability and capacity. A non-hospital CSU/CSSU is not subject to EMTALA.

Q. We are considering the closure of our Child and Adolescent unit. If we were to move forward with this would we still be required to receive ages 0-13 when placed on a Baker Act? Is there a statute to this effect and if so what is it? Concerning the possibility of the Transportation Exception Plan, what are the steps involved/time frames to get this? Is there criteria that must be met in order to qualify for this? Do you know of facilities that have a Transportation Exception Plan in effect, and if so, how does it work for them?

Enclosed information below that describes the statutory and code requirements related to Transportation Exception Plans.

394.462 Transportation.--

(1) Transportation to a Receiving Facility.--

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

(3) EXCEPTIONS.--An exception to the requirements of this section may be granted by the secretary of the department for the purposes of improving service coordination or better meeting the special needs of individuals. A proposal for an exception must be submitted by the district administrator after being approved by the governing boards of any affected counties, prior to submission to the secretary.

(a) A proposal for an exception must identify the specific provision from which an exception is requested; describe how the proposal will be implemented by participating law enforcement agencies and transportation authorities; and provide a plan for the coordination of services such as case management.

(b) The exception may be granted only for:

1. An arrangement centralizing and improving the provision of services within a district, which may include an exception to the requirement for transportation to the nearest receiving facility;
 2. An arrangement by which a facility may provide, in addition to required psychiatric services, an environment and services which are uniquely tailored to the needs of an identified group of persons with special needs, such as persons with hearing impairments or visual impairments, or elderly persons with physical frailties; or
 3. A specialized transportation system that provides an efficient and humane method of transporting patients to receiving facilities, among receiving facilities, and to treatment facilities.
- (c) Any exception approved pursuant to this subsection shall be reviewed and approved every 5 years by the secretary.

65E-5.2601 Transportation Exception Plan.

- (1) In determining whether to approve a proposal for an exception or exceptions to the transportation requirements of Section 394.462(3), F.S., the following shall be considered by the department:
- (a) The specific provision from which an exception is requested;
 - (b) Evidence presented by the department's district or region of community need and support for the request;
 - (c) Whether the proposal is presented in a format that is clear, simple, and can be readily implemented by all parties and the public;
 - (d) How the proposed plan will improve services to the public and persons needing Baker Act services; and
 - (e) Whether the geographic boundaries identified in the proposal are distinct and unambiguous.
- (2) The proposal must include provisions which address:
- (a) Accountability for delays or confusion when transportation fails to respond appropriately;
 - (b) How disputes which may arise over implementation of the plan will be resolved;
 - (c) Identification of the public official whose position is responsible for the continuing oversight and monitoring of the service in compliance with the terms of the approved proposal;
 - (d) The plan for periodically monitoring compliance with the proposal, public satisfaction with the service provided, and assurance of rights of each person served by the facility;
 - (e) The method complaints and grievances are to be received and resolved; and
 - (f) Community support and involvement including a description of the participation of designated public and private receiving facilities, law enforcement, transportation officials, consumers, families, and advocacy groups.
- (3) The approval by the governing boards of any affected counties, shall be certified in writing by the district or region's mental health and substance abuse program supervisor, prior to the plan's submission to the Secretary of the Department.

Under the federal EMTALA law, your hospital is required to accept all persons and to perform a medical screening examination, regardless of age or type of condition. This applies to those on voluntary or involuntary status. An emergency psychiatric condition is considered by the federal government to be an emergency medical condition even if no other medical condition exists. If you had no beds for psychiatrically impaired minors,

your hospital would be responsible for seeking out a specialty hospital or receiving facility and obtaining prior approval before transferring the child once stabilized for transfer. You would be responsible for arranging safe and appropriate transport for the child to the destination facility.

EMTALA, the Emergency Medical Treatment and Active Labor Act, is the patient “antidumping” provision of Section 1867 of the Social Security Act. Corresponding state statutes are included in Chapter 395.1041 governing Access to Emergency Care. Chapter 395 is Florida’s hospital licensing statute. It is more stringent than the federal EMTALA law in places.

With regard to your questions about hospitals’ obligations under the Baker Act, chapter 395 addresses this in several cites.

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

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

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

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

395.1065(6) governing criminal and administrative penalties states “In seeking to impose penalties against a facility as defined in s. 394.455 for a violation of part I of chapter 394, the agency is authorized to rely on the investigation and findings by the Department of Health in lieu of conducting its own investigation”.

It appears from your message that your hospital may intend to retain its adult psychiatric unit and its designation as a receiving facility? If so, even under the state’s Baker Act it would required to accept any person brought by law enforcement for involuntary examination. A Transportation Exception Plan could be submitted to your Board of County Commissioners and to the DCF Secretary for approval to have minors of the age you specify diverted away from your hospital unless they have significant medical issues.

Q. We have an adolescent who will be going to a residential program where a teacher will work with him to try to get him to, or keep him at, grade level work. Whose responsibility is it to inform his school that he will not be returning? Do you have any educational tools or communication with the schools?

There was a specific right to education in the Baker Act until the 1996 amendments. However, that was removed because it is the responsibility of DOE to provide this education, regardless of where the child is. The 65E-12 CSU rules have no specific requirements governing this issue. You would have to contact the school system to find out how each school boards meet this obligation, whether through visiting teachers, web-based, sending lessons via family, etc. It may be different methods used in each school system.

Release of Information

Q. A School Resource Officer initiated an involuntary examination on a 14 yr. old. who was transported to an adolescent unit where she was retained for a few days. The school is now inquiring about the absence of this student and is requesting documentation evidencing that the student was in fact "Baker Acted". They have no cooperation from the student's mother. Can a school request the paperwork from law enforcement? Although public record, is a minor protected from such disclosure? If law enforcement initiates an involuntary exam. on a child or adolescent while in the school, would you recommend that police provide a copy of the form to the school? Is there any way to ameliorate this dilemma, protect minors and meet the request of the school?

The Florida Attorney General has issued two opinions on this subject. Both indicate that the Baker Act forms (initiation and transport) are confidential and exempt from the state's public record law. They cannot be released. However, any other forms prepared by law enforcement, such as incident reports, are public records and anyone can ask for them, including the school personnel. Some agencies include the same information on the incident report forms as on the official Baker Act forms. Other agencies only reference the BA-52A form on the incident report form but don't include any information. Others do something in between.

There is no difference between an agency's responsibilities to a minor as to an adult with regard to the Baker Act. The officer should seek a legal opinion from the attorney representing his/her agency. There is a general counsel to a sheriff in a different part of the state who believes that even the incident reports must be kept confidential -- that the Attorney General is "just another attorney".

Q. I am a therapist seeing a 14 year old patient. The parents are getting divorced and they are both asking what is being said during the patient sessions. Does the therapist have to reveal any information to the parents? If an attorney calls and subpoenas for information about the session does the therapist have to disclose?

This is a very difficult situation. The attorneys representing each of the parents need to stipulate what information should be shared by the therapist with either or both of the parents.

However, both parents are natural guardians of the minor child and generally both have a right to information about the child. Chapter 61, FS governs the dissolution of marriage in Florida. One paragraph may address your situation:

61.13 Support of children; parenting and time-sharing; powers of court.

(2)(c)3. Access to records and information pertaining to a minor child, including, but not limited to, medical, dental, and school records, may not be denied to either parent. Full rights under this subparagraph apply to either parent unless a court order specifically revokes these rights, including any restrictions on these rights as provided in a domestic violence injunction. A parent having rights under this subparagraph has the same rights upon request as to form, substance, and manner of access as are available to the other parent of a child, including, without limitation, the right to in-person communication with medical, dental, and education providers.

The Marchman Act governs substance abuse issues. If the minor in the situation you mention is being treated for a substance abuse issue, the following section may apply:

397.501, FS RIGHT TO CONFIDENTIALITY OF INDIVIDUAL RECORDS.—

(7)(a) The records of service providers which pertain to the identity, diagnosis, and prognosis of and service provision to any individual are confidential in accordance with this chapter and with applicable federal confidentiality regulations and are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. Such records may not be disclosed without the written consent of the individual to whom they pertain except that appropriate disclosure may be made without such consent:

(e)1. 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.

Another issue is HIPAA. HIPAA generally defers to state laws to identify who stands in the shoes of a patient who doesn't have capacity (due to age or disability). In such situations, a therapist could generally share information with a child's guardian.

One can never ignore a subpoena unless one is willing to risk contempt of court. You might have to appear with the records and ask a court to conduct a good cause hearing on whether the records should be released – an in camera inspection of the records by the judge might occur.

Bottom line – you should consult with an attorney or have the parents get their attorneys to negotiate what (if any) information about their child can be withheld by the therapist, given chapter 61, FS above.

Q. I had a question regarding minors signing release of information forms in Florida. Is it required? Is there a statute on this?

A minor has no authority to provide consent to release of mental health information – it must come from the minor's legal guardian. However, a minor can provide consent to release of substance abuse information as permitted by the Marchman Act.

Q. I'm an attorney for DCF. Do you know if HIPAA prevents the department from releasing medical records of children in our care when they are requesting them as part of a dependency proceeding? It would seem to me that these judges would need these records in order to rule. I wonder if there is an exception for this purpose?

HIPAA defers to state law when the state law is more protective of a person's privacy. Otherwise, HIPAA prevails.

If the department is the legal guardian of the child in our care, we always would have the authority of consenting to the release of information on behalf of the child.

Otherwise, the parent or legal guardian of the child would have the same right to decide on release of medical records as they would to the consent to examine or treat their child. If refusing to sign a release or documented as being unavailable, I believe a court order might be needed. A court order always is sufficient to allow release of medical information.

You are much more familiar with the dependency laws than I am, however, chapter 39 would prevail over anything in the Baker Act. Some provisions that might apply are:

39.402 Placement in a shelter.

(11)(b)The court shall request that the parents consent to provide access to the child's medical records and provide information to the court, the department or its contract agencies, and any guardian ad litem or attorney for the child. If a parent is unavailable or unable to consent or withholds consent and the court determines access to the records and information is necessary to provide services to the child, the court shall issue an order granting access. The court may also order the parents to provide all known medical information to

The following applies to the provision of examination and treatment (especially psychotropic medications) and address the provision of medical records to the court.

39.407 Medical, psychiatric, and psychological examination and treatment of child; physical, mental, or substance abuse examination of person with or requesting child custody.

(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 the department has performed the medical screening authorized by subsection (1), 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)1.Consent to medical treatment shall be obtained from a parent or legal custodian of the child; or

2.A court order for such treatment shall be obtained.

(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, including immunization, 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, the department shall have the authority to consent to necessary medical treatment. This authority is limited to the time reasonably necessary to obtain court authorization. In no case shall the department consent to sterilization, abortion, or termination of life support.

(3)(a)1.Except as otherwise provided in subparagraph (b)1. or paragraph (e), before the department provides psychotropic medications to a child in its custody, the prescribing physician shall attempt to obtain express and informed consent, as defined in s. 394.455(9) and as described in s. 394.459(3)(a), 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 decision making process regarding the provision of psychotropic medications. If, at any time, a parent whose parental rights have not been terminated provides express and informed consent to the provision of a psychotropic medication, the requirements of this section that 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 as provided in subparagraph 1. **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 physician licensed under chapter 458 or chapter 459 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 shall 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 physician licensed under chapter 458 or chapter 459 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)Except as provided in paragraphs (b) and (e), **the 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.

(d)1. The department must notify all parties of the proposed action taken under paragraph (c) in writing or by whatever other method best ensures that all parties receive notification of the proposed action within 48 hours after the motion is filed. If any party objects to the department's motion, that party shall file the objection within 2 working days after being notified of the department's motion. If any party files an objection to the authorization of the proposed psychotropic medication, the court shall hold a hearing as soon as possible before authorizing the department to initially provide or to continue providing psychotropic medication to a child in the legal custody of the department. At such hearing and notwithstanding s. 90.803, the medical report described in paragraph (c) is admissible in evidence. The prescribing physician need not attend the hearing or testify unless the court specifically orders such attendance or testimony, or a party subpoenas the physician to attend the hearing or provide testimony. If, after considering any testimony received, the court finds that the department's motion and the physician's medical report meet the requirements of this subsection and that it is in the child's best interests, the court may order that the department provide or continue to provide the psychotropic medication to the child without additional testimony or evidence. At any hearing held under this paragraph, the court shall further inquire of the department as to whether additional medical, mental health, behavioral, counseling, or other services are being provided to the child by the department which the prescribing physician considers to be necessary or beneficial in treating the child's medical condition and which the physician recommends or expects to provide to the child in concert with the medication. The court may order additional medical consultation, including consultation with the MedConsult line at the University of Florida, if available, or require the department to obtain a second opinion within a reasonable timeframe as established by the court, not to exceed 21 calendar days, after such order based upon consideration of the best interests of the child. The department must make a referral for an appointment for a second opinion with a physician within 1 working day. The court may not order the discontinuation of prescribed psychotropic medication if such order is contrary to the decision of the prescribing physician unless the court first obtains an opinion from a licensed psychiatrist, if available, or, if not available, a physician licensed under chapter 458 or chapter 459, stating that more likely than not, discontinuing the medication would not cause significant harm to the child. If, however, the prescribing psychiatrist specializes in mental health care for children and adolescents, the court may not order the discontinuation of prescribed psychotropic medication unless the required opinion is also from a psychiatrist who specializes in mental health care for children and adolescents. The court may also order the discontinuation of prescribed psychotropic medication if a child's treating physician, licensed under chapter 458 or chapter 459, states that continuing the

prescribed psychotropic medication would cause significant harm to the child due to a diagnosed nonpsychiatric medical condition.

2. The burden of proof at any hearing held under this paragraph shall be by a preponderance of the evidence.

(e)1. If the child's prescribing physician certifies in the signed medical report required in paragraph (c) that delay in providing a prescribed psychotropic medication would more likely than not cause significant harm to the child, the medication may be provided in advance of the issuance of a court order. In such event, the medical report must provide the specific reasons why the child may experience significant harm and the nature and the extent of the potential harm. The department must submit a motion seeking continuation of the medication and the physician's medical report to the court, the child's guardian ad litem, and all other parties within 3 working days after the department commences providing the medication to the child. The department shall seek the order at the next regularly scheduled court hearing required under this chapter, or within 30 days after the date of the prescription, whichever occurs sooner. If any party objects to the department's motion, the court shall hold a hearing within 7 days.

2. Psychotropic medications may be administered in advance of a court order in hospitals, crisis stabilization units, and in statewide inpatient psychiatric programs. Within 3 working days after the medication is begun, the department must seek court authorization as described in paragraph (c).

(f)1. The department shall fully inform the court of the child's medical and behavioral status as part of the social services report prepared for each judicial review hearing held for a child for whom psychotropic medication has been prescribed or provided under this subsection. As a part of the information provided to the court, the department shall furnish copies of all pertinent medical records concerning the child which have been generated since the previous hearing. On its own motion or on good cause shown by any party, including any guardian ad litem, attorney, or attorney ad litem who has been appointed to represent the child or the child's interests, the court may review the status more frequently than required in this subsection.

2. The court may, in the best interests of the child, order the department to obtain a medical opinion addressing whether the continued use of the medication under the circumstances is safe and medically appropriate.

(g) The department shall adopt rules to ensure that children receive timely access to clinically appropriate psychotropic medications. These rules must include, but need not be limited to, the process for determining which adjunctive services are needed, the uniform process for facilitating the prescribing physician's ability to obtain the express and informed consent of a child's parent or guardian, the procedures for obtaining court authorization for the provision of a psychotropic medication, the frequency of medical monitoring and reporting on the status of the child to the court, how the child's parents will be involved in the treatment-planning process if their parental rights have not been terminated, and how caretakers are to be provided information contained in the physician's signed medical report. The rules must also include uniform forms to be used in requesting court authorization for the use of a psychotropic medication and provide for the integration of each child's treatment plan and case plan. The department must begin the formal rulemaking process within 90 days after the effective date of this act.

(4)(a) A judge may order a child in an out-of-home placement to be examined by a licensed health care professional.

Even if the court's dependency records are sealed, HIPAA shouldn't be a problem. If a guardian provides consents or a court order to produce the records is available, the release to the courts should be done.