CHAPTER 394

MENTAL HEALTH

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PART I

FLORIDA MENTAL HEALTH ACT

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394.451 Short title.—This part shall be known as "The Florida Mental Health Act" or "The Baker Act."

History.—s. 1, ch. 71-131.

394.453 Legislative intent; responsibilities of department.—

(1) It is the intent of the Legislature to authorize and direct the Department of Health and Rehabilitative Services to evaluate, research, plan, and recommend to the Governor and the Legislature programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders. The department is directed to implement and administer mental health programs as authorized and approved by the Legislature, based on the annual program budget of the department. It is the further intent of the Legislature that programs of the department coordinate the development, maintenance, and improvement of receiving and community treatment facilities within the programs of the district mental health boards as authorized by the Community Mental Health Act, part IV of this chapter. Treatment programs shall include, but not be limited to, comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment in order to encourage them to assume responsibility for their treatment and recovery. It is intended that patients be provided with emergency service and temporary detention for evaluation when required; that patients be admitted to treatment facilities on a voluntary basis when extended or continuing care is needed and unavailable in the community; that involuntary placement be provided only when expert evaluation determines that it is necessary; that any involuntary treatment or examination be accomplished in a setting which is appropriate, most likely to facilitate proper care and treatment that would return the patient to the community as soon as possible, and the least restrictive of the patient's liberty; and that individual dignity and human rights be guaranteed to all persons admitted to mental health facilities. It is further the intent of the Legislature that the least restrictive means of intervention be employed based on the individual needs of each patient within the scope of available services.

(2) The Department of Health and Rehabilitative Services shall assume the responsibility for designing and distributing appropriate materials for the orientation and training of persons actively engaged in implementing the provisions of this chapter relating to the involuntary placement of persons alleged to be mentally ill. The department is further directed to ensure that no civil patient is admitted to a state treatment facility unless previously evaluated and found to meet the criteria for admission by a community-based public receiving facility or by a community mental health center or clinic in cases in which the public receiving facility is not a community mental health center or clinic. Nothing in this act shall be construed to affect any policies relating to admission to hospital staff.

History.—s. 2, ch. 71-131; s. 198, ch. 77-147; s. 1, ch. 79-298; s. 4, ch. 82-212.

394.455 Definitions.—As used in this part, unless the context clearly requires otherwise:

(1) "Hospital" means a public or private hospital or institution or part thereof licensed by the Department of Health and Rehabilitative Services and equipped to provide inpatient care and treatment facilities or any hospital under the supervision of the department.

(2) With respect to the professionals referred to in this part:

(a) "Physician" means a medical practitioner licensed pursuant to chapter 458 or chapter 459 who has experience in the diagnosis and treatment of mental and nervous disorders.

(b) "Psychiatrist" means a medical practitioner licensed pursuant to chapter 458 or chapter 459 who has primarily diagnosed and treated mental and nervous disorders for a period of not less than 3 years, inclusive of psychiatric residency.

(c) "Clinical psychologist" means a graduate of an accredited institution of higher learning with a doctor's degree in clinical psychology and 3 years of postdoctoral experience in the practice of clinical psychology, including experience prerequisite to licensure, who is licensed as a psychologist pursuant to the provisions of chapter 490.

(d) "Clinical social worker" means an individual who has received a master's degree or a doctor's degree, with a major emphasis in direct patient health-care services, through a program of study which includes psychiatric social work, medical social work, social casework, psychotherapy, or group psychotherapy, from a graduate school of social work approved by the Council on Social Work Education, and who is licensed as a clinical social worker pursuant to the provisions of chapter 490.

(e) "Psychiatric nurse" means a registered nurse with a master's degree or a doctor's degree in psychiatric nursing and 2 years of post-master's clinical experience under the supervision of a physician.

For the purpose of providing services described in this act to patients at facilities operated by the United States Veterans Administration, which facilities meet the requirements of receiving and treatment facilities, a physician or psychologist employed by the United States Veterans Administration shall be considered to have met the licensure requirements set forth in this subsection.

(3) "Mentally ill" means an impairment of the emotional processes, of the ability to exercise conscious control of one's actions, or of the ability to perceive reality or to understand, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology; except that, for the purposes of this act, the term does not include retardation or developmental disability as defined in chapter 393, simple intoxication, or conditions manifested only by antisocial behavior or drug addiction.

(4) "Department" means the Department of Health and Rehabilitative Services.

(5) "Secretary" means the secretary of the Department of Health and Rehabilitative Services.

(6) "Mental health board" means the board within a board district established in accordance with the provisions of the Community Mental Health Act, part IV of this chapter, for the purposes of administering the community mental health program.

(7) "Board district" means that area over which a single mental health board has jurisdiction for administering mental health programs as provided by the Community Mental Health Act, part IV of this chapter, and may consist of one or more services districts.

(8) "Facility" means any state-owned or state-operated hospital or state-aided community facility designated by the department to be utilized for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who are mentally ill, and any other hospital within the state approved and designated for such purpose by the department.

(9) "Community facility" means a facility which receives funds from the state under the Community Mental Health Act, part IV of this chapter.

(10) "Receiving facility" means a facility designated by the department to receive patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment, and also means a private facility when rendering services to a private patient pursuant to the provisions of this act.

(11) "Treatment facility" means a state-owned, state-operated, or state-supported hospital, center, or clinic designated by the department for the treatment and hospitalization of persons who are mentally ill, including facilities of the United States Government, and also means a private facility when rendering services to a private patient pursuant to the provisions of this act. Patients treated in facilities of the United States Government shall be solely those whose care is the responsibility of the Veterans Administration.

(12) "Private facility" means any hospital or facility operated by a nonprofit corporation or association or a proprietary hospital approved by the department.

(13) "Patient" means any mentally ill person who seeks treatment under this part or any person for whom such treatment is sought.

(14) "Administrator" means the chief administrative officer of a receiving or treatment facility or his designee.

(15) "Staff member" means an employee of a receiving or treatment facility who has been designated as a staff member by the department.

(16) "Law enforcement officer" means any city police officer, officer of the Florida Highway Patrol, sheriff, or deputy sheriff.

(17) "Guardian" means a natural guardian of a minor or a legal guardian appointed by a court to maintain custody and control of the person or of the property of an incompetent. "Guardian advocate" is one to whom the court has entrusted the custody and control of the patient's competence to consent to treatment.

(18) "Representative" means a person appointed to receive notice of proceedings for and during hospitalization and to take actions for and on behalf of the patient.

(19) "Court," unless otherwise specified, means the circuit court.

(20) "Clinical record" means all parts of the record required to be maintained and includes all medical records, progress notes, charts, admission and discharge data, and all other information recorded by a facility which pertains to the patient's hospitalization and treatment.

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

History.—s. 3, ch. 71-131; s. 1, ch. 72-396; s. 1, ch. 73-133; s. 25, ch. 73-334; s. 199, ch. 77-147; s. 2, ch. 79-298; s. 1, ch. 80-398; s. 5, ch. 82-212; s. 46, ch. 83-218.

394.457 Operation and administration.—

(1) ADMINISTRATION.—The Department of Health and Rehabilitative Services is designated the "Mental Health Authority" of Florida. The department shall exercise executive and administrative supervision over all mental health facilities, programs, and services.

(2) RESPONSIBILITIES OF THE DEPARTMENT.—The department is responsible for the planning, evaluation, and coordination of a complete and comprehensive statewide program of mental health including community services, receiving and treatment facilities, child services, research, and training. The department is also responsible for the implementation of programs and coordination of efforts with other departments and divisions of the state government, county and municipal governments, and private agencies concerned with and providing mental health services. It is responsible for establishing standards, providing technical assistance, and exercising supervision of mental health programs of state-supported community facilities and other facilities for the mentally ill. The department shall provide for the publication and distribution of an information handbook to facilitate understanding of this act, the policies and procedures involved in its implementation, and the responsibilities of the various providers of services under this act. It shall stimulate research by public and private agencies, institutions of higher learning, and hospitals in the interest of the elimination and amelioration of mental illness. The department may contract for residential and nonresidential services to be provided by receiving and treatment facilities and shall promulgate rules to implement any such services.

(3) POWER TO CONTRACT.—The department may contract to provide, and be provided with, services and facilities in order to carry out its responsibilities under this part with the following agencies: district mental health boards; public and private hospitals; clinics; laboratories; departments, divisions, and other units of state government; the state colleges and universities; the community colleges; private colleges and universities; counties, municipalities, and any other governmental unit, including facilities of the United States Government; and any other public or private entity which provides or needs facilities or services. Services contracted for by the department may be reimbursed by the state at a rate up to 100 percent. The department shall make periodic audits and inspections to assure that the contracted services are provided and meet the standards of the department.

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

(5) RULES; PERSONNEL.—

(a) The department shall adopt rules necessary for administration of this part in accordance with the Administrative Procedure Act, chapter 120. No program subject to the provisions of this act shall be operated without rules established to ensure the protection of the health, safety, and welfare of the patients treated through such program.

(b) The department shall, by regulation, establish standards of education and experience for professional and technical personnel employed in mental health programs.

(6) HEARING OFFICERS.—

(a) One or more hearing officers shall be assigned by the Division of Administrative Hearings to conduct hearings for continued involuntary placement.

(b) Hearings on requests for orders authorizing continued involuntary placement filed in accordance with s. 394.467(4) shall be conducted in accordance with the provisions of s. 120.57(1), except that any order entered by the hearing officer shall be final and subject to judicial review in accordance with s. 120.68, except that orders concerning patients committed after successfully pleading not guilty by reason of insanity shall be governed by the provisions of s. 916.16.

(7) PAYMENT FOR CARE OF PATIENTS.—Fees and fee collections for patients in treatment facilities shall be according to s. 402.33.

(8) DESIGNATION OF TREATMENT FACILITIES.—Florida State Hospital located at Chattahoochee, Gadsden County; G. Pierce Wood Memorial Hospital located at Arcadia, DeSoto County; South Florida State Hospital located at Hollywood, Broward County; and Northeast Florida State Hospital located at Macclenny, Baker County; and such other facilities as may be established by law or designated by the department in order to ensure availability of the least restrictive environment, including facilities of the United States Government, if such designation is agreed to by the appropriate governing body or authority, are designated as treatment facilities.

(9) DESIGNATION OF APPROVED PRIVATE PSYCHIATRIC FACILITIES.—Private psychiatric facilities may be approved by the department to provide examination and treatment on an involuntary basis. Such facilities are authorized to act in the same capacity as receiving and treatment facilities and are subject to all the provisions of this part.

History.—s. 1, ch. 57-317; s. 1, ch. 59-222; s. 1, ch. 65-13; s. 3, ch. 65-22; s. 1, ch. 65-145; s. 1, ch. 67-334; ss. 11, 19, 31, 35, ch. 69-106; s. 4, ch. 71-131; s. 70, ch. 72-221; s. 2, ch. 72-396; s. 2, ch. 73-133; s. 25, ch. 73-334; s. 1, ch. 74-233; s. 200, ch. 77-147; s. 19, ch. 78-95; s. 3, ch. 78-332; s. 3, ch. 79-298; s. 6, ch. 82-212.

Note.—Former s. 965.01(3), s. 402.10.

394.4573 Mental health services plan; case management system; measures of performance; reports.—

(1) The Department of Health and Rehabilitative Services is directed to develop a plan for the provision of continuity of mental health care, through the provision of case management, including clients referred from state treatment facilities to community mental health facilities. Such plan shall include the creation of a case management system throughout the state designed to:

(a) Reduce the possibility of a client's admission or readmission to a state treatment facility.

(b) Provide for the creation or designation of an agency in each county to provide single intake services for each person seeking mental health services. Such agency shall provide information and referral services necessary to ensure that clients receive the most appropriate and least restrictive form of care, based on the individual needs of the person seeking treatment. Such agency shall have a single telephone number, manned 24 hours per day, 7 days per week, where practical, at a central location, where each client will have a central record.

(c) Advocate on behalf of the client to ensure that all appropriate services are afforded to the client in a timely and dignified manner.

(2) The department is directed to develop and include in contracts with the district mental health boards, measures of performance with regard to goals and objectives as specified in the state plan. Such measures shall use, to the extent practical, existing data collection methods and reports and shall not require, as a result of this subsection, additional reports on the part of service providers. The department is also directed to combine, where practical, reports and reporting requirements with the data requirements of district mental health boards. The department shall plan monitoring visits of community mental health facilities with other state, federal, and local governmental and private agencies charged with monitoring such facilities.

(3) Beginning in 1982, the department is directed to submit a report to the Legislature, prior to April 1 of each year, outlining departmental progress towards the implementation of the minimum staffing patterns' standards in state mental health treatment facilities. The report shall contain, by treatment facility, information regarding goals and objectives and departmental performance toward meeting each such goal and objective.

History.—ss. 3-5, ch. 80-384.

394.458 Introduction or removal of certain articles unlawful; penalty.—

(1)(a) Except as authorized by law or as specifically authorized by the person in charge of each hospital, it is unlawful to introduce into or upon the grounds of any mental health hospital under the supervision or control of the Department of Health and Rehabilitative Services, or to take or attempt to take or send therefrom, any of the following articles, which are hereby declared to be contraband for the purposes of this section:

1. Any intoxicating beverage or beverage which causes or may cause an intoxicating effect;

2. Any controlled substance as defined in chapter 893; or

3. Any firearms or deadly weapon.

(b) It is unlawful to transmit to, or attempt to transmit to, or cause or attempt to cause to be transmitted to, or received by, any patient of any hospital any article or thing declared by this section to be contraband, at any place which is outside of the grounds of such hospital, except as authorized by law or as specifically authorized by the person in charge of such hospital.

(2) Whoever violates any provision of this section is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

History.—s. 1, ch. 75-253; s. 201, ch. 77-147; s. 1, ch. 77-174.

394.459 Rights of patients.—

(1) RIGHT TO INDIVIDUAL DIGNITY.—The policy of the state is that the individual dignity of the patient shall be respected at all times and upon all occasions, including any occasion when the patient is taken into custody, detained, or transported. Procedures, facilities, vehicles, and restraining devices utilized for criminals or those accused of crime shall not be used in connection with the noncriminal mentally ill except for the protection of the patient or others. The noncriminal mentally ill shall not be detained or incarcerated in the jails of this state. In criminal cases, a jail may be used as an emergency facility no longer than 45 days. Treatment shall be provided to the patient by his physician or clinical psychologist or the receiving facility staff. No person who is receiving treatment for mental illness in a facility shall be deprived of any constitutional rights. However, if such a person is adjudicated incompetent pursuant to the provisions of chapter 744, his rights may be limited to the same extent the rights of any incompetent person are limited by general law.

(2) RIGHT TO TREATMENT.—

(a) The policy of the state is that the department shall not deny treatment for mental illness to any person, and that no services shall be delayed at a receiving or treatment facility because of inability to pay. However, every reasonable effort to collect appropriate reimbursement for the cost of providing mental health services to persons able to pay for services, including insurance or third-party payments, shall be made by facilities providing services pursuant to this act.

(b) It is further the policy of the state that the least restrictive available treatment be utilized based on the individual needs and best interests of the patient and consistent with optimum improvement of the patient's condition.

(c) Each person who is admitted to a receiving or treatment facility, and each person who remains at a facility for a period in excess of 12 hours, shall be given a physical examination by a health practitioner authorized by law to give such examinations within 24 hours after arrival at any such facility.

(d) Every patient in a treatment facility shall be afforded the opportunity to participate in activities designed to enhance self-image and the beneficial effects of other treatments, as determined by the facility.

(e) Not more than 5 days after admission to a treatment facility, each patient shall have and receive an individualized treatment plan in writing which the patient has had an opportunity to assist in preparing.

(3) RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT.—

(a) Each patient entering a facility shall be asked to give express and informed consent for treatment after disclosure to the patient if he is competent, or to his guardian if he is a minor or is incompetent, of the purpose of the treatment to be provided, the common side effects thereof, alternative treatment modalities, the approximate length of care, and that any consent given by a patient may be revoked orally or in writing prior to or during the treatment period by the patient or his guardian. If a voluntary patient refuses to consent to or revokes consent for treatment, such patient shall be discharged within 3 days or, in the event the patient meets the criteria for involuntary placement, such proceedings shall be instituted within 3 days. If any patient refuses treatment and is not discharged as a result, emergency treatment may be rendered such patient in the least restrictive manner, upon the written order of a physician when it is determined that such treatment is necessary for the safety of the patient or others. If any patient refuses to consent to treatment or revokes consent previously provided and the treatment not consented to is essential to appropriate care for the patient, then the administrator shall immediately petition the court for a hearing to determine the competency of the patient to consent to treatment. A patient is incompetent to consent to treatment if his judgment is so affected by his mental illness that he lacks the capacity to make a well-reasoned, willful, and knowing decision concerning treatment. If the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate. A guardian advocate appointed pursuant to the provisions of this act shall meet the qualifications of a guardian contained in part IV of chapter 744, except that no professional referred to in this act, department employee, or facility administrator shall be appointed.

(b) In addition to the provisions of paragraph (a), in the case of surgical procedures requiring the use of a general anesthetic or electroconvulsive treatment, and prior to performing the procedure, written permission shall be obtained from the patient, if he is legally competent, from the parent or guardian of a minor patient, or from the guardian of an incompetent patient. The facility administrator or his designated representative may, with the concurrence of the patient's attending physician, authorize emergency surgical treatment if such treatment is deemed lifesaving and permission of the patient and his guardian or representative cannot be obtained.

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

(4) QUALITY OF TREATMENT.—Each patient in a facility shall receive treatment suited to his needs, which shall be administered skillfully, safely, and humanely with full respect for his dignity and personal integrity. Each patient shall receive such medical, vocational, social, educational, and rehabilitative services as his condition requires to bring about an early return to his community. In order to achieve this goal, the department is directed to coordinate its mental health programs with all other programs of the department.

(5) COMMUNICATION, ABUSE REPORTING, AND VISITS.—

(a) Each patient in a facility pursuant to the provisions of this part has the right to communicate freely and privately with persons outside the facility unless it is determined that such communication is likely to be harmful to the patient or others.

(b) Each patient hospitalized under the provisions of this part shall be allowed to receive, send, and mail sealed, unopened correspondence; and no patient's incoming or outgoing correspondence shall be opened, delayed, held, or censored by the facility unless there is reason to believe that it contains items or substances which may be harmful to the patient or others, in which case the administrator may direct reasonable examination of such mail and may regulate the disposition of such items or substances.

(c) If a patient's right to communicate is restricted by the administrator, written notice of such restriction shall be served on the patient and his guardian or representatives; and such restriction shall be recorded on the patient's clinical record with the reasons therefor. The restriction of a patient's right to communicate shall be reviewed at least every 90 days.

(d) Each facility shall establish reasonable rules governing visitors, visiting hours, and the use of telephones by patients in the least restrictive possible manner.

(e) Each patient receiving mental health treatment in any facility shall have ready access to a telephone in order to report an alleged abuse. The facility staff shall verbally and in writing inform each patient of the procedure for reporting abuse. A written copy of that procedure, including the telephone number of the abuse registry and reporting forms, shall be posted in plain view.

(f) The department shall adopt rules providing a procedure for reporting abuse. Facility staff shall be required, as a condition of employment, to become familiar with the procedures for the reporting of abuse.

(6) CARE AND CUSTODY OF PERSONAL EFFECTS OF PATIENTS.—A patient's right to his clothing and personal effects shall be respected. The administrator may take temporary custody of such effects when required for medical and safety reasons. Custody of such personal effects shall be recorded in the patient's clinical record.

(7) VOTING IN PUBLIC ELECTIONS.—A patient in a facility who is eligible to vote according to the laws of the state has the right to vote in the primary and general elections. The department shall establish rules and regulations to enable patients to obtain voter registration forms, applications for absentee ballots, and absentee ballots.

(8) EDUCATION OF CHILDREN.—The department shall provide education and training appropriate to the needs of all children in treatment facilities. Efforts shall be made to provide this education and training in the least restrictive setting available.

(9) CLINICAL RECORD; CONFIDENTIALITY.—A clinical record for each patient shall be maintained. The record shall include data pertaining to admission and such other information as may be required under rules of the department. Unless waived by express and informed consent by the patient or his guardian, the privileged and confidential status of the clinical record shall not be lost by either authorized or unauthorized disclosure to any person, organization, or agency. The clinical record shall not be a public record; and no part of it shall be released, except:

(a) The record may be released to such persons and agencies as designated by the patient or his guardian. A medical discharge summary of the clinical record of any patient committed to, or to be returned to, the Department of Corrections from the Department of Health and Rehabilitative Services shall be released to the Department of Corrections without charge upon its request. The Department of Corrections shall treat such information as confidential and shall not release such information except as provided in this section.

(b) The record shall be released to persons authorized by order of court, excluding matters privileged by other provisions of law.

(c) The record or any part thereof may be disclosed to a qualified researcher, a staff member of the facility, or an employee of the department when the administrator of the facility or secretary of the department deems it necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, or evaluation of programs.

(d) Information from the clinical records may be used for statistical and research purposes if the information is abstracted in such a way as to protect the identity of individuals.

(10) HABEAS CORPUS.—

(a) At any time, and without notice, a person detained by a facility, or a relative, friend, guardian, representative, or attorney on behalf of such person, may petition for a writ of habeas corpus to question the cause and legality of such detention and request that the circuit court issue a writ for release. Each patient admitted to a facility for involuntary placement shall receive a written notice of the right to petition for a writ of habeas corpus.

(b) A patient or his guardian or representatives may file a petition in the circuit court in the county where the patient is hospitalized alleging that the patient is being unjustly denied a right or privilege granted herein or that a procedure authorized herein is being abused. Upon the filing of such a petition, the circuit court shall have the authority to conduct a judicial inquiry and to issue any appropriate order to correct an abuse of the provisions of this part.

(11) TRANSPORTATION.—If neither the patient nor any person legally obligated or responsible for the patient is able to pay for the expense of transporting the patient to a treatment facility, the governing board of the county from which the patient is hospitalized shall arrange for such required transportation and, pursuant thereto, shall ensure the safe and dignified transportation of any such patient.

(12) DESIGNATION OF REPRESENTATIVES; NOTICE OF ADMISSION.—

(a) At the time a patient is admitted to a facility, the names and addresses of two representatives or one guardian shall be entered in the patient's clinical record.

1. A treatment facility shall give written notice of the patient's admission to his guardian or representatives.

2. A receiving facility shall give notice of admission to the patient's guardian or representatives by telephone or in person within 24 hours.

(b) If the patient has no guardian, he may designate one representative; the second representative, or both in the absence of designation of one representative by the patient, shall be selected by the facility. The first representative selected by the facility shall be made from the following in the order of listing:

1. The patient's spouse;
2. An adult child;
3. Parent;
4. Adult next of kin;
5. Adult friend;
6. Appropriate human rights advocacy committee as defined in s. 20.19; or
7. The department.

The second representative selected by the facility shall be without regard to the order of listing, except that the department shall only be selected as the representative of last resort in cases where the patient is receiving service in a state-operated facility. If the facility can locate only one person from the categories listed above, it shall only be required to select one representative.

(c) The patient shall be consulted with regard to the appointment of a representative and have authority to request that an appointed representative be replaced.

(d) Unless otherwise provided, notice to the patient's guardian or representatives shall be served by registered or certified mail or receipted hand delivery, and the date on which such notice was mailed shall be entered on the patient's clinical record.

(13) LIABILITY FOR VIOLATIONS.—Any person who violates or abuses any rights or privileges of patients provided by this act shall be liable for damages as determined by law. Any person who acts in good faith in compliance with the provisions of this part shall be immune from civil or criminal liability for his actions in connection with the admission, diagnosis, treatment, or discharge of a patient to or from a facility. However, this section shall not relieve any person from liability if such person is guilty of negligence.

(14) RIGHT TO PARTICIPATE IN TREATMENT AND DISCHARGE PLANNING.—The patient shall be provided the opportunity to participate in treatment and discharge planning and shall be notified in writing of his right, upon release or discharge from the facility, to seek treatment from the professional or agency of his choice.

History.—s. 5, ch. 71-131; s. 3, ch. 73-133; s. 25, ch. 73-334; s. 2, ch. 74-233; s. 202, ch. 77-147; s. 1, ch. 78-434; s. 12, ch. 79-3; s. 4, ch. 79-298; s. 10, ch. 79-320; s. 1, ch. 80-171; s. 7, ch. 82-212.

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

History.—s. 4, ch. 73-133; s. 5, ch. 79-298; s. 8, ch. 82-212.

394.461 Facilities; transfers of patients.—

(1) RECEIVING FACILITY.—The Department of Health and Rehabilitative Services may designate any community facility as a receiving facility to provide examination and emergency, short-term treatment. The governing board of any county is authorized to contract with the department or with the mental health board of a board district, with the approval of the department, to set aside an area of any facility of the department to function, and be designated, as the receiving facility. Any other facility within the state, including a federal facility, may be so designated by the department at the request of and with the consent of the governing officers of the facility.

(2) TREATMENT FACILITY.—Any state-owned, state-operated, or state-supported facility may be designated by the department as a treatment facility. Any other facility, including a federal facility, may be so designated by the department at the request of, or with the consent of, its governing officers.

(3) TRANSFERS OF PATIENTS.—

(a) Any patient who has been admitted to a treatment or receiving facility on a voluntary basis and is able to pay for treatment in a private facility may apply to the department for transfer at his expense to such private facility. A patient may apply to the department for transfer from a private facility to a public facility. An involuntary patient may be transferred at the discretion of the department or upon application by the patient or the guardian of the patient.

(b) When the medical needs of the patient or efficient utilization of the facilities of the department require, a patient may be transferred from one facility of the department to another or, with the express and informed consent of the patient and his guardian or representatives, to a facility in another state.

(c) When any patient is to be transferred, notice shall be given to his guardian or representatives prior to the transfer.

(4) CRIMINALLY CHARGED OR CONVICTED MENTALLY ILL PERSONS.—

(a) There shall be established separate and secure facilities within the Department of Health and Rehabilitative Services for the treatment of any person:

1. Who has been determined to need treatment for a mental illness;

2. Who has charges pending, has been convicted of a criminal offense, has been acquitted of a criminal offense by reason of insanity, or is serving sentence for a criminal offense; and

3. Who has been determined by the Department of Health and Rehabilitative Services to:

a. Be dangerous to himself or others; or

b. Present a clear and present potential to escape.

(b) Such separate and secure facilities shall be maximum-security-grade buildings located on grounds distinct in location from other treatment facilities for persons who are mentally ill.

(c) The Florida State Hospital shall not be required to maintain separate treatment facilities for criminally charged or convicted mentally ill persons.

(d) No receiving facility shall be required to accept for examination and treatment any person with pending felony charges involving a crime of violence or a crime against a person.

History.—s. 6, ch. 71-131; s. 3, ch. 72-396; s. 5, ch. 73-133; s. 1, ch. 77-90; s. 203, ch. 77-147; s. 6, ch. 79-298; ss. 1, 2, ch. 80-384; s. 9, ch. 82-212.

394.463 Involuntary examination.—

(1) CRITERIA.—A person may be taken to a receiving facility for involuntary examination if:

(a) There is reason to believe that he is mentally ill;

(b) He has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; and

(c) He is unable to determine for himself whether examination is necessary, and:

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

2. It is more likely than not that in the near future he will inflict serious, unjustified bodily harm on another person, as evidenced by behavior causing, attempting, or threatening such harm, including at least one incident thereof within 20 days prior to the examination.

(2) INVOLUNTARY EXAMINATION.—

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

1. A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based and, if other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, directing that a law enforcement officer, or other designated agent of the court, take the person into custody and deliver him to the nearest receiving facility for involuntary examination. The order of the court shall be made a part of the patient's clinical record.

2. A law enforcement officer may take a person who appears to meet the criteria for involuntary examination into custody and deliver him or have him delivered to the nearest receiving facility for exami-

nation. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, and the report shall be made a part of the patient's clinical record.

3. A physician, psychologist licensed pursuant to chapter 490, psychiatric nurse, or clinical social worker may execute a certificate stating that he 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, the certificate shall authorize a law enforcement officer to take the person into custody and deliver him to the nearest available 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.

(b) *Examination.*—A patient may be detained at a receiving facility for involuntary examination no longer than 72 hours. A patient who is provided such an examination at a receiving facility shall be examined by a physician or clinical psychologist without unnecessary delay and may be given emergency treatment pursuant to s. 394.459(3)(a). The least restrictive form of treatment shall be made available when determined to be necessary by a facility physician or clinical psychologist.

(c) *Disposition upon examination.*—Within the examination period, one of the following actions shall be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he is under criminal charges, in which case he shall be returned to the custody of a law enforcement officer;

2. The patient shall be released, subject to the provisions of subparagraph 1., for outpatient treatment;

3. The patient shall be asked to give express and informed consent to placement as a voluntary patient; or

4. A petition for involuntary placement shall be executed by the facility administrator when treatment is deemed necessary; in which case, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available.

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

History.—s. 7, ch. 71-131; s. 6, ch. 73-133; s. 204, ch. 77-147; s. 7, ch. 79-298; s. 10, ch. 82-212.

394.465 Voluntary admissions.—

(1) AUTHORITY TO RECEIVE PATIENTS.—

(a) A facility may receive for observation, diagnosis, or treatment any individual 18 years of age or older making application by express and informed consent for admission or any individual age 17 or under for whom such application is made by his parent or guardian pursuant to s. 394.467. If found to show evidence of mental illness and to be suitable for treatment, such person 18 years of age or older may be admitted to the facility.

(b) A facility may admit for evaluation, diagnosis, or treatment any individual who makes application by express and informed consent therefor; however, any individual age 17 or under may be admitted only after a hearing to verify the voluntariness of the consent. If such individual is under 18 years of age, his parent or guardian may apply for his discharge, and the administrator shall release the patient within 3 days of such application for discharge.

(2) RIGHT OF VOLUNTARY PATIENTS TO DISCHARGE.—

(a) A facility shall discharge a voluntary patient who has sufficiently improved so that retention in the facility is no longer desirable. A patient may also be discharged to the care of a community facility. A voluntary patient or his guardian, representative, or attorney may request discharge in writing at any time following admission to the facility. This request may be submitted to a member of the staff of the facility for transmittal to the administrator. If the patient, or another on his behalf, makes an oral request for release to a staff member, such request shall be immediately entered in the patient's clinical record, and the patient must within 8 hours be given counseling and assistance in preparing a written request. If a written request is submitted to a staff member, it shall be delivered to the administrator within 16 hours. Within 3 days of delivery of a written request for release to the administrator, the patient must be discharged from the facility or a plan instituted for a discharge of the patient. Such plan shall be approved by the patient. If the administrator determines that the patient meets the criteria for involuntary placement, proceedings for involuntary placement must be initiated within 3 days of delivery of the written request, exclusive of weekends and legal holidays. If the patient was admitted on his own application and the request for discharge is made by a person other than the patient, the discharge may be conditioned upon the express and informed consent of the patient. If the patient is under the age of 18, his parent or guardian may act for him.

(b) If the administrator, upon the advice of the patient's attending physician or clinical psychologist, determines that the patient needs to be transferred to a long-term treatment facility and the patient refuses to go as a voluntary patient, the administrator shall be authorized to file a petition for involuntary placement.

(3) NOTICE OF RIGHT TO RELEASE.—At the time of his admission and each 6 months thereafter, a voluntary patient and his guardian or representatives shall be notified in writing of his right to apply for a discharge.

(4) TRANSFER TO VOLUNTARY STATUS.—Staff members of all treatment facilities shall encourage an involuntary patient to give express and informed consent to transfer to voluntary status unless the patient is under criminal charge, or unless the patient is unable to understand the nature of voluntary placement, or unless voluntary placement would be harmful to the patient, in which case a finding to this effect shall be entered in the patient's clin-

ical record. Any involuntary patient who applies shall be transferred to voluntary status immediately, unless such transfer would not be in the best interest of the patient, in which case such finding shall be entered in the patient's clinical record and shall be subject to review every 90 days. When transfer to voluntary status occurs, notice shall be given to the patient and his guardian or representatives and, if the patient is involuntarily placed under an order of court, to the court which entered such order.

(5) TRANSFER TO INVOLUNTARY STATUS.—A patient who has, while at the receiving facility, given express and informed written consent to be hospitalized as a voluntary patient and who, upon arrival at the treatment facility, refuses to remain as a voluntary patient may be detained by the treatment facility and provided emergency treatment pursuant to s. 394.459(3)(a), if express and informed consent to treatment is refused or revoked, for a period not to exceed 3 days while the administrator of the treatment facility initiates procedures for involuntary placement.

History.—s. 8, ch. 71-131; s. 7, ch. 73-133; s. 109, ch. 73-333; s. 8, ch. 79-298; s. 11, ch. 82-212.

394.467 Involuntary placement.—

(1) CRITERIA.—

(a) A person who is acquitted of criminal charges because of a finding of not guilty by reason of insanity may be involuntarily hospitalized pursuant to the provisions of chapter 916 and the applicable Florida Rules of Criminal Procedure.

(b) A person may be involuntarily placed for treatment upon a finding by the court of clear and convincing evidence that:

1. He suffers from an apparent or manifest mental illness;

2. He has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment;

3. He is unable to determine for himself whether placement is necessary;

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

b. It is more likely than not that in the near future he will inflict serious, unjustified bodily harm on another person, as evidenced by behavior causing, attempting, or threatening such harm, including at least one incident thereof within the 20 days prior to the initiation of the proceedings for involuntary placement;

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

(2) ADMISSION TO A TREATMENT FACILITY.—

(a) A patient may be involuntarily placed in a treatment facility, after notice and hearing, upon recommendation of the administrator of a receiving facility where the patient has been examined. When a patient is not an inpatient in a receiving facility, the administrator of a designated receiving facility may make a recommendation for involuntary placement of a patient who has been given an examination, evaluation, or treatment by staff of the receiving facility or a private mental health professional upon receipt of the opinions referred to in paragraph (b). In a proceeding involving a person 18 years of age or older, the hearing may be waived by express and informed consent in writing by the patient. In a proceeding involving a person under the age of 18, the hearing shall not be waived; however, if, at the hearing, the court finds that attendance at the hearing is not consistent with the best interests of the patient, the court may waive the presence of the patient from all or any portion of the hearing.

(b) The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 5 days, that the criteria for involuntary placement are met; however, in counties of less than 50,000 population, if the administrator certifies that no psychiatrist or clinical psychologist is available to provide the second opinion, such second opinion may be provided by a licensed physician with postgraduate training and experience in diagnosis and treatment of mental and nervous disorders or a psychiatric nurse. Such recommendation shall be entered on an involuntary placement certificate, which certificate shall authorize the receiving facility to retain the patient pending transfer to a treatment facility or completion of a hearing. The certificate shall be filed with the court in the county where the patient is located and shall serve as a petition for a hearing on involuntary placement. A copy of the certificate shall also be filed with the department; and copies shall be served on the patient and his guardian or representatives, accompanied by:

1. A written notice, in plain and simple language, that the patient or his guardian or representative may apply at any time for a hearing on the issue of the patient's need for involuntary placement if he has previously waived such a hearing.

2. A petition for such hearing, which requires only the signature of the patient or his guardian or representative for completion.

3. A written notice that the petition may be filed with a court in the county in which the patient is hospitalized and the name and address of the judge of such court.

4. A written notice that the patient or his guardian or representative may apply immediately to the court to have an attorney appointed if the patient cannot afford one.

The petition may be filed in the county in which the patient is involuntarily placed at any time within 6 months of the date of the certificate. The hearing shall be held in the same county, and one of the patient's physicians at the facility shall appear as a witness at the hearing.

(c) If the hearing is waived, the court shall order that the patient be transferred to the least restrictive type of treatment facility based on the individual

needs of the patient or, if he is at a treatment facility, that he be retained there. The patient may be immediately transferred to the treatment facility by waiving his hearing without awaiting the court order. If the patient waives his hearing, the involuntary placement certificate shall serve as authorization for the patient to be transferred to a treatment facility and as authorization for the treatment facility to admit the patient.

(d) The treatment facility may retain a patient for a period not to exceed 6 months from the date of the order for involuntary placement. If continued involuntary placement is necessary at the end of that period, the administrator shall apply to the hearing examiner for an order authorizing continued involuntary placement.

(3) PROCEDURE FOR HEARING ON INVOLUNTARY PLACEMENT.—

(a) If the patient does not waive his right to a hearing on involuntary placement, or if the patient, his guardian, or a representative files a petition for such a hearing after having waived it as provided in paragraph (2)(c), the court shall serve notice on the administrator of the facility in which the patient is placed and on the patient. The notice of hearing shall specify the date, time, and place of hearing; the basis for detention; and the name of each examining expert and of every other person testifying in support of continued detention and the substance of their proposed testimony. The court shall serve notice on the state attorney of the judicial circuit of the county in which the patient is placed, who shall represent the state. The court shall hold the hearing within 5 days unless a continuance is granted. The hearing shall be as convenient to the patient as may be consistent with orderly procedure and should be conducted in physical settings not likely to be injurious to the patient's condition. The court may appoint a master to preside. The patient, his guardian or representative, or the administrator may apply for a change of venue for the convenience of parties or witnesses or because of the condition of the patient. Venue may be ordered changed within the discretion of the court. The patient and his guardian or representative shall be informed of the right to counsel by the court. If the patient cannot afford an attorney, the court shall appoint one. The patient's counsel shall have access to facility records and to facility personnel in defending the patient. One of the professionals who executed the involuntary placement certificate shall be a witness. The patient and his guardian or representative shall be informed by the court of the right to an independent expert examination. If the patient cannot afford such an examination, the court shall provide for one.

(b) If the court concludes that the patient meets the criteria for involuntary placement, it shall order that the patient be transferred to a treatment facility or, if the patient is at a treatment facility, that he be retained there or that he be treated at any other appropriate facility or service on an involuntary basis. The order shall adequately document the nature and extent of the patient's mental illness.

(c) At the hearing on involuntary placement, the court shall consider testimony and evidence regarding the patient's competence to consent to treatment. If the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate who shall act on the patient's behalf relating to the provision of express and informed consent to treatment.

(d) The court may adjudicate a person incompetent pursuant to the provisions of chapter 744 at the hearing on involuntary placement.

(e) The treatment facility may accept and retain a patient admitted involuntarily for a period not to exceed 6 months whenever the patient is accompanied by a court order and adequate documentation of the patient's mental illness. Such documentation shall include a psychiatric evaluation and any psychological and social work evaluations of the patient. If further involuntary placement is necessary at the end of that period, the administrator shall apply to the hearing examiner for an order authorizing continued involuntary placement.

(f) The court shall provide a court order, a psychiatric evaluation, and other adequate documentation of each patient's mental illness to the administrator of a treatment facility whenever a patient is ordered for involuntary placement, whether by civil or criminal court. The administrator of a treatment facility may refuse admission to any patient directed to its facilities on an involuntary basis, whether by civil or by criminal court order, who is not accompanied at the same time by adequate orders and documentation.

(4) PROCEDURE FOR CONTINUED INVOLUNTARY PLACEMENT.—

(a) If continued placement of an involuntary patient is necessary, the administrator shall, prior to the expiration of the period during which the treatment facility is authorized to retain the patient, request an order authorizing continued involuntary placement. This request shall be accompanied by a statement from the patient's physician or clinical psychologist justifying the request and a brief summary of the patient's treatment during the time he was involuntarily placed. In addition, the administrator shall submit an individualized plan for the patient for whom he is requesting continued involuntary placement. Notification of this request for retention shall be mailed to the patient and his guardian or representative along with a completed petition, requiring only a signature, for a hearing regarding the continued hospitalization and a waiver-of-hearing form. The waiver-of-hearing form shall require express and informed consent and shall state that the patient is entitled to a hearing under the law; that he is entitled to be represented by an attorney at the hearing and, if he cannot afford an attorney, that one will be appointed; and that, if it is shown at the hearing that the patient does not meet the criteria for involuntary placement, he is entitled to be released. If the patient or his guardian or representative does not sign the petition, or if the patient does not sign a waiver within 15 days, the hearing officer shall notice a hearing with regard to the patient involved in accordance with s. 120.57(1). In a proceeding involving a person under the age of 18, the hearing shall not be waived; however, if, at the hearing, the hearing examiner finds that attendance at the hearing is not consistent with the best interests of the patient, he may

waive the presence of the patient from all or any portion of the hearing.

(b) Any time continued involuntary placement is requested, the hearing officer may, on his own motion, notice a hearing.

(c) Any time continued involuntary placement is requested by the administrator, the administrator may request a hearing; and the hearing officer shall hold a hearing within 30 days of such request.

(d) The administrator shall not transfer any patient to voluntary status when he has reasonable cause to believe that the patient is dangerous to himself or others. In any case in which the administrator has reasonable cause to believe that an involuntary patient is dangerous to himself or others, the administrator shall request continued involuntary placement. In any case in which a request for continued involuntary placement is necessary, but the administrator after reviewing the case believes there is not reasonable cause to believe that the patient meets the criteria for involuntary placement at the time of application for transfer to voluntary status and the patient needs continued placement, the patient shall be transferred to a voluntary status.

(e) If the patient or his guardian or representative returns the signed petition noted in paragraph (a), the hearing officer shall notice a hearing in accordance with s. 120.57(1). The patient and his guardian or representative shall be informed of the right to counsel by the hearing officer. In the event a patient cannot afford counsel in a hearing before a hearing officer, the public defender in the county where the hearing is to be held shall act as attorney for the patient. The hearing shall be conducted in accordance with chapter 120.

(f) If the patient by express and informed consent waives his hearing or if at a hearing it is shown that the patient continues to meet the criteria for involuntary placement, the hearing officer shall sign the order for continued involuntary placement. The treatment facility shall be authorized to retain the patient for a period not to exceed 6 months. The same procedure shall be repeated prior to the expiration of each additional 6-month period the patient is retained.

(g) If continued involuntary placement is necessary for an individual admitted while serving a criminal sentence, but whose sentence is about to expire, or for an individual involuntarily placed while a minor, but who is about to reach the age of 18, the administrator shall petition the hearing officer for an order authorizing continued involuntary placement.

(h) At any hearing hereunder for a patient who has been previously adjudicated incompetent to consent to treatment, the hearing examiner shall consider testimony and evidence regarding the patient's competence. If the hearing examiner finds evidence that the patient is competent to consent to treatment, he may issue to the court in which the patient was adjudicated incompetent to consent to treatment a recommended order that the patient's competence be restored and that any guardian advocate previously appointed be discharged.

History.—s. 9, ch. 71-131; s. 8, ch. 73-133; ss. 3, 4, ch. 74-233; s. 1, ch. 75-305; s. 17, ch. 77-121; s. 205, ch. 77-147; s. 1, ch. 77-174; ss. 2, 8, ch. 77-312; s. 19, ch. 78-95; s. 1, ch. 78-197; s. 9, ch. 79-298; s. 2, ch. 79-336; ss. 2, 4, ch. 80-75; s. 12, ch. 82-212.

cf.—s. 916.15 Hospitalization of defendant adjudicated not guilty by reason of insanity.

s. 945.46 Initiation of involuntary placement proceedings with respect to a mentally ill inmate scheduled for release.

394.4674 Plan and report.—

(1) The Department of Health and Rehabilitative Services is directed to develop a comprehensive plan for the deinstitutionalization of those state mental health hospital patients over age 55 who do not meet the criteria for involuntary hospitalization pursuant to s. 394.467. The plan shall include, but need not be limited to, the projected numbers of patients, the timetables for deinstitutionalization, and the specific actions to be taken to accomplish the deinstitutionalization.

(2) The department shall prepare and submit a semiannual report to the Legislature, until the conditions specified in (1) are met, which shall include, but not be limited to:

(a) The status of compliance with the deinstitutionalization plan;

(b) The specific efforts to stimulate alternative living and support resources outside the hospitals and all documentation of the success of these efforts;

(c) The specific efforts to facilitate the development and retention of daily living skills identified by the department as being necessary for living outside an institution and any evidence of the success of these efforts;

(d) The specific plans for new efforts to accomplish the deinstitutionalization of patients in this age group; and

(e) Any evidence of involvement between the Alcohol, Drug Abuse, and Mental Health Program Office and other program offices within the department and between the department and other state and private agencies and individuals to accomplish the deinstitutionalization of patients in this age group.

History.—s. 2, ch. 80-293; s. 245, ch. 81-259; s. 6, ch. 81-290.

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

History.—s. 9, ch. 77-312.

394.469 Discharge of patients.—

(1) POWER TO DISCHARGE.—At any time a patient is found no longer to meet the criteria for involuntary placement, the administrator may:

(a) Discharge the patient, unless the patient is under a criminal charge, in which case he shall be transferred to the custody of the appropriate law enforcement officer;

(b) Transfer the patient to voluntary status on his own authority or at the patient's request, unless the patient is under criminal charge; or

(c) Place an improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.

(2) NOTICE.—Notice of discharge or transfer of status shall be given to the patient, his guardian or representative, the referring professional, and, if the patient was involuntarily placed, the court which entered the order.

(3) CONVALESCENT STATUS; INVOLUN-

TARY PLACEMENT.—An improved patient may be placed on convalescent status for a period of up to 1 year in the care of a less restrictive community setting when such action is in the best interest of the patient. Notice of the patient's placement on convalescent status shall be given to the patient and his guardian or representative, to the referring professional, to the community facility, and to the court which entered the order for involuntary placement. Placement on convalescent status shall include provisions for continuing responsibility by a professional or facility in the community, including a plan for treatment as an outpatient. The administrator of the treatment facility from which the patient is given convalescent status may, at any time during the continuance of such convalescent status, readmit the patient to the treatment facility when the condition of the patient requires. An involuntary patient may be readmitted for the remainder of his authorized treatment period, and the treatment facility shall have up to 1 additional month during which to apply for continued involuntary placement.

(4) When a patient who has been declared incompetent to consent to treatment is discharged or is released from active treatment, such competency shall be restored by operation of law, and any guardian advocate previously appointed shall stand discharged. However, transfer from one inpatient placement to another shall not be considered as a discharge for this purpose. A record of restoration of competency shall be entered on the patient's certificate of discharge, and a copy of the certificate shall be provided to the patient.

History.—s. 10, ch. 71-131; s. 9, ch. 73-133; s. 10, ch. 79-298; s. 13, ch. 82-212.

394.471 Validity of prior involuntary placement orders.—No involuntary placement of a mentally ill person, lawful before January 1, 1972, shall be deemed unlawful because of the enactment of this part. The department shall establish reasonable rules to require the administrator of each treatment facility to apply for an order authorizing continued involuntary placement of any patient for whom involuntary placement is necessary and who was initially involuntarily placed under an order of a court prior to July 1, 1972. Such prior orders, unless superseded by an order under this part, shall remain valid until July 1, 1973, after which all such orders shall be null and void and of no effect, and every patient retained shall become a voluntary patient unless previously placed on involuntary status pursuant to procedures under this part. Nothing in this part invalidates any order appointing a guardian or determining incompetency.

History.—s. 11, ch. 71-131; s. 11, ch. 79-298.

394.473 Attorney's fee; expert witness fee.—(1) In case of indigency of any person for whom an attorney is appointed pursuant to the provisions of this part, the attorney shall be entitled to a reasonable fee to be determined by the court and paid from the general fund of the county from which the patient was involuntarily detained. In case of indigency of any such person, the court may appoint a public defender. The public defender shall receive no additional compensation other than that usually paid his office.

[1](2) In case of indigency of any person for whom expert testimony is required in a court hearing pursuant to the provisions of this act, the expert, except one who is classified as a full-time employee of the state or who is receiving remuneration from the state for his time in attendance at the hearing, shall be entitled to a reasonable fee to be determined by the court and paid from the general fund of the county from which the patient was involuntarily detained.

History.—s. 13, ch. 71-131; s. 10, ch. 73-133; s. 25, ch. 73-334; s. 12, ch. 79-298; s. 3, ch. 82-176; s. 14, ch. 82-212.

[1]**Note.**—Published as amended by s. 14, ch. 82-212. The amendment of this subsection by s. 3, ch. 82-176, during the special session of March 29-April 7, 1982, failed to incorporate the amendment of the same subsection by s. 14 of ch. 82-212 during the regular session. Although the circumstance that separate sessions were involved takes the transaction out of the operation of s. 1.04, there was no apparent legislative intent to nullify the amendment of the regular session. However, s. 7, ch. 82-176, provides that those provisions of that act "which provide for state assumption of witness fees which are currently paid by the counties shall take effect on a date determined by the appropriation of funds for this purpose." Upon the occurrence of this contingency, the subsection, giving full effect to both amendments, will read as follows:

(2) In case of indigency of any person for whom expert testimony is required in a court hearing pursuant to the provisions of this act, the expert, except one who is classified as a full-time employee of the state or who is receiving remuneration from the state for his time in attendance at the hearing, shall be entitled to a reasonable fee to be determined by the court and paid by the state.

394.475 Acceptance, examination, and involuntary placement of Florida residents from out-of-state mental health authorities.—(1) Upon the request of the state mental health authority of another state, the Department of Health and Rehabilitative Services is authorized to accept as a patient, for a period of not more than 15 days, a person who is and has been a bona fide resident of this state for a period of not less than 1 year.

(2) Any person received pursuant to subsection (1) shall be examined by the staff of the state facility where such patient has been accepted, which examination shall be completed during the 15-day period.

(3) If upon examination such a person requires continued involuntary placement, a petition for a hearing regarding involuntary placement shall be filed with the court of the county wherein the treatment facility receiving the patient is located or the county where the patient is a resident.

(4) During the pendency of the examination period herein provided for and the pendency of the involuntary placement proceedings herein provided for, such person may continue to be detained by the treatment facility unless the court having jurisdiction enters an order to the contrary.

History.—s. 14, ch. 71-131; s. 25, ch. 73-334; s. 206, ch. 77-147; s. 13, ch. 79-298; s. 15, ch. 82-212.

394.477 Residence requirements.—No person shall be involuntarily placed in a facility under the provisions of this part who has not been a bona fide resident of the state continuously for 1 year immediately preceding his involuntary placement. However, any person not a bona fide resident of the state may be involuntarily placed in a treatment facility pending transfer of said person back to the state of his residence. An indigent nonresident patient shall be transferred to the state of his residence at the expense of the county from which he was involuntarily placed. The treatment facility, with the approval of the department, shall retain any nonresident who cannot be transferred subject to the provisions of this part.

History.—s. 15, ch. 71-131; s. 14, ch. 79-298.

394.478 Autopsy of deceased patient.—In every case where a person is committed to and received as a patient in the Florida State Hospital, and shall die while a patient therein, it is lawful for the superintendent of the Florida State Hospital, and he may hold and perform, or cause to be held and performed, an autopsy on such deceased patient, when such deceased patient leaves surviving him no relative or guardian, or when said superintendent shall be unable to communicate with or contact any relative or guardian of such deceased patient for the purpose of procuring consent to such autopsy, and when in the judgment and discretion of the superintendent of the Florida State Hospital, such autopsy is in the interest of medical science necessary or desirable.

History.—s. 1, ch. 19367, 1939; CGL 1940 Supp. 3653(11).
Note.—Former s. 394.19.

394.4781 Residential care for psychotic and emotionally disturbed children.—

(1) DEFINITIONS.—As used in this section:

(a) "Psychotic or severely emotionally disturbed child" means a child so diagnosed by a psychiatrist or clinical psychologist who has specialty training and experience with children. Such a severely emotionally disturbed child or psychotic child shall be considered by this diagnosis to benefit by and require residential care as contemplated by this section.

(b) "Department" means the Department of Health and Rehabilitative Services.

(2) FUNDING OF PROGRAM.—The department shall provide for the purposes of this section such amount as shall be set forth in the annual appropriations act as payment for part of the costs of residential care for psychotic or severely emotionally disturbed children.

(3) ADMINISTRATION OF THE PROGRAM.—

(a) The department shall provide the necessary application forms and office personnel to administer the purchase-of-service program.

(b) The department shall review such applications monthly and, in accordance with available funds, the severity of the problems of the child, the availability of the needed residential care, and the financial means of the family involved, approve or disapprove each application. If an application is approved, the department shall contract for or purchase the services of an appropriate residential facility in such amounts as are determined by the annual appropriations act.

(c) The department is authorized to promulgate such rules as are necessary for the full and complete implementation of the provisions of this section.

(d) The department shall purchase services only from those facilities which are in compliance with standards promulgated by the department.

History.—ss. 1, 2, 3, ch. 77-287; s. 156, ch. 79-400; s. 16, ch. 82-212.

394.4785 Minors; admission and placement in state mental hospitals.—

(1) Beginning July 1, 1983, a minor who is admitted to a state mental hospital and placed in the general population or in a specialized unit for children or adolescents shall reside in living quarters separate from adult patients, and a minor who has not attained the age of 14 shall reside in living quarters separate from minors who are 14 years of age or older. Such separation shall be accomplished, and the department shall develop a plan to accomplish such separation and submit the plan to the Governor, President of the Senate, and the Speaker of the House of Representatives by November 1, 1982.

(2) In all cases involving the admission of minors to a state mental hospital, the case record shall document that a good-faith effort was made to place the minor in a less restrictive form of treatment. Admission to a state mental hospital shall be regarded as the last and only treatment option available. Notwithstanding the provision of subsection (1), an individual under the age of 18 may be housed in the general population if the hospital multidisciplinary treatment and rehabilitation team has reviewed the patient and has documented in the case record that such placement is necessary for reasons of safety. Such patients placed in the general population must be reviewed by this team every 30 days and recertified as appropriate for placement in the general population.

History.—ss. 1, 2, ch. 82-212.

PART II

INTERSTATE COMPACT ON MENTAL HEALTH

394.479 Interstate Compact on Mental Health.
394.480 Compact administrator.
394.481 Supplemental agreements with other states.
394.482 Payment of financial obligations imposed by compact.
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394.479 Interstate Compact on Mental Health.—The Interstate Compact on Mental Health is hereby enacted into law and entered into by this state with all other states legally joining therein in the form substantially as follows:

INTERSTATE COMPACT ON MENTAL HEALTH

The contracting states solemnly agree that:

ARTICLE I

The party states find that the proper and expeditious treatment of the mentally ill and mentally deficient can be facilitated by cooperative action, to the benefit of the patients, their families, and society as a whole. Further, the party states find that the necessity of and desirability for furnishing such care and treatment bears no primary relation to the residence or citizenship of the patient but that, on the contrary, the controlling factors of community safety and humanitarianism require that facilities and services be made available for all who are in need of them. Consequently, it is the purpose of this compact and of the party states to provide the necessary legal basis for

the institutionalization or other appropriate care and treatment of the mentally ill and mentally deficient under a system that recognizes the paramount importance of patient welfare and to establish the responsibilities of the party states in terms of such welfare.

ARTICLE II

As used in this compact:

(a) "Sending state" shall mean a party state from which a patient is transported pursuant to the provisions of the compact or from which it is contemplated that a patient may be so sent.

(b) "Receiving state" shall mean a party state to which a patient is transported pursuant to the provisions of the compact or to which it is contemplated that a patient may be so sent.

(c) "Institution" shall mean any hospital or other facility maintained by a party state or political subdivision thereof for the care and treatment of mental illness or mental deficiency.

(d) "Patient" shall mean any person subject to or eligible as determined by the laws of the sending state, for institutionalization or other care, treatment, or supervision pursuant to the provisions of this compact.

(e) "Aftercare" shall mean care, treatment, and services provided a patient, as defined herein, on convalescent status or conditional release.

(f) "Mental illness" shall mean mental disease to such extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others, or of the community.

(g) "Mental deficiency" shall mean mental deficiency as defined by appropriate clinical authorities to such extent that a person so afflicted is incapable of managing himself and his affairs, but shall not include mental illness as defined herein.

(h) "State" shall mean any state, territory or possession of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

ARTICLE III

(a) Whenever a person physically present in any party state shall be in need of institutionalization by reason of mental illness or mental deficiency, he shall be eligible for care and treatment in an institution in that state irrespective of his residence, settlement or citizenship qualifications.

(b) The provisions of paragraph (a) of this article to the contrary notwithstanding, any patient may be transferred to an institution in another state whenever there are factors based upon clinical determinations indicating that the care and treatment of said patient would be facilitated or improved thereby. Any such institutionalization may be for the entire period of care and treatment or for any portion or portions thereof. The factors referred to in this paragraph shall include the patient's full record with due regard for the location of the patient's family, character of the illness and probable duration thereof, and such other factors as shall be considered appropriate.

(c) No state shall be obliged to receive any patient pursuant to the provisions of paragraph (b) of this article unless the sending state has given advance notice of its intention to send the patient; furnished all available medical and other pertinent records concerning the patient; given the qualified medical or other appropriate clinical authorities of the receiving state an opportunity to examine the patient if said authorities so wish; and unless the receiving state shall agree to accept the patient.

(d) In the event that the laws of the receiving state establish a system of priorities for the admission of patients, an interstate patient under this compact shall receive the same priority as a local patient and shall be taken in the same order and at the same time that he would be taken if he were a local patient.

(e) Pursuant to this compact, the determination as to the suitable place of institutionalization for a patient may be reviewed at any time and such further transfer of the patient may be made as seems likely to be in the best interest of the patient.

ARTICLE IV

(a) Whenever, pursuant to the laws of the state in which a patient is physically present, it shall be determined that the patient should receive aftercare or supervision, such care or supervision may be provided in a receiving state. If the medical or other appropriate clinical authorities having responsibility for the care and treatment of the patient in the sending state shall have reason to believe that aftercare in another state would be in the best interest of the patient and would not jeopardize the public safety, they shall request the appropriate authorities in the receiving state to investigate the desirability of affording the patient such aftercare in said receiving state, and such investigation shall be made with all reasonable speed. The request for investigation shall be accompanied by complete information concerning the patient's intended place of residence and the identity of the person in whose charge it is proposed to place the patient, the complete medical history of the patient, and such other documents as may be pertinent.

(b) If the medical or other appropriate clinical authorities having responsibility for the care and treatment of the patient in the sending state and the appropriate authorities in the receiving state find that the best interest of the patient would be served thereby, and if the public safety would not be jeopardized thereby, the patient may receive aftercare or supervision in the receiving state.

(c) In supervising, treating, or caring for a patient on aftercare pursuant to the terms of this article, a receiving state shall employ the same standards of visitation, examination, care, and treatment that it employs for similar local patients.

ARTICLE V

Whenever a dangerous or potentially dangerous patient escapes from an institution in any party state, that state shall promptly notify all appropriate authorities within and without the jurisdiction of the escape in a manner reasonably calculated to facilitate the speedy apprehension of the escapee. Immediately

upon the apprehension and identification of any such dangerous or potentially dangerous patient, he shall be detained in the state where found pending disposition in accordance with law.

ARTICLE VI

The duly accredited officers of any state party to this compact, upon the establishment of their authority and the identity of the patient, shall be permitted to transport any patient being moved pursuant to this compact through any and all states party to this compact, without interference.

ARTICLE VII

(a) No person shall be deemed a patient of more than one institution at any given time. Completion of transfer of any patient to an institution in a receiving state shall have the effect of making the person a patient of the institution in the receiving state.

(b) The sending state shall pay all costs of, and incidental to, the transportation of any patient pursuant to this compact, but any two or more party states may, by making a specific agreement for that purpose, arrange for a different allocation of costs as among themselves.

(c) No provision of this compact shall be construed to alter or affect any internal relationships among the departments, agencies and officers of and in the government of a party state, or between a party state and its subdivisions, as to the payment of costs, or responsibilities therefor.

(d) Nothing in this compact shall be construed to prevent any party state or subdivision thereof from asserting any right against any person, agency or other entity in regard to costs for which such party state or subdivision thereof may be responsible pursuant to any provision of this compact.

(e) Nothing in this compact shall be construed to invalidate any reciprocal agreement between a party state and a nonparty state relating to institutionalization, care or treatment of the mentally ill or mentally deficient, or any statutory authority pursuant to which such agreements may be made.

ARTICLE VIII

(a) Nothing in this compact shall be construed to abridge, diminish, or in any way impair the rights, duties, and responsibilities of any patient's guardian on his own behalf or in respect of any patient for whom he may serve, except that where the transfer of any patient to another jurisdiction makes advisable the appointment of a supplemental or substitute guardian, any court of competent jurisdiction in the receiving state may make such supplemental or substitute appointment and the court which appointed the previous guardian shall upon being duly advised of the new appointment, and upon the satisfactory completion of such accounting and other acts as such court may by law require, relieve the previous guardian of power and responsibility to whatever extent shall be appropriate in the circumstances; provided, however, that in the case of any patient having settlement in the sending state, the court of competent jurisdiction in the sending state shall have the sole discretion to relieve a guardian appointed by it or continue his power and responsibility, whichever it shall deem advisable. The court in the receiving state may, in its discretion, confirm or reappoint the person or persons previously serving as guardian in the sending state in lieu of making a supplemental or substitute appointment.

(b) The term "guardian" as used in paragraph (a) of this article shall include any guardian, trustee, legal committee, conservator, or other person or agency however denominated who is charged by law with power to act for or responsibility for the person or property of a patient.

ARTICLE IX

(a) No provision of this compact except Article V shall apply to any person institutionalized while under sentence in a penal or correctional institution or while subject to trial on a criminal charge, or whose institutionalization is due to the commission of an offense for which, in the absence of mental illness or mental deficiency, said person would be subject to incarceration in a penal or correctional institution.

(b) To every extent possible, it shall be the policy of states party to this compact that no patient shall be placed or detained in any prison, jail or lockup, but such patient shall, with all expedition, be taken to a suitable institutional facility for mental illness or mental deficiency.

ARTICLE X

(a) Each party state shall appoint a "compact administrator" who, on behalf of his state, shall act as general coordinator of activities under the compact in his state and who shall receive copies of all reports, correspondence, and other documents relating to any patient processed under the compact by his state either in the capacity of sending or receiving state. The compact administrator or his duly designated representative shall be the official with whom other party states shall deal in any matter relating to the compact or any patient processed thereunder.

(b) The compact administrators of the respective party states shall have power to promulgate reasonable rules and regulations to carry out more effectively the terms and provisions of this compact.

ARTICLE XI

The duly constituted administrative authorities of any two or more party states may enter into supplementary agreements for the provision of any service or facility or for the maintenance of any institution on a joint or cooperative basis whenever the states concerned shall find that such agreements will improve services, facilities, or institutional care and treatment in the fields of mental illness or mental deficiency. No such supplementary agreement shall be construed so as to relieve any party state of any obligation which it otherwise would have under other provisions of this compact.

ARTICLE XII

This compact shall enter into full force and effect as to any state when enacted by it into law and such state shall thereafter be a party thereto with any and all states legally joining therein.

ARTICLE XIII

(a) A state party to this compact may withdraw therefrom by enacting a statute repealing the same. Such withdrawal shall take effect one year after notice thereof has been communicated officially and in writing to the governors and compact administrators of all other party states. However, the withdrawal of any state shall not change the status of any patient who has been sent to said state or sent out of said state pursuant to the provisions of the compact.

(b) Withdrawal from any agreement permitted by Article VII(b) as to costs or from any supplementary agreement made pursuant to Article XI shall be in accordance with the terms of such agreement.

ARTICLE XIV

This compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this compact shall be severable and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this compact shall be held contrary to the constitution of any state party thereto, the compact shall remain in full force and effect as to the remaining states and in full force and effect as to the state affected as to all severable matters.

History.—s. 1, ch. 71-219.

394.480 Compact administrator.—Pursuant to said compact, the Secretary of Health and Rehabilitative Services shall be the compact administrator who, acting jointly with like officers of other party states, shall have power to promulgate rules and regulations to carry out more effectively the terms of the compact. The compact administrator is hereby authorized, empowered, and directed to cooperate with all departments, agencies, and officers of and in the government of this state and its subdivisions in facilitating the proper administration of the compact of any supplementary agreement or agreements entered into by this state thereunder.

History.—s. 2, ch. 71-219.

394.481 Supplemental agreements with other states.—The compact administrator is hereby authorized and empowered to enter into supplementary agreements with appropriate officials of other states pursuant to Articles VII and XI of the compact. In the event that such supplementary agreements shall require or contemplate the use of any institution or facility of this state or require or contemplate the provision of any service by this state, no such agreement shall have force or effect until approved by the head of the department or agency under whose jurisdiction said institution or facility is operated or whose department or agency will be charged with the rendering of such service.

History.—s. 3, ch. 71-219.

394.482 Payment of financial obligations imposed by compact.—The compact administrator, subject to the approval of the Comptroller, may make or arrange for any payments necessary to discharge any financial obligations imposed upon this state by the compact or by any supplementary agreement entered into thereunder.

History.—s. 4, ch. 71-219.

394.483 Authorized actions by administrator.—The compact administrator is hereby directed to consult with the immediate family representatives or guardian of any proposed transferee and, in the case of a proposed transferee from an institution in this state to an institution in another party state, to take no final action without approval of the committing court, if any.

History.—s. 5, ch. 71-219.

394.484 Transmission of copies of act adopting compact.—Copies of this act shall upon its approval be transmitted by the Department of State to the governor of each state, the Attorney General and the Administrator of General Services of the United States, and the Council of State Governments.

History.—s. 6, ch. 71-219.

PART III

CHILDREN'S RESIDENTIAL AND DAY TREATMENT CENTERS

394.50 Children's residential and day treatment centers.
394.56 Voluntary admission to a center; procedure; etc.
394.57 Involuntary admission to a center; procedure; etc.
394.58 Records.
394.59 Payment for care and treatment of patients.
394.60 Transfer of patients.
394.61 Discharge of voluntary patients.
394.62 Age limit.

394.50 Children's residential and day treatment centers.—There are established in this state children's residential and day treatment centers which shall be under the supervision and control of the Department of Health and Rehabilitative Services. The purpose of the centers shall be to provide for evaluation, care, treatment, and education of emotionally, mentally, or behaviorally disturbed children. The department is authorized to develop children's residential and day treatment centers and children's programs in such locations as it deems appropriate and within the limits of funds appropriated by the Legislature.

History.—s. 1, ch. 59-383; ss. 19, 35, ch. 69-106; s. 207, ch. 77-147; s. 2, ch. 78-434.

394.56 Voluntary admission to a center; procedure; etc.—

(1) Application for admission to a residential or day treatment program shall be made to the center on forms provided by the department. Applications should be signed by the parent or legal guardian of the applicant or, in absence of such, the person or agency having legal custody of the applicant. A child 12 years or older has the same right to volunteer for treatment without parental consent as specified in s. 394.465(1)(b). An application for admission to a residential or day treatment program shall be accompanied by a certificate signed by a physician licensed or authorized to practice in Florida under chapter 458 and by any comprehensive community mental health center director or mental health clinic director, designated receiving facility, licensed clinical psychologist, or social or child care agency director. The certificate shall be based on an examination conducted not more than 15 days prior to the date of application. The application shall contain the history of and the results of any examinations of the applicant and a diagnosis of the applicant's condition, and it shall state that admission to the center, including related evaluation, treatment, and educational programs, would, in the physician's opinion, be beneficial to the child.

(2) Upon receipt of the application, the director of a center shall, on the basis of the certificate and any other evaluation methods he determines, accept or reject the applicant as a patient in the center. The director of the center shall determine the order of admission of applicants. The ability to pay shall never be a prerequisite to admission, evaluation, treatment, and education in a center.

History.—s. 7, ch. 59-383; ss. 19, 35, ch. 69-106; s. 4, ch. 70-432; s. 1, ch. 70-439; s. 25, ch. 73-334; s. 213, ch. 77-147; s. 3, ch. 78-434.

394.57 Involuntary admission to a center; procedure; etc.—Whenever any child in the state is believed to be severely emotionally, mentally, or behaviorally disturbed and voluntary admission is not possible, the involuntary admission criteria and procedures established in s. 394.467 shall be followed. In the event a child has been a patient in a children's residential or day treatment center on a voluntary basis and it becomes necessary to initiate involuntary proceedings, the criteria and procedures established in s. 394.467 shall be followed by the director of the center.

History.—s. 8, ch. 59-383; s. 5, ch. 70-432; s. 25, ch. 73-334; s. 23, ch. 78-414; s. 4, ch. 78-434.

394.58 Records.—The order of involuntary hospitalization shall be forwarded to the center. This shall be accompanied by a copy of the medical and psychiatric examination and a social history of the child.

History.—s. 9, ch. 59-383; ss. 19, 35, ch. 69-106; s. 214, ch. 77-147; s. 5, ch. 78-434.

394.59 Payment for care and treatment of patients.—Fees and fee collections for patients at a residential or day treatment center shall be based on the provisions of s. 402.33.

History.—s. 10, ch. 59-383; ss. 19, 35, ch. 69-106; s. 215, ch. 77-147; s. 4, ch. 78-332; s. 6, ch. 78-434.

394.60 Transfer of patients.—If the director of a center upon advice of his clinical staff determines that any child at the center is not responding to or benefiting from the treatment and education programs at the center and that such child is in need of further care, rehabilitation, special training, education, and treatment and would be more suitably cared for, rehabilitated, trained, educated, and treated at another of the state facilities under the Department of Health and Rehabilitative Services, the center shall request the child's transfer to the proper facility. Transfers of such child to a mental health facility or retardation facility shall follow the procedures as set forth in part I of chapter 394 and chapter 393, respectively.

History.—s. 11, ch. 59-383; ss. 19, 35, ch. 69-106; s. 131, ch. 77-104; s. 216, ch. 77-147; s. 24, ch. 78-414; s. 7, ch. 78-434.

394.61 Discharge of voluntary patients.—

(1) When a child has been a patient at a center and subject to care, treatment, and education, and the director, upon advice of his professional staff, is of the opinion that the child has sufficiently improved or will no longer benefit from care, treatment, and education at the center, the director may issue a certificate of discharge and discharge the child from the center.

(2) The director of the center shall discharge a child within 5 days of receipt of written request from the parent or legal guardian for discharge, unless the discharge is, in the opinion of the center staff, unsafe for the patient or others; in which case, the director of the center shall initiate proceedings for involuntary hospitalization within 3 days of the delivery of the written request. A center is authorized to retain a child after proceedings for involuntary admission have been initiated pending the outcome of the judicial decision. Upon discharge of a child who was involuntarily admitted, a copy of the certificate of discharge shall be mailed to the circuit judge who ordered the child's involuntary admission. A copy of the discharge certificate shall also be sent by registered or certified mail to the parent or guardian of the child. Upon the filing and docketing of the certificate, the case shall be terminated. In the event the parent or legal guardian cannot be found or refuses to accept custody of the discharged child, the child shall be placed in the care and custody of an appropriate community agency. If no community agency is willing or able to accept care and custody of the child, the circuit court of the judicial district from which the child was originally admitted shall place the child in the care and custody of the department. The circuit court may make such other order as it deems in the best interest of the child.

History.—s. 12, ch. 59-383; ss. 19, 35, ch. 69-106; s. 25, ch. 73-334; s. 217, ch. 77-147; s. 8, ch. 78-434.

394.62 Age limit.—Any child 5 to 14 years of age is eligible for admission to a children's residential or day treatment center.

History.—s. 13, ch. 59-383; s. 9, ch. 78-434.

PART IV

COMMUNITY MENTAL HEALTH SERVICES

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394.81 Consideration for funding.

394.65 Short title.—This part IV of this chapter shall be known as as "The Community Mental Health Act."

History.—s. 1, ch. 70-109.

394.66 Legislative intent.—It is the intent of the Legislature to:

(1) Organize and finance community mental health services in local communities throughout the state through locally administered and locally controlled community mental health programs.

(2) Better utilize existing resources at both the state and local levels in order to improve the effectiveness of necessary mental health services.

(3) Integrate state-operated and community mental health programs into a unified mental health system.

(4) Ensure that all mental health professions are appropriately utilized in such mental health programs to provide a means for participation by local governments in the determination of the need for, and the allocation of, mental health resources.

(5) Establish a uniform ratio of state government responsibility and local participation in financing mental health services.

(6) Provide a means of allocating state mental health funds according to community needs.

(7) Ensure that, to the maximum degree feasible, the districts of the Department of Health and Rehabilitative Services are the focal point of all district board activities, including budget submissions, grant applications, contracts, and other arrangements that can be effected at the district level.

(8) Include community mental health care as a component of the integrated delivery system of the Department of Health and Rehabilitative Services.

(9) Involve local citizens in the administration of community mental health services on a policymaking level.

(10) Ensure nonduplication of the activities of the staffs of the district administrator and the mental health board or boards.

History.—s. 2, ch. 70-109; s. 30, ch. 75-48; s. 1, ch. 76-221.

394.67 Definitions.—When used in this part, unless the context clearly requires otherwise:

(1) "Service district" means a community service district as established by the department pursuant to s. 20.19(4)(a) for the purpose of providing community mental health services.

(2) "Governing body" means the chief legislative body of a county, a board of county commissioners, or boards of county commissioners in counties acting jointly, or their counterparts in a charter government.

(3) "District plan" or "plan" means the combined district alcohol and mental health plan adopted by a mental health board and approved by the district administrator and governing bodies in accordance with this part.

(4) "Department" means the Department of Health and Rehabilitative Services.

(5) "Program office" means the Alcohol, Drug Abuse, and Mental Health Program Office of the Department of Health and Rehabilitative Services.

(6) "Advisory council" means a district advisory council as created by s. 20.19(5).

(7) "Patient fees" means compensation received by a community mental health facility for services rendered to clients from any source of funds, including city, county, state, federal, and private sources.

(8) "Local matching funds" means funds received from governing bodies of local government, including city commissions, county commissions, district school boards, special tax districts, private hospital funds, private gifts, both individual and corporate, and bequests and funds received from community drives or any other sources.

(9) "Federal funds" means funds expended by a community mental health facility from federal sources for mental health facilities and programs. This is exclusive of federal funds that are deemed eligible by the Federal Government and are eligible through state regulation for matching purposes.

(10) "Mental health board" or "board" means the board within a Department of Health and Rehabilitative Services district or subdistrict established in accordance with provisions of this part for the purposes of coordinating community mental health programs.

(11) "Board district" means that area over which a single mental health board has jurisdiction for coordinating mental health programs as provided in this part. There may be more than one board district in a service district.

(12) "District administrator" means the person appointed by the Secretary of Health and Rehabilitative Services for the purpose of administering a department service district as set forth in s. 20.19.

(13) "Term" means a 2-year term of appointment on a mental health board.

(14) "Community mental health facility" means any facility in which all or any portion of the programs or services set forth in ss. 394.75(2)(c)5., 394.75(2)(e)2., and 394.75(3) are carried out.

History.—s. 3, ch. 70-109; s. 2, ch. 76-221; s. 132, ch. 77-104; s. 7, ch. 81-290; s. 2, ch. 82-223.

394.69 District mental health boards.—Men-

tal health boards shall be established as hereinafter provided to coordinate mental health services within department service districts or subdistricts as set forth in s. 20.19.

(1) Each district administrator shall initiate and coordinate the reorganization of the mental health board within his district.

(2) The district administrator shall decide if a mental health board shall be established within a subdistrict.

(3) In instances in which board district boundaries are altered, board responsibilities set forth in this part shall be transferred to the appropriate board on the effective date of this section.

(4) The total state funding of the operating budget of the board or boards within any Health and Rehabilitative Services district shall not exceed $125,000 and shall conform to the matching requirements of s. 394.76. The total operating budget, including all state, local, and federal funds, for the boards in a service district with only one board shall be no greater than $200,000, and the total operating budget, including all state, local, and federal funds, for the boards in a service district with two or more boards shall be no greater than $225,000.

(5) Each board shall comply with the provisions for incorporation of nonprofit corporations as set forth in chapter 617.

(6) A local governing body is authorized to appropriate moneys, in lump sum or otherwise, from its public funds for the purpose of carrying out the provisions of this act. In addition to payment of claims upon submission of a proper voucher, such moneys may also, at the option of the governing body, be disbursed in the form of a lump sum or advance payment for services for expenditure in turn by the recipient of the disbursement without prior audit by the auditor of the governing body. Such funds shall be expended only for mental health purposes as provided in the approved mental health district board plan. Each governing body appropriating and disbursing moneys pursuant to this subsection shall require the expenditure of such moneys by the recipient of the disbursement to be audited annually, either in conjunction with an audit of other expenditures or by a separate audit. Such annual audits shall be furnished to the governing bodies of each participating county and municipality for their examination.

History.—s. 5, ch. 70-109; s. 4, ch. 76-221; s. 1, ch. 77-174; s. 1, ch. 77-372; s. 157, ch. 79-400; s. 1, ch. 80-195.

394.70 Method of appointment of mental health boards.—

(1) The mental health board shall be appointed by the governing body or bodies having jurisdiction in the board district. In its selection and appointment of the board, the governing body shall adhere to the following:

(a) First priority shall be given to individuals with a demonstrated commitment to the mental health of the general public.

(b) At least one member of a local governing body or bodies within the board district shall be a member of the mental health board. At least one member of the mental health board shall be a physician or psychiatrist.

(c) The terms of members of the board shall be for 2 years and shall be staggered. Vacancies by resignation or expiration of term shall be filled by the governing body or bodies which made the original appointment.

(d) When a person qualifies for membership on the board because he holds a specified office, membership on the board ceases when the term of office ceases. No person shall be appointed for more than four successive terms or 8 successive years on the board.

(e) No member of the board shall serve as a full-time or part-time employee of the Department of Health and Rehabilitative Services or as an employee or a member of a board of a community mental health facility or as an employee of the district mental health board.

(2)(a) The board shall consist of not fewer than 10 or more than 21 members who shall be as fairly representative as possible of a broad range of community mental health interests.

(b) When more than one governing body exists within the board district, each governing body shall be entitled to that number of appointments to the board as fairly represents its county's percentage of population in the board district. However, each county in the district or subdistrict shall have no less than one member.

(c) Each member of the board shall have a weighted vote, with no member having less than one vote, which weighted vote shall be determined by the following formula:

1. The representation of each governing body shall constitute a percentage of the total board votes equal to its county's percentage of the population of the board district as a whole.

2. The total number of votes assigned to the representation of each governing body shall be divided among that governing body's appointees to the board.

(d) In the event that a board member fails to attend two-thirds of the regular board meetings during the course of a year, it shall be the responsibility of the governing body by whom the member was appointed to designate a replacement. In addition, each board shall have a provision in its bylaws for defining misfeasance and malfeasance of duty. The board shall petition the governing body to replace any member guilty of either misfeasance or malfeasance.

(3) Board members shall serve without pay, but shall be entitled to travel and per diem expense as authorized by s. 112.061.

(4) Each board shall designate one of its members to serve as treasurer who, before he assumes office, shall post with the Department of State a surety bond in an amount to be set by the department with a surety approved by the department. Such bond shall be conditioned on the faithful discharge of the duties of the office and be made payable to the Governor.

History.—s. 6, ch. 70-109; s. 1, ch. 74-147; s. 5, ch. 76-221; s. 1, ch. 77-174.

394.71 Duties of board.—Subject to the provi-

sions of this part and the regulations of the department, each mental health board:

(1) Shall review and evaluate the mental health needs, services, and facilities of its area of jurisdiction and prepare a district plan and budget based on its evaluation.

(2) Shall receive and disburse such funds as are entrusted to it by law or otherwise, including funds from both private and public sources, charitable foundations, and agencies of the Federal Government.

(3) Shall contract for state funds with the district administrator for the coordination and disbursement of such funds as provided in this part.

(4) Shall report to the governing body as to a program of community mental health services and facilities and submit an annual report to the governing body.

(5) May appoint a director of mental health for the board district.

(6) Shall schedule meetings with local governments, community and citizen groups, and service providers, no less than once a year, to enhance information exchange and access to decision making. Such meetings shall be advertised in a newspaper of general circulation in the board district, at least one time, no more than 10 days and no less than 7 days prior to such meeting. It is intended that such meetings shall be widely publicized.

History.—s. 7, ch. 70-109; s. 6, ch. 76-221.

394.72 Staff.—

(1) The board director appointed by the board shall meet such standards of training and experience as the department shall require by regulation. Applicants for such positions need not be residents of the city, county, or state and may be employed on a full-time or part-time basis. If a board is unable to secure the services of a person who meets the standards of the department, the board may select an alternate administrator, subject to the approval of the district administrator.

(2) The staff of the district administrator shall not duplicate the activities of the staff of the district mental health board.

(3) No board staff member shall also be on the staff of a mental health service provider.

History.—s. 8, ch. 70-109; s. 1, ch. 70-439; s. 7, ch. 76-221.

394.73 Joint mental health programs in two or more counties.—

(1) Subject to rules and regulations established by the department, any county within a board district shall have the same power to contract for mental health services as the department has under existing statutes.

(2) In order to carry out the intent of this part and to provide mental health services in accordance with the district plan, the counties within a board district may enter into agreements with each other for the establishment of joint mental health programs. The agreements may provide for the joint provision or operation of services and facilities or for the provision or operation of services and facilities by one participating county under contract with other participating counties.

(3) When a board district comprises two or more counties or portions thereof, it shall be the obligation of the mental health board to submit to the governing bodies, prior to the budget submission date of each governing body, an estimate of the proportionate share of costs of mental health services proposed to be borne by each such governing body.

(4) Any county desiring to withdraw from a joint program may submit to the board and to the district administrator a resolution requesting withdrawal therefrom together with a plan for the equitable adjustment and division of the assets, property, debts, and obligations, if any, of the joint program. Unless all participating counties agree to an earlier withdrawal, no county participating in a joint program may withdraw therefrom without the consent of the district administrator or earlier than 2 years after submission of the withdrawal resolution to the district administrator.

History.—s. 9, ch. 70-109; s. 1, ch. 70-439; s. 8, ch. 76-221.

394.74 Contracts for services.—

(1) Each mental health board, with the approval and subject to rules of the department, and when funds are available for such purposes, is authorized to contract for state funds on a matching basis in the establishment and operation of local alcohol and mental health programs with any hospital, clinic, laboratory, institution, or other appropriate service agency. Any such contract may be entered into notwithstanding that a local director of the mental health program is a member of the medical or consultant staff of such hospital, clinic, laboratory, institution, or other appropriate service agency.

(2) Contracts shall include, but not be limited to, the following:

(a) A provision that, within the limits of available resources, a continuum of integrated and comprehensive alcohol and mental health services should be available to any individual residing or employed within the service area, regardless of ability to pay for such services, current or past health condition, or any other factor.

(b) A provision that such services should be available with attention to individuals exhibiting symptoms of chronic or acute alcoholism or mental illness who are unable to pay the cost of receiving such services being given priority.

(c) A provision that every reasonable effort to collect appropriate reimbursement for the cost of providing alcohol and mental health services to persons able to pay for services, including first-party and third-party payments, shall be made by facilities providing services pursuant to this act.

(d) Evidence of the availability of local matching funds.

(e) A requirement that the plan and budget of the board must conform to the department rules and the priorities established thereunder.

(f) Standard contract forms shall be developed by the department for use between:

1. The district administrator and district mental health boards.

2. District mental health boards and community mental health service providers.

(3) Nothing in this part shall prevent any city or combination of cities from owning, financing, and operating an alcohol program or a mental health program by entering into arrangements with the board to provide and be reimbursed for services provided as part of the district plan.

History.—s. 10, ch. 70-109; s. 9, ch. 76-221; s. 3, ch. 82-223; s. 32, ch. 83-216.

394.75 The board district plan.—

(1)(a) The board shall prepare a combined district alcohol and mental health plan. The plan shall reflect both the program priorities established by the department and the needs of the district. The plan shall include a program description and line-item budget for alcohol and mental health service agencies which will receive state funds. The entire proposed operating budget for each service agency shall be displayed. A schedule, format, and procedure for development and review of the plan shall be promulgated by the department.

(b) The plan shall be submitted to the district administrator and to the governing bodies for review, comment, and approval.

(2) The plan shall:

(a) Describe the proposed objectives and programs.

(b) Set forth:

1. The sources of local matching funds.

2. Priorities for the services included in the plan for the next fiscal year.

(c) Provide:

1. The basis for reimbursement pursuant to the provisions of this part.

2. A plan for the coordination of services in such manner as to insure effectiveness and avoid duplication, fragmentation of services, and unnecessary expenditures.

3. For the most appropriate and economical use of all existing public and private agencies and personnel.

4. For the fullest possible and most appropriate participation by existing programs; state hospitals and clinics; public and private general and psychiatric hospitals; city, county, and state health and family service agencies; drug abuse and alcoholism programs; probation departments; physicians; psychologists; social workers; public health nurses; and all other public and private agencies and personnel which are required to, or may agree to, participate in the plan.

5. An inventory of all public and private mental health resources within the board district.

(d) Specify all other mental health services in addition to those included under the provisions of this part which the board district wishes to continue to operate in the next fiscal year and the estimated costs of such services.

(e) Include:

1. Provisions for evaluating mental health services in the board district. Program evaluations shall include studies of progress toward attainment of objectives, relative cost, and effectiveness of alternative comparable forms and patterns of services.

2. A projection of board district needs for mental health services for the succeeding 3-year period. The plan shall provide for the orderly and economical development of those services and shall indicate priorities and anticipated expenditures and revenues.

(3) The plan may include, but not be limited to, the establishment of any of the following services:

(a) Inpatient services;

(b) Outpatient services;

(c) Partial hospitalization services, such as day care, night care, or weekend care;

(d) Emergency services 24 hours per day available within one of the three services listed in paragraphs (a), (b), and (c);

(e) Consultation and education services available to community agencies and professional, personnel, and information services to the general public;

(f) Diagnostic services, including screening of persons referred for admission to state hospitals;

(g) Rehabilitative services, including vocational and educational programs;

(h) Precare and aftercare services in the community, including foster home placement, home visiting, and halfway houses;

(i) Training; and

(j) Research and evaluation.

(4) In developing the plan, optimum use shall be made of federal, state, and local funds which may be available for mental health planning.

(5) All departments of state government and all local public agencies shall cooperate with officials to assist them in mental health planning. Each district administrator shall, upon request and availability of staff, provide consultative services to the local mental health directors, governing bodies, and mental health boards.

History.—s. 11, ch. 70-109; s. 1, ch. 70-439; s. 10, ch. 76-221; s. 2, ch. 77-372; s. 4, ch. 82-223.

394.76 Financial provisions.—

(1) The district administrator shall inform the board of which services included in the adopted district plan would be funded by the state and shall ensure that, to the extent possible within available resources, a continuum of integrated and comprehensive services will be available within the district.

(2) If in any fiscal year the approved appropriation is insufficient to finance the programs and services specified by this part, the department shall have the authority to determine the amount of state funds available to each service district for such purposes in accordance with the priorities in both the state and district plans.

(3) The state share of financial participation shall be determined by the following formula:

(a) The state share of approved program costs shall be a percentage of the net balance determined by deducting from the total operating cost of services and programs as specified in s. 394.75(3):

1. Those expenditures which are not reimbursable as provided in subsection (6) and those nonreimbursable expenditures established by rule of the department pursuant to s. 394.78.

2. All federal funds unless otherwise designated by the department.

(b) Residential and case management services funded as part of a deinstitutionalization project shall not require local matching funds. All other contracted community alcohol and mental health ser-

vices and programs, except as identified in s. 394.457(3), shall require local participation on a 75-to-25 state-to-local ratio.

(c) In order to be qualified for receipt of any state matching funds, the board applying for such funds must submit annually to the district administrator a budget, in such a form as prescribed by the department, specifying how such funds will be used. The district administrator shall integrate such board district budgets into a single budget document for submission to the Secretary of Health and Rehabilitative Services.

(d) The expenditure of 100 percent of all third-party payments and fees shall be considered as eligible for state financial participation if such expenditures are in accordance with subsection (6) and the approved district plan.

(4) The district administrator is authorized to make investigations and to require audits of expenditures. The district administrator may authorize the use of private certified public accountants for such audits. Audits shall follow department guidelines.

(5) Claims for state payment shall be made in such form and in such manner as the department shall determine.

(6) Expenditures subject to state payment shall include expenditures for approved salaries of personnel; approved facilities and services provided through contract; operation, maintenance, and service cost; depreciation of facilities; and such other expenditures as may be approved by the district administrator. They shall not include expenditures for compensation to members of a community alcohol or mental health board, except actual and necessary expenses incurred in the performance of official duties, or expenditures for a purpose for which state payment is claimed under any other provision of law.

(7) Expenditures for capital improvements relating to construction of, additions to, purchase of, or renovation of a community alcohol or mental health facility may be made by the state, provided that such expenditures or capital improvements are part and parcel of an adopted board district plan approved by the district administrator. Nothing shall prohibit the use of such expenditures for construction of, additions to, renovation of, or purchase of facilities owned by a county, city, or other governmental agency of the state or a nonprofit entity. Such expenditures shall be subject to the provisions of subsections (3) and (5).

(8) State funds for community alcohol and mental health services shall be matched by local matching funds as provided in paragraph (3)(b). Governing bodies within a district or subdistrict shall be required to participate in the funding of alcohol and mental health services under the jurisdiction of said governing body. The amount of the participation shall be at least that amount which, when added to other available local matching funds, is necessary to match state funds.

History.—s. 12, ch. 70-109; s. 1, ch. 70-439; s. 111, ch. 71-355; ss. 1, 2, ch. 72-386; s. 1, ch. 74-291; s. 11, ch. 76-221; s. 33, ch. 77-312; ss. 3, 5, ch. 77-372; s. 5, ch. 82-223.

394.77 Control of costs.—The department shall establish, for the purposes of control of costs:

(1) A uniform management information system and fiscal accounting system for use by providers of community alcohol and mental health services.

(2) A uniform reporting system with uniform definitions and reporting categories.

The department is directed to simplify information and fiscal reporting requirements while increasing accountability for the expenditures of state funds.

History.—s. 13, ch. 70-109; s. 1, ch. 70-439; s. 12, ch. 76-221; s. 6, ch. 82-223.

394.78 Operation and administration.—

(1) The Department of Health and Rehabilitative Services shall administer this part and shall adopt rules and regulations necessary for its administration.

(2)(a) The department shall, by regulation, establish standards of education and experience for professional and technical personnel employed in mental health programs.

(b) Rules and regulations of the department shall be adopted in accordance with the Administrative Procedure Act under chapter 120.

(3) The district administrator shall review the district plan to determine that:

(a) It complies with the state plan, the requirements of this part, and the standards adopted under this part;

(b) The most effective and economical use will be made of available public and private mental health resources in the service district;

(c) Adequate provisions have been made for review and evaluation of the services provided in the service district.

(4) The district administrator and district governing bodies shall require modifications in the district plan which they deem necessary to bring the plan into conformance with the provisions of this part. Each governing body shall have the authority to require necessary modification to only that portion of the district plan which affects mental health programs and services within the jurisdiction of said governing body.

(5) In unresolved disputes regarding this part or rules established pursuant to this part, providers and boards will adhere to formal procedures as provided by the rules and regulations established by the department.

History.—s. 14, ch. 70-109; s. 1, ch. 70-439; s. 13, ch. 76-221; s. 4, ch. 77-372.

394.79 State plan.—

(1) The program office shall prepare a state plan which shall be in conformity with federal requirements. The state plan shall be annually revised, shall consider the community mental health needs set forth in the district plans, shall list core programs, and shall include a system of priorities for allocating state mental health funds to the service district.

(2) The program office shall consult with the local district administrators and mental health boards in developing the state plan.

(3) The state plan shall be reviewed and revised as necessary to provide a basis for allocating mental health funds throughout the state. The state plan and the system of priorities shall encourage innovations by community mental health programs.

History.—s. 15, ch. 70-109; s. 1, ch. 70-439; s. 14, ch. 76-221.

394.80 Authorization to appropriate funds.—The several cities and counties of this state are authorized to appropriate funds to support all or any portion of the cost of services and construction not met through support by the state or federal governments.

History.—s. 16, ch. 70-109.

394.81 Consideration for funding.—Priority in the consideration for funding shall be given to agencies which have previously contracted for the expenditure of state dollars, provided the services offered by those agencies are consistent with the priorities in the district plan and meet departmental quality standards.

History.—s. 17, ch. 70-109; s. 1, ch. 70-439; s. 15, ch. 76-221; s. 7, ch. 82-223.