

Express and Informed Consent

(See also Voluntary Admissions and Emergency Treatment Orders)

Competence to Consent

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

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

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

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

Q. Is it true that a non-psychiatrist physician, during the involuntary examination, can determine competency? I think the answer is yes, but just need verification.

You are correct. A non-psychiatric physician can determine competency to consent to treatment. No professional other than a physician can do so. Whether on voluntary or involuntary status, the physician must certify that the person is able to make well-reasoned, willful and knowing decisions about his/her health and mental health care – the definition of competence to consent – before permitting the individual to consent to treatment. All voluntary patients must be certified as "competent" within 24 hours of admission and any persons on involuntary status who are refusing examination but allowed to consent to their own treatment must also be certified.

It's important that the documentation in the clinical record reflects that the individual maintains this competence as long as treatment is provided. If at any time the individual displays statements or behaviors that suggest he/she isn't any longer able to make such well reasoned decisions, treatment can't be continued except when imminent danger has been documented (ETO) or a legally authorized substitute decision-maker is designated to provide consent.

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

It's unclear what kind of legal documents are involved. Just because a person hasn't been adjudicated incapacitated by a court, doesn't mean he/she is competent for various purposes.

If the patient is on voluntary or involuntary status and has been allowed to provide consent to his/her own treatment, a physician would have had to document the person's competence to provide express and informed consent on a sustained basis (not just some "window of lucidity"). This medical statement means that the person is able to make well-reasoned, willful and knowing medical and mental health decisions.

If the person's clinical record has notes from nurses, social workers or other personnel that reflect the person's judgment or insight was impaired at the, the legitimacy of any consent would be questionable, even for treatment not to mention other legal documents. One would question how the person would meet the acuity criteria for inpatient psychiatric care and yet be able to pass the high threshold of competence to do so.

If a person was being held involuntarily because of "refusal" instead of "unable to determine the exam/placement was needed", it may be possible to overcome with sufficient documentation a presumption of incapacity.

The person could later challenge any document signed at such a time and place due to diminished capacity or perceived coercion, whether the documents are Advance Directives, quit claim deeds, a will, powers of attorney, or any other legal document.

Q. If a person is admitted on involuntary examination status and the box on the BA-52 form is checked 'refusing voluntary exam' – can the patient be capable of providing consent to their psychotropic medications and treatments as long as the staff notes that they appeared to be consistently able to make well-reasoned, willful and knowing decisions about their treatment?

Yes. A person may refuse admission but may be competent to consent or refuse consent to treatment.

Q. Can a person on involuntary status still be competent to consent or refuse consent to their own treatment?

YES. The issue of competence to consent is considered separately from the placement issue. If the person meets the criteria for involuntary examination or involuntary placement but is capable of making well-reasoned, willful, and knowing decisions about their medical or mental health, he or she may continue to consent, withhold consent, or refuse consent to treatment.

A person on involuntary status may or may not be competent to consent to his or her own treatment. If the person who initiated the involuntary examination noted on the form that the person was unable to determine the exam was necessary, as opposed to refusing the exam, the person must be presumed to be incompetent to consent to treatment until determined by a physician to have such capacity.

Q. Does a physician need to complete Certification of Person's Competence to Provide Express and Informed Consent (Form #3104) if the patient is to be discharged from involuntary status and our facility within 24 hours of admission, or can s/he complete the 3111 only?

The Certification of Competence is used as follows:

- If the person arrives on voluntary status and is released in less than 24 hours, the 3104 form doesn't need to be completed.
- If the person arrives on either voluntary or involuntary status and consents to/receives psychotropic medications, the 3104 form must be used even if the person is released within 24 hours.
- If the person arrives on involuntary status and is subsequently released either within or outside the 24 hour window and regardless of whether the person has been medicated, the 3111 or it's equivalent must be completed.

Q. Does competency to consent to treatment have to be documented by a physician before consent can be sought and treatment administered?

NO. Chapter 65E-5.170(1), FAC requires that as soon as possible, but in no event longer than 24 hours from entering a designated receiving facility on a voluntary or involuntary basis, each person shall be examined by the admitting physician to determine the person's ability to provide express and informed consent to admission and treatment.

This doesn't require that the examination or completion of the form be done prior to administering psychotropic medications. However, the law is very clear that the person must be able to provide express and informed consent for any treatment rendered, after full disclosure of all the legally required information.

With regard to adults on **voluntary** status, one can presume the person is competent to consent to medications and other treatment prior to being certified by a physician as long as staff notes that the person appears to be able to consistently make well-reasoned, willful, and knowing decisions about his/her medical and mental health treatment. However, at any time the person displays statements or behaviors that would lead one to believe that he or she is not able to make well-reasoned, willful and knowing decisions, the treatment must be discontinued until informed consent can be obtained from a legally authorized person, unless an emergency treatment order is issued because of imminent danger.

If a person is admitted on **involuntary** status and the block on the BA-52 form indicates the person was unable to determine a voluntary examination was needed is checked, a facility would have to presume the person is incompetent to consent to medications or

other treatment. If the box marked "refusing voluntary exam" is checked instead, the person on involuntary status might be capable of providing consent to his/her own treatment as long as staff noted that the person appeared to be consistently able to make well-reasoned, willful, and knowing decisions about his/her medical and mental health treatment.

Q. Does a nurse have a blanket period between admission and the psychiatrist competency exam to obtain consents even when the patient appears incompetent (In other words, assume competence)?

No such "blanket period" between admission and the physician's certification to obtain consent exists, even when the patient appears incompetent. At any time a voluntary patient displays statements or behaviors reflecting an inability to make "well-reasoned, willful, and knowing decision-making" (definition of competence in the Baker Act), one has to presume the person is incompetent to consent to treatment. Even if a person on involuntary status has had the initiation form checked "unable to determine the exam is needed", one has to presume incompetency. Where the patient's initiation form is checked "refused examination" and appears to be making well-reasoned, willful, and knowing decisions, one can accept authorization for treatment from an adult competent patient. The Baker Act is explicit that no psychiatric treatment can be provided without express and informed consent from a legally authorized decision-maker after full disclosure, unless and emergency treatment order is written due to imminent danger. An alternative to an ETO is for a surrogate or proxy to be an interim decision maker as soon as the physician documents that the person lacks the capacity to make his or her own decisions. Of course, a petition for a guardian advocate would be filed with the court within 2 working days.

A nurse needs to protect his or her own license by not administering medications to a person unable to meet the legal definition of competence. The U.S. Supreme Court made it abundantly clear that treating a person without his or her express and informed consent, short of imminent danger, was impermissible. The Baker Act is consistent with this opinion. The case that led to this opinion resulted in the physician's insurance companies and the facility's insurance company paying for the battery they had committed against the patient, even though the patient received quality treatment with positive outcomes.

Q. Who specifically may determine competency for a person to sign into a facility on a voluntary basis? It is our interpretation that a physician must make this determination. In reading over the laws and rules, there is some contradiction however. Some areas simply state "physician" while others state "admitting physician". Basically, does it need to be a psychiatrist solely, or can it be a non-psychiatric physician with training in the diagnosis

While the law governing voluntary admissions refers to the "admitting physician" documenting capacity to provide express and informed consent, there isn't any definition provided for such an admitting physician. The statute, as you noted, does define a physician. As a result, the rules and even the 3104 Certification form refers only to "physician". It does not require this function to be performed by a psychiatrist unless the receiving facility's policies and procedures are more stringent than what is required by

Baker Act law or rules. However, this function cannot be delegated to a physician extender such as a PA or ARNP and cannot be extended to a psychologist.

Q. Can a patient remain on involuntary status and be competent to consent for treatment (medication)? The 2008 Baker Act Handbook stated that a person admitted on an involuntary status may or may not be competent to provide consent to his or her own treatment. I have never done it this way but one of our new psychiatrists informs me that this is okay.

Yes, a person can be on involuntary status and possibly still be competent to consent or refuse consent to treatment. This is contingent on the involuntary status being based on the person's "refusal" of examination but who has been certified by a physician as able to make well-reasoned, willful, and knowing decisions about his/her mental health and medical treatment. A person found competent to consent is also fully competent to refuse consent to treatment.

At any time any physician or staff member notes that the person's statements or behaviors reflect loss of ability to make well-reasoned decisions, the person must be considered incompetent to consent and a guardian advocate sought for such decision-making. Administering medications without "express and informed consent", short of imminent danger where an ETO has been justified, could result in criminal, civil or administrative penalties. It is important that the person's legal status (for consenting to admission and to treatment) be consistent with their true clinical status as described by the various professionals charting in the medical record.

Q. Can you please clarify what the 3rd box on the Competency form CF-MH 3104 means. The main thing I want to know is can a person be maintained on court petitions to continue the Baker Act with this box checked or does the doctor have to either discharge or transfer the patient to involuntary status like the third box notes?

The issue of incompetence is applied to admission and to treatment. If a person is incompetent for either admission or for treatment, he/she must be considered incompetent for both. However, the Baker Act involuntary examination and involuntary inpatient placement criteria makes a distinction between a person who may be refusing examination / placement and a person who is unable to determine (incompetence) that such an examination/placement is necessary, as follows:

394.463 Involuntary examination.--

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

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

A person who is competent to consent to treatment must be competent to consent to treatment and the first box is checked. A person who is not able to make "well-

reasoned, willful and knowing decisions about his/her mental health or medical treatment” is incompetent to consent to admission and to treatment – the second box is checked. However, a person may be competent to consent or refuse consent to treatment, but be refusing admission – the third box is checked. A person refusing to stay may be competent or incompetent to consent to treatment; that is a clinical decision by the physician.

However, if a petition for involuntary placement is pending with the court and a guardian advocate has been requested, you can treat the person with the interim consent of a health care surrogate or proxy if one exists. (see chapter 65E-5.2301, FAC governing Health Care Surrogate or Proxy).

If a continuance of the person’s involuntary placement hearing occurs beyond the five days permitted by law, you may want to ask the court to rule on the person’s incompetence to consent and to appoint a guardian advocate even before the issue of “placement” is heard.

The only other method of rendering treatment without the express and informed consent of an adult patient is when you’ve documented imminent danger, in which case, an emergency treatment order can be issued by a physician.

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

If the patient had been certified by a physician while on voluntary status as competent to make well reasoned, willful and knowing medical and mental health decisions (required within 24 hours of all voluntary admissions) and was provided all disclosures about medications required by law and rule, that authority would only be valid while the patient remained competent - not valid after a subsequent determination that the patient was no longer competent to consent.

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

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

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

Q. I'm a therapist at hospital based receiving facility. After a patient has been found incompetent by the MD, when can the staff give the medication? Is it after the proxy contents to the meds or does the 2nd option have to be done with the proxy consent then medication?

No medication can be administered without express and informed consent by a competent adult or, if incompetent to consent, by a legally authorized substitute decision-maker, short of documented imminent danger in which case a physician can do an ETO.

As soon as a physician documents that a patient can't give well-reasoned, willful and knowing decision making (the legal definition for incompetence), a health care proxy can be designated from among family members or close friends (in the order of listing found in the law). Once a proxy has been designated and the physician has spoken in person with the proxy (if not possible to do in person, conversation can be by phone. The proxy must be offered the GA training, but doesn't have to complete it before providing consent. However, there must be the same full disclosure provided to the proxy of all medications as would have been given to the patient (elements of required disclosure prescribed in statute and rule). Then authorization for treatment can be accepted and treatment administered.

This can all happen immediately if the physician has documented the patient's lack of capacity and has spoken with the proxy. If this occurs at a time when the physician isn't immediately present, it may take longer. In any case, there is no need to wait until the first or second opinion on the BA-32 is completed. If a substitute decision maker is to provide the authorization, the petition for involuntary placement and appointment of a guardian advocate must be filed with the court within two court working days after the physician determined the patient's incompetence to consent.

Q. Regarding Certification of competency, I know the physician should document whether patient is competent to give informed consent for voluntary admission and treatment within 24 hours on all voluntary or involuntary patients. Some of our physicians fail to document this information for fear the patients may signed their Right to Release if they are deemed competent, and will wait until the 72 hours are near to expire to indicate the patient is competent at which time the patient has been receiving medications. Aren't we in violation of the patient's rights?

You are correct that unless the physician has documented the patient is competent to consent to treatment, treatment should not be rendered except when the physician has documented the nature and extent of dangerousness and issued an ETO.

If an individual on voluntary status requests discharge, the physician is obligated to document that request as follows:

394.4625 Voluntary admissions.--

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

The box at the bottom of form 3104 indicates that the form should be used each time

- A person is admitted on a voluntary basis
- Permitted to provide consent to treatment
- Allowed to transfer from involuntary to voluntary status
- Prior to permitting a person to consent after having been previously found incompetent to consent.

If a person is competent to consent to treatment, he or she is competent to consent or refuse consent to admission and to treatment. A person may be competent to make those decisions but still be refusing to stay at the facility for the involuntary examination which can take up to 72 hours. This is a maximum period; not a minimum. The person should be released or transferred to voluntary status as soon as it is determined not to meet involuntary placement criteria.

Incompetence to Consent

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

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

Q. I have a question about the Baker Act Process with a patient that is not a citizen of the U.S and in our care. The patient is psychotic and in need of medications for stabilization. He is refusing medications. Do we follow the same process of 1st and 2nd Opinion, obtain a Proxy and Court or does INS act as the decision maker / Court?

Any person who is present in the state of Florida is subject to the Baker Act. Such persons, if they meet the criteria for involuntary examination, can be taken into custody and legally examined under the law. If they are found to meet the criteria for involuntary placement, a petition can be filed to further detain the person for treatment.

This isn't unusual in that Florida has many people visiting from other countries, both legally and illegally.

Regarding medications, if the person has been certified by a physician as able to make well-reasoned, willful and knowing decisions about his/her treatment, the patient can consent or refuse consent to treatment. If not competent and without a duly executed advance directive, a relative or close personal friend can be designated as a health care proxy until a guardian advocate is appointed by the court. Otherwise, an emergency treatment order can be used in cases where the physician has documented imminent danger.

If the person is a foreign national with citizenship in another country (even if with dual citizenship in the US), you need to remember your obligations for Consular Notification and Access.

Q. We have a 70 yr old woman on voluntary status at our CSU. She was brought here under involuntary status after 2 attempts at suicide and at end of 72 hrs she was transferred to voluntary. Our MDs say she is competent under Baker Act definitions. In the meantime family members filled for guardianship and the court appointed an attorney for her who met with her yesterday. Yesterday the court declared her to meet the criteria for emergency guardianship and appointed a professional guardian. It is my understanding that the Baker Act will not allow us to admit - or to retain - a person whose had been adjudicated as incapacitated. Our choices are to discharge or file for involuntary placement. In this case, the attending MD has evidence to file, and we will do that if that is our only option for safety reasons. HOWEVER, clinically, this lady is making more progress than she has in other times, and part of the is because she made the decision to be here voluntarily. Do we have any choices or are there any judicial remedies that would allow us to maintain this client as voluntary? Anything that we can recommend to the attorneys?

The following provision of law governs the issue you raise:

394.4625 Voluntary admissions.--

(1) AUTHORITY TO RECEIVE PATIENTS.--

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

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

You indicate in your inquiry below that the court found the woman to meet the criteria for a Temporary Emergency Guardianship and appointed a professional guardian. If this resulted from a judicial finding of incapacity, you have no choice but to discharge or convert to involuntary status. It will be important to see the order to ensure that it is either a plenary guardianship or if a limited guardianship, it has removed the right of the patient to consent to medical or mental health treatment. If it is an order for limited guardianship related to property only, this might have a different result.

Even the right to express and informed consent require that a person be competent to provide authorization for treatment.

65E-5.170 Right to Express and Informed Consent.

(1) Establishment of Consent.

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

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

(g) If a person entering a designated receiving or treatment facility has been adjudicated incapacitated under Chapter 744, F.S., as described in Section 394.455(14), F.S., express and informed consent to treatment shall be sought from the person's guardian.

While chapter 744, FS that governs guardianship has a special provision allowing the court to provide extraordinary authority to a guardian to have a ward admitted / treated as a voluntary patient, the more recent, specific, and contrary provisions of the Baker Act prevail. The 1st DCA also ruled that when the rights of the guardian under chapter 744 conflict with the rights of the ward under chapter 394, the Baker Act prevails (Handley v. Dennis). This may also include a right to the elevated protections of the involuntary provisions.

Q. One of the Chief's here at the Sheriff's Office asked me if a judge may order a psychiatrist (who is under contract with the jail) to medicate an inmate, based upon the observations of Detention staff, or the Master's Level Forensic Specialist (a MSW, but not LCSW), if the inmate is refusing to take medications?

Most judges believe they have no authority to order an inmate to receive psychotropic medications. If the inmate charged with a felony is too ill to be willing or able to consent to treatment, a petition for "incompetent to proceed" under chapter 916 if filed and the inmate eventually gets the needed treatment after transfer to DCF custody. A physician can generally order and ETO administration on a single dose basis for dangerousness

based solely on his/her medical license – no court order is usually entered. However, if an inmate is simply refusing medications and no imminent danger exists from that refusal, I would think there is no basis for forcing medications on the inmate – people have the right to refuse medical (including psychiatric) treatment in such situations.

Physicians often order emergency medications for patients in Baker Act receiving facilities based solely on the observation of registered nurses. I would think relying on the observations of personnel other than nurses might expose the physician to substantial civil and administrative liability. Even then the Florida Administrative Code limits. I've enclosed the Code related to emergency treatment orders below – they only apply in Baker Act receiving facilities – not jails. However, they might give you some idea of what is acceptable in treatment settings. Please note section (9) below that states “ To assure the safety and rights of the person, and since emergency treatment orders by a physician absent express and informed consent are permitted only in an emergency, any use of psychotropic medications other than rapid response psychotropic medications requires a detailed and complete justification for the use of such medication. Both the nature and extent of the imminent emergency and any orders for the continuation of that medication must be clearly documented daily as required above”

65E-5.1703 Emergency Treatment Orders.

(1) An emergency treatment order shall be consistent with the least restrictive treatment interventions, including the emergency administration of psychotropic medications or the emergency use of restraints or seclusion.

(a) The issuance of an emergency treatment order requires a physician's review of the person's condition for causal medical factors, such as insufficiency of psychotropic medication blood levels, as determined by drawing a blood sample; medication interactions with psychotropic or other medications; side effects or adverse reactions to medications; organic, disease or medication based metabolic imbalances or toxicity; or other biologically based or influenced symptoms.

(b) All emergency treatment orders may only be written by a physician licensed under the authority of Chapter 458 or 459, F.S.

(c) The physician must review, integrate and address such metabolic imbalances in the issuance of an emergency treatment order. The use of an emergency treatment order, consistent with the least restrictive treatment requirements, for persons must include:

1. Absent more appropriate interventions, an emergency treatment order for immediate administration of rapid response psychotropic medications to a person to expeditiously treat symptoms, that if left untreated, present an immediate danger to the safety of the person or others.

2. Absent more appropriate medical interventions, an emergency treatment order for restraint or seclusion of a person to expeditiously treat symptoms that if left untreated, present an imminent danger to the safety of the person or others.

(d) An emergency treatment order, as used in this chapter, excludes the implementation of individualized behavior management programs as described and authorized in Rule 65E-5.1602, F.A.C., of this rule chapter.

(2) An emergency treatment order for psychotropic medication supersedes the person's right to refuse psychotropic medication if based upon the physician's assessment that the individual is not capable of exercising voluntary control over his or her own symptomatic behavior and that these uncontrolled symptoms and behavior are an imminent danger to the person or to others in the facility. When

emergency treatment with psychotropic medication is ordered for a minor or an incapacitated or incompetent adult, facility staff shall document attempts to promptly contact the guardian, guardian advocate, or health care surrogate or proxy to obtain express and informed consent for the treatment in advance of administration where possible and if not possible, as soon thereafter as practical.

(3) The physician's initial order for emergency treatment may be by telephone but such a verbal order must be reduced to writing upon receipt and signed by a physician within 24 hours.

(4) Each emergency treatment order shall only be valid and shall be authority for emergency treatment only for a period not to exceed 24 hours.

(5) The need for each emergency treatment order must be documented in the person's clinical record in the progress notes and in the section used for physician's orders and must describe the specific behavior which constitutes a danger to the person or to others in the facility, and the nature and extent of the danger posed.

(6) Upon the initiation of an emergency treatment order the facility shall, within two court working days, petition the court for the appointment of a guardian advocate pursuant to the provisions of Section 394.4598, F.S., to provide express and informed consent, unless the person voluntarily withdraws a revocation of consent or requires only a single emergency treatment order for emergency treatment.

(7) If a second emergency treatment order is issued for the same person within any 7 day period, the petition for the appointment of a guardian advocate pursuant to the provisions of Section 394.4598, F.S., to provide express and informed consent shall be filed with the court within 1 court working day.

(8) While awaiting court action, treatment may be continued without the consent of the person, but only upon the daily written emergency treatment order of a physician who has determined that the person's behavior each day during the wait for court action continues to present an immediate danger to the safety of the person or others and who documents the nature and extent of the emergency each day of the specific danger posed. Such orders may not be written in advance of the demonstrated need for same.

(9) To assure the safety and rights of the person, and since emergency treatment orders by a physician absent express and informed consent are permitted only in an emergency, any use of psychotropic medications other than rapid response psychotropic medications requires a detailed and complete justification for the use of such medication. Both the nature and extent of the imminent emergency and any orders for the continuation of that medication must be clearly documented daily as required above.

A legislative bill has been filed a couple of times in the last decade to address just this issue, but it never seems to get any momentum. It is a great bill that still provides for the inmate's attorney to be notified and to intervene if necessary. Jails could partially address this problem within existing law by requesting a relative or close friend of the inmate to serve as a health care proxy to provide express and informed consent for needed treatment (that the inmate would have consented to if he/she were competent to do so) once a physician determined the inmate lacked capacity/competence to consent. There should be no reason why it wouldn't work for those that had a relative or close friend.

Q. Once a patient has a petition for involuntary placement filed (BA-32), but before having the hearing, do medication orders remain Emergency Treatment Orders or do they become regular CMTs and PRNs once the petition is filed?

Emergency treatment orders cannot be done either before or following the filing of the BA-32 unless the record documents imminent danger and that there are no less restrictive interventions. Only after the appointment of a Guardian Advocate can such medications needed for the person's treatment be authorized/administered if the person is found by the court to be incompetent to consent. Prior to that time, short of imminent danger, only a health care surrogate/proxy can authorize medications for which the person either refuses or lacks capacity to consent.

Q. I have a question regarding the 1st and 2nd opinion. Is it necessary for the 1st and 2nd opinion to be done prior to a proxy consenting for treatment for a person who is determined to be incompetent to consent to treatment.

No. A proxy can begin providing consent as soon as a physician determines and documents that the person is incompetent to consent to treatment. The completion of the first and second opinions on the petition for involuntary placement may take place after the designation of and decision-making by the proxy, but the petition must be completed and filed with the court within two working days of the physician's determination.

65E-5.2301 Health Care Surrogate or Proxy.

(1) During the interim period between the time a person is determined to be incompetent to consent to treatment by one or more physicians, pursuant to Section 765.204, F.S., and the time a guardian advocate is appointed by a court to provide express and informed consent to the person's treatment, a health care surrogate designated by the person, pursuant to Chapter 765, Part II, F.S., may provide such consent to treatment.

(2) In the absence of an advance directive or when the health care surrogate named in the advance directive is no longer able or willing to serve, a health care proxy, pursuant to Chapter 765, Part IV, F.S., may also provide interim consent to treatment.

(3) Upon the documented determination that a patient is incompetent to make health care decisions for himself or herself by one or more physicians, pursuant to Section 765.204, F.S., the facility shall notify the surrogate or proxy in writing that the conditions under which he or she can exercise his or her authority under the law have occurred. Recommended form CF-MH 3122, Feb. 05, "Certification of Person's Incompetence to Consent to Treatment and Notification of Health Care Surrogate/Proxy," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

(4) If the surrogate selected by the person is not available or is unable to serve or if no advance directive had been prepared by the person, a proxy may be designated as provided by law. Recommended form CF-MH 3123, Feb. 05, "Affidavit of Proxy," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.

(5) A petition for adjudication of incompetence to consent to treatment and appointment of a guardian advocate shall be filed with the court within 2 court working days of the determination of the patient's incompetence to consent to treatment by one or more physicians, pursuant to Section 765.204, F.S.

Recommended form CF-MH 3106, "Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate," as referenced in subparagraph 65E-5.170(1)(d)2., F.A.C., may be used for this purpose.

(6) The facility shall immediately provide to the health care surrogate or proxy the same information required by statute to be provided to the guardian advocate. In order to protect the safety of the person, the facility shall make available to the health care surrogate or proxy the training required of guardian advocates and ensure that the surrogate or proxy communicate with the person and person's physician prior to giving express and informed consent to treatment.

(7) Each designated receiving and treatment facility shall adopt policies and procedures specifying how its direct care and assessment staff will be trained on how to honor each person's treatment preferences as detailed in his or her advance directives. The person being served shall be provided information about advance directives and offered assistance in completing an advance directive, if willing and able to do so.

Q. If a person is determined by a psychiatrist NOT to have capacity to consent, it is my understanding they can't be given any psychotropic medications unless under an ETO if they have no one to serve as Health Care Proxy until after a court appointed Guardian Advocate has been selected. Correct?

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

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

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

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

The "Certification of Person's Competency to Provide Express and Informed Consent" form #3104 offers three mutually exclusive options to the physician. They are:

1. Competent to provide express and informed consent, as defined above, for voluntary admission to this facility and is competent to provide express and informed consent for treatment. He/she has the consistent capacity to make well reasoned, willful, and knowing decisions concerning his or her medical or mental health treatment. The person fully and consistently understands the purpose of the admission for examination/placement and is fully capable of personally exercising all rights assured under section 394.459, F.S.
2. Incompetent to provide express and informed consent to voluntary admission. And thus is incompetent to provide express and informed consent to treatment. The person must be transferred to involuntary status and a petition for a guardian advocate filed with the Circuit Court.
3. Refusing to provide express and informed consent to voluntary admission but is competent to provide express and informed consent for treatment. The person must be discharged or transferred to involuntary status.

If a person is incompetent to consent to treatment, he/she must be placed on involuntary status (option 2 above). If a person is competent to consent but refuses treatment and refuses to stay on a voluntary basis, he or she must be on involuntary status but no guardian advocate would be requested. (option 3 above).

Physicians and staff need to understand that no person should be allowed to consent to treatment unless they would also be allowed to refuse treatment. It is the capacity of the person to make the decisions -- not the quality of the decisions the person makes.

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

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

Q. If the Professional's Certificate initiating Involuntary Examination reflects that the person is unable to determine for himself/herself whether exam is necessary" checked off rather than "refusing" the examination, should the person then be signing any of the other legal consents/ paperwork or should that wait until the MD has evaluated and deemed the person competent? If those papers are not signed, what reason should be documented?

You have to presume the person is incompetent to consent to the admission and to treatment when that box is checked. If the box for “refused examination” had been checked instead, you might be able to presume otherwise if the person presents with the consistent ability to make well-reasoned decisions.

Therefore, in this situation, no form implying consent should be signed by the person until after a physician documents he/she is able to make well-reasoned, willful, and knowing decisions. The medical record should consistently reflect this ability – not just a form saying so.

In the meantime, an adult can get psychiatric medications only under an ETO or if the ED physician had determined the person lacked capacity to make his/her own decisions and a health care surrogate/proxy was available to provide consent. Of course a court appointed guardian or parent/legal guardian of a minor can provide consent to treatment.

You may not need a reason stated on why these other forms aren’t signed since the record would document that the person lacked capacity (“unable to determine”) on the initiation form. However, if you want, you could always write on/stamp the forms that the person was “incompetent to consent” just like you probably do if the person refuses consent. Then, as the person’s condition improves, the forms can be presented to the person again to be signed with the current date.

Q. A patient came into our ED and was placed on a Baker Act by the ED physician. The psychiatrist overturned the Baker Act and the patient was released. She came in again under a BA52 and was admitted to the psychiatric unit. The psychiatrist rescinded and released the patient the following morning. The family then got an ex parte order and the patient is being reviewed by a different psychiatrist. The new psychiatrist feels the person does not have capacity to make decisions for her own care. We obtained a next of kin proxy. The Doctor ordered PO meds to begin stabilization, but the patient is refusing. Her 72 hours have expired and we have petitioned the court to continue her stay due to her illness -- a court date is set. Can the patient be given the medication via IM injection even though she is refusing to take the meds even though the proxy gave permission to treat? The patient’s symptoms are increasing, but no ETO has been written at the moment. Would medication treatment fall under this with an ex parte and/or the proxy?

A person who is deemed competent to consent to admission and treatment is also competent to refuse. However, a person determined by a physician to lack competence to consent (unable to make well-reasoned, willful, and knowing medical and mental health decisions) is incompetent to refuse.

Therefore, once documentation of this incompetence is made and a relative or close personal friend is appointed by the facility as the patient’s health care proxy, that proxy can make any and all health care decisions he/she believes the patient would have made if competent, even though the patient might be currently refusing the treatment. This must be based on full and prior disclosure of all information required by the Baker Act law and rule and the proxy must have spoken with the physician and the patient in person if possible, by phone if not, prior to providing the authorization for treatment.

In short, yes, the proxy can consent to the IM medications as you describe. The proxy will likely be appointed as the patient's guardian advocate and will be able to continue to provide such consent until the patient regains sufficient competence to make his/her own decisions.

Q. An individual is brought to a receiving facility and the facility offers the person an opportunity to consent to treatment. If the person refuses, this is documented in the clinical record. Then the facility immediately determines that the individual is not competent to consent to treatment, and seeks appointment of a guardian advocate. Has the facility acted inappropriately?

Signing a form is just an action -- it isn't reflective of the capacity of the person to make well-reasoned, willful and knowing medical and mental health decisions - the definition of express and informed consent. A man in Florida was just such a case -- he was very willing to sign an application for voluntary admission and an authorization for treatment because he thought he was in Heaven. The U.S. Supreme Court felt otherwise --that his due process rights had been violated by allowing him to be voluntary which evaded all the protective mechanisms. There are people who will sign anything, go anywhere, and do anything you ask, but they aren't necessarily capable of providing express and informed consent. This isn't "implied consent" or even "informed consent", both of which require lower levels of competence. It is the highest level of consent.

A person has the right to consent and the right to refuse consent -- both if competent to do so. Allowing a person to sign an authorization for treatment when the clinical record reflects from the patient's own words and actions a lack of competence means that no consent exists. To refuse to accept a denial of consent is a violation of the person's rights. To consider a person as "incompetent to consent" simply because he/she refuses consent is unacceptable. There should be a detailed description in the clinical record as to how a person's mental state had deteriorated between the time of certifying competence to consent and a petition for involuntary placement & appointment of a GA. Simple refusal is insufficient.

This is the most widespread problem throughout the state -- doctors routinely chart "let him go voluntarily" in order to avoid the paper work of an involuntary and the uncompensated time to attend a hearing. This is in the middle of notes describing a person who is psychotic, delusional, hallucinating, with poor insight and judgment.

Assuming that the circumstance that you're questioning is for a transfer from involuntary to voluntary status, the law and rule governing this is as follows:

65E-5.170 Right to Express and Informed Consent.

(1) Establishment of Consent.

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

Q. If an incompetent adult MH patient that has been deemed incompetent by the courts and is hospitalized involuntarily, can the guardian sign for meds and patient start meds before obtaining 1st psychiatric opinion or do we have to wait to have the 1st opinion?

A plenary guardian or guardian of person can begin signing consent for treatment as soon as he/she is provided all disclosures required by law and rule. There is no need to wait until the first opinion is signed by the psychiatrist. Just be sure you have the court order and letters of guardianship to ensure the guardian indeed has the authority to provide the consent.

Disclosure

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

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

- Reason for admission or treatment
- Proposed treatment
- Purpose of the treatment to be provided
- Identification of the proposed psychotropic medication
- Common risks, benefits, and short and long-term side effects thereof
- Specific dosage range for the medication
- Frequency and method of administration
- Any contraindications which may exist
- Clinically significant interactive effects with other medications
- Similar information on alternative medications which may have less severe or serious side effects
- Alternative treatment modalities
- Potential effects of stopping treatment
- Approximate length of care
- How treatment will be monitored; and
- That any consent given for treatment may be revoked orally or in writing before or during the treatment period

Q. Our hospital has been approached by a state university (with an IRB) to accept some patients who will be involved in experimental drug trials. We think increased research may lead to better treatment of serious mental illnesses. Is this permissible?

The only reference in the Baker Act to this issue is for the extraordinary authority granted to guardian advocates in agreeing to such treatment. The Baker Act only requires court approval if the experimental treatment isn't overseen by an IRB, as follows:

394.4598 Guardian advocate.--

(6) If a guardian with the authority to consent to medical treatment has not already been appointed or if the patient has not already designated a health care surrogate, the court may authorize the guardian advocate to consent to medical treatment, as well as mental health treatment. Unless otherwise limited by the court, a guardian advocate with authority to consent to medical treatment shall have the same authority to make health care decisions and be subject to the same restrictions as a proxy appointed under part IV of chapter 765. Unless the guardian advocate has sought and received express court approval in proceeding separate from the proceeding to determine the competence of the patient to consent to medical treatment, the guardian advocate may not consent to:

- (a) Abortion.
- (b) Sterilization.
- (c) Electroconvulsive treatment.
- (d) Psychosurgery.
- (e) Experimental treatments that have **not been approved by a federally approved institutional review board in accordance with 45 C.F.R. part 46 or 21 C.F.R. part 56.** The court must base its decision on evidence that the treatment or procedure is essential to the care of the patient and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects. The court shall follow the procedures set forth in subsection (1) of this section.

The only other issue is the statutory requirement for express and informed consent. The Baker Act law and rule requires a substantial range of information be disclosed to the individual or his/her legally authorized decision-maker prior to seeking consent, such as:

- The reason for admission or treatment,
- Proposed treatment, including psychotherapeutic medications
- Purpose of treatment
- Alternative treatments
- Specific dosage range for medications
- Frequency and method of administration
- Common risks, benefits and short-term/long-term side effects
- Contraindications
- Clinically significant interactive effects with other medications,
- Similar information on alternative medication which may have less severe or serious side effects.
- Potential effects of stopping treatment
- Approximate length of care
- How treatment will be monitored, and that
- Any consent for treatment may be revoked orally or in writing before or during the treatment period by the person legally authorized to make health care decisions for the person.

In such research, the participating individuals may be given the experimental medications, while others get a placebo or other traditional medication. The double-blind nature of the research prevents the individual from knowing which alternative they may be taking. The decision-maker would have to be provided the full disclosure on each of the alternatives and give consent to each.

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

YES. Prior to the administration of treatment, a qualified staff person must provide information about the reason for admission, the proposed treatment, the purpose of the treatment to be provided, the common side effects, alternative treatments, the approximate length of care, and that any consent given may be revoked. Specifically with regard to medication disclosure, such qualified staff member must, in plain understandable language, identify the proposed medication, the proposed dosage range, the frequency and method of administration, recognized short-term and long-term side effects, any contraindications which may exist, clinically significant interactive effects with other medications, and similar information on alternative medications which may have less severe or serious side effects.

Q. The Psychotropic Med form is specific for Psychotropic medications such as Haldol, Seroquel and Zyprexa for example. Other nurses who have been in the field a while state that we should be putting ALL medications that are specific to psychiatric care on it as well. This would mean adding Ativan, Celexa, Prozac and the like to the list of medications we are asking the patient to agree to. Can you clarify this for us please? I have been addressing the psychotropics. The ones that say we need to include all say that they have heard of court cases where the case was lost because antidepressants and anti-anxiety meds were not listed on this form. Are we also suppose to list all the meds ordered for them, what they are and what their purpose is and have them sign that as well?

The Baker Act statute and rules require that the following disclosure be provided in order that **Express & Informed Consent** is obtained [394.459(3), FS and 65E-5.170, FAC]

Prior to requesting consent to treatment, the following must be provided and explained in plain language:

- The reason for admission or treatment,
- Proposed treatment, including psychotherapeutic medications
- Purpose of treatment
- Alternative treatments
- Specific dosage range for medications
- Frequency and method of administration
- Common risks, benefits and short-term/long-term side effects
- Contraindications
- Clinically significant interactive effects with other medications,
- Similar information on alternative medication which may have less severe or serious side effects.
- Potential effects of stopping treatment
- Approximate length of care
- How treatment will be monitored, and that
- Any consent for treatment may be revoked orally or in writing before or during the treatment period by the person legally authorized to make health care decisions for the person.

DCF has made a distinction between treatment that entails use of any psychotropic medication and treatment that does not. It makes no distinction between the various forms of psychotropic meds. If the order is for a medication used to treat a diagnosed psychiatric condition, it should be incorporated in any authorization for treatment so you have indeed documented the authorized decision-maker's express and informed consent prior to administering the treatment.

Consent should only be sought from an adult that has been certified by a physician as being able to make well-reasoned, willful, and knowing decisions about their mental health and medical conditions. This is the statutory definition of competence.

Q. If the inpatient staff provides education to patient at each point in medication changes, and documents in the MAR, does this meet the spirit as well as the letter of the Baker Act?

With regard to disclosure requirements for express and informed consent, neither the law nor rules prescribe the form that disclosure must be in. It simply must be clearly documented in the clinical record and include each required element of disclosure. If the required disclosure is reflected in the MAR, that would meet the requirements of the law/rules. There is no recommended form for this purpose

Consent to Treatment

Q. When we admit an adult patient voluntarily to our psychiatric unit we have them sign the 3040 and the 3042a. We don't have them sign the 3042b. At the present time we are waiting until the psychiatrist evaluates the patient to determine competency to consent to psychotropic medications. It seems to me that if we are making the decision that they are competent to sign into the facility voluntarily then we should be able to have them consent for medications as well as psychotropic medications. I have looked at the statute but I am having difficulty finding a clear answer on this. Is there anything that states who can make this determination of competency and does it specify what decision can be made? Does this require an evaluation by a psychiatrist to determine competency to authorize psychotropic medications? Can this be completed by a licensed person such as an LCSW, LMHC, RN?

The Baker Act permits a competent adult to apply for voluntary admission, as follows:

394.4625, FS Voluntary admissions.--

(1) AUTHORITY TO RECEIVE PATIENTS.--

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

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

65E-5.170, FAC Right to Express and Informed Consent.

(1) Establishment of Consent.

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

65E-5.170, FAC Right to Express and Informed Consent.

(1) Establishment of Consent.

(c) If the admission is voluntary, the person's **competence to provide express and informed consent for admission shall be documented by the admitting physician.** Recommended form CF-MH 3104, Feb. 05, "Certification of Person's Competence to Provide Express and Informed Consent," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. The completed form or other documentation shall be retained in the person's clinical record. Facility staff monitoring the person's condition shall document any observations which suggest that a person may no longer be competent to provide express and informed consent to his or her treatment. In such circumstances, staff shall notify the physician and document in the person's clinical record that the physician was notified of this apparent change in clinical condition.

As you can see above, only the admitting physician is authorized to determine and document a person's competence to provide express and informed consent to treatment. The statutory definition of "express and informed consent" requires that a person be competent. The definition of "incompetent to consent to treatment" requires the physician to certify that the person has the capacity to make well-reasoned, willful, and knowing treatment decisions. One would presume that this capacity is sustained on an on-going basis and that staff hasn't noted any incidents where the person's statements or behaviors would indicate otherwise.

394.455 Definitions

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

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

Finally, with regard to your question about the difference between a general consent and specific consent for psychotropic medications, the Baker Act statute and the Florida Administrative Code below prescribes that any consent for medications be obtained only after full disclosure is provided to the competent adult patient.

65E-5.170, FAC Right to Express and Informed Consent.

(2) Authorization for Treatment.

(a) **Express and informed consent, including the right to ask questions about the proposed treatment, to receive complete and accurate answers to those questions, and to negotiate treatment options, shall be obtained from a person who is competent to consent to treatment.** If the person is

incompetent to consent to treatment, such express and informed consent shall be obtained from the duly authorized substitute decision-maker for the person before any treatment is rendered, except where emergency treatment is ordered by a physician for the safety of the person or others. Chapter 394, Part I, F.S., and this rule chapter govern mental health treatment. Medical treatment for persons served in receiving and treatment facilities and by other service providers are governed by other statutes and rules.

(b) A copy of information disclosed while attempting to obtain express and informed consent shall be given to the person and to any substitute decision-maker authorized to act on behalf of the person.

(c) When presented with an event or an alternative which requires express and informed consent, a competent person or, if the person is incompetent to consent to treatment, the duly authorized substitute decision-maker shall provide consent to treatment, refuse consent to treatment, negotiate treatment alternatives, or revoke consent to treatment. Recommended forms CF-MH 3042a, Feb. 05, "General Authorization for Treatment Except Psychotropic Medications," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, and CF-MH 3042b, Feb. 05, "Specific Authorization for Psychotropic Medications," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used as documentation of express and informed consent and any decisions made pursuant to that consent. If used, recommended form CF-MH 3042a, "**General Authorization for Treatment Except Psychotropic Medications,**" as **referenced in paragraph 65E-5.170(2)(c), F.A.C., shall be completed at the time of admission** to permit routine medical care, psychiatric assessment, and other assessment and treatment except psychotropic medications. **The more specific recommended form CF-MH 3042b, "Specific Authorization for**

Psychotropic Medications,” as referenced in paragraph 65E-5.170(2)(c), F.A.C., or its equivalent, **shall be completed prior to the administration of any psychotropic medications,** except under an emergency treatment order. The completed forms, or equivalent documentation, shall be retained in the person’s clinical record.

(d) No facility or service provider shall initiate any mental health treatment, including psychotropic medication, until express and informed consent for psychiatric treatment is sought from a person legally qualified to give it, except in instances where emergency treatment is ordered by a physician to preserve the immediate safety of the person or others.

394.459 Rights of patients.--

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

(a)2. **Before giving express and informed consent, the following information shall be provided and explained** in plain language to the patient, or to the patient’s guardian if the patient is 18 years of age or older and has been adjudicated incapacitated, or to the patient’s guardian advocate if the patient has been found to be incompetent to consent to treatment, or to both the patient and the guardian if the patient is a minor: the reason for admission or treatment; the proposed treatment; the purpose of the treatment to be provided; the common risks, benefits, and side effects thereof; the specific dosage range for the medication, when applicable; alternative treatment modalities; the approximate length of care; the potential effects of stopping treatment; how treatment will be monitored; and that any consent given for treatment may be revoked orally or in writing before or during the treatment period by the patient or by a person who is legally authorized to make health care decisions on behalf of the patient.

65E-5.170, FAC Right to Express and Informed Consent.

(4) **In addition to any other requirements, at least the following must be given to the person before express and informed consent will be valid:**

(a) Identification of the proposed psychotropic medication, together with a plain language explanation of the proposed dosage range, the frequency and method of administration, the recognized short-term and long-term side effects, any contraindications which may exist, clinically significant interactive effects with other medications, and similar information on alternative medications which may have less severe or serious side effects.

(b) A plain language explanation of all other treatments or treatment alternatives recommended for the person.

If the person conducting the admission is a clinically trained medical or nursing professional with expertise in all aspects of the required disclosure required to meet the conditions for “express and informed consent” above, both forms could be signed at the same time. However, it is unlikely that most facilities’ policies and procedure authorize their non-medical staff to make diagnoses and provide / explain all the above required elements of express and informed consent.

Q. When a person presents on involuntary status, must he/she be seen by a psychiatrist PRIOR to being given consents to sign (within 24 hours), or are the consents offered if the person appears to be of sound mind/judgment, etc., prior to seeing the psychiatrist?

If the involuntary examination initiation form indicates that the person is "unable" to determine that the examination is needed, instead of "refused", staff must presume that that the person isn't competent to consent until a physician (not necessarily a psychiatrist) certifies such competence to make well-reasoned, willful and knowing decision-making ability.

Q. Does a person brought to a receiving facility for involuntary examination have to provide consent for the assessment? What is included in the term "assessment" on the General Authorization for Treatment except Psychotropic Medications (Form 3042a)? Does examination and assessment have separate and distinct meanings as used in the Baker Act? Does assessment refer to nursing assessments or other assessments apart from mental health examination?

The involuntary examination itself doesn't require a person's consent, since by definition, the person is refusing or is unable to determine that the examination is necessary. It is performed to determine if the person meets the criteria for involuntary inpatient or involuntary outpatient placement -- if so, a petition is filed with the court. If not, the person is either released or is converted to voluntary status.

A person may require a variety of other assessments or routine medical care that is separate and apart from the involuntary examination performed by the physician or clinical psychologist. Assessment is defined in Chapter 65E-5.100(2), FAC to mean

"the systematic collection and integrated review of individual-specific data. It is the process by which individual-specific information such as examinations and evaluations are gathered, analyzed, monitored and documented to develop the person's individualized plan of treatment and to monitor progress toward recovery. Assessment specifically includes efforts to identify the person's key medical and psychological needs, competency to consent to treatment, patterns of co-occurring mental illness and substance abuse, as well as clinically significant neurological deficits, traumatic brain injury, physical disability, developmental disability, need for assistive devices, and physical or sexual abuse or trauma."

This general authorization form can be completed at the time of admission, without the more extensive disclosure that must be given by a qualified professional prior to obtaining consent for psychotropic medication.

Q. The Baker Act form CF-MH 3042b "Specific Authorization for Psychotropic Medication" has a section (bottom half of the page) that states:

"If I am the guardian advocate, health care surrogate, or health care proxy of the person, I certify that I have met and talked with the person and the person's physician in person, if at all possible, and by telephone, if not about the proposed treatment prior to signing this form"

Does this include parents in minors' cases? The question came out because sometimes the doctor may not be available to speak with the child's parents right

away when the child gets arrives and sometimes the conversation with the parent may take place the following day. In situations where the child was already taking psychotropics prescribed by an outpatient doctor, the parents are asking the receiving facility to continue with the medication even if the face to face/or phone conversation with the physician does not take place until the following day.

No. This requirement doesn't apply to guardians at all -- not for those appointed by the court for adults or for natural/adoptive parents of minors. The Baker Act law only requires this of guardian advocates and it extended the same requirements through rule to surrogates/proxies who are temporary decision-makers until a guardian advocate is appointed by the court. However, the minor's parents must provide express and informed consent (after receiving full disclosure) before any treatment can be provided, short of an emergency treatment order in cases of imminent danger.

Q. Can a guardian or guardian advocate give a verbal consent for medications over the phone or is a written authorization required before medications can be given?

Verbal authorization for medications, after a full disclosure about the medications as required under 65E-5.170(4)(a) and (b), FAC by a qualified person, is fairly routine practice throughout the state. However, such verbal authorization should be obtained by a nurse and witnessed by a second staff person. The treatment can then be administered, but the Guardian Advocate should be encouraged to come into the facility promptly to sign the form later.

Q. If a person has been ordered for involuntary inpatient placement but found to be competent to provide his own authorization for treatment, can a witnessed and documented verbal authorization suffice if the person doesn't want to sign any documents?

The court must have heard testimony about the person's competence to consent and found he/she was able to make well reasoned, willful and knowing decisions about his care. Otherwise the court would have appointed a guardian advocate to make such decisions and to sign authorizations for treatment.

If the chart reflects that the medical staff has provided a full disclosure of all required aspects of the medication ordered, answered his questions, there is no indication in the chart that his judgment is so impaired by his mental illness that he isn't making well-reasoned decisions, and he verbalizes knowledge about/satisfaction with the medications that have been ordered, a verbal authorization can be documented in the chart. An explanation of his reasons for refusing to sign an authorization form and the signature of two staff documenting this authorization should suffice.

One would probably question the real reason for the person's refusal to sign. If it is related to the mental illness, the facility may need to return to court to seek a Guardian Advocate. Further, if the person later states that he or she didn't understand the required disclosures made about the medications, signature of the witnesses wouldn't be of much help.

Initiation of Psychiatric Treatment

Q. We were having patients come in and admitted to our psychiatric unit signing consent for treatment prior to being seen by our psychiatrist. All patients are seen in our ED by a physician and there's a view that this counts as a determination of whether the patient is deemed competent to sign the consent forms. However we have now changed it to having all patients wait to be seen by the admitting psychiatrist to determine whether their competent to sign. This is done within 24hours of admission. Which is correct? The latter is presenting logistical issues as far as prescribing meds as they require emergency medication orders. However the former we felt was legally questionable. Please advise.

If a person is brought on a **voluntary** basis to your receiving facility and is consistently demonstrating not only a willingness to be at your facility but able to make well-reasoned, willful and knowing decisions about health and mental health treatment issues, treatment can start as soon as orders are received. The person would have to be examined by a physician within 24 hours of arrival for certification of competency (form 3104). The record should not reflect staff notes that suggest the person isn't making good judgment about these issues or lacking insight into his/her illness/treatment.

If a person is brought on an **involuntary** basis to your facility or the involuntary examination is initiated at St. Mary's, you must check the basis for initiating.

1. If the person is "**refusing**" the exam, he/she may still be able to articulate ability to be competent to consent to treatment if there is a consistently documented ability to make well-reasoned, willful, and knowing decisions.
2. If the person is "**unable to determine**" the examination is needed, you must presume the person is incompetent to consent until a physician documents the person's ability to provide express and informed consent.

No psychotropic medications can be provided to a patient without obtaining express and informed consent from a legally authorized person after full disclosure is made, except in cases where imminent danger has been documented. Any person allowed to consent to his/her own treatment (voluntary or involuntary status) must be certified as competent to do so within 24 hours of arrival.

If the person isn't competent to consent to his/her own treatment, a health care proxy (relative or close personal friend) may be available to provide such substitute judgment on an interim basis until a guardian advocate is appointed. This requires a physician to complete form 3122 or its equivalent documenting the incompetence and designating a proxy.

We agree that medically necessary treatment should be started at the earliest possible time, but it can't be done without consent from a competent person or legally authorized proxy except in cases of emergency.

Q. Regarding consent for psychotropic medication, is this a requirement that applies hospital-wide, or just to patients being admitted to a psychiatric unit? For example, does the staff need to get consent from a patient in the E.D. who is administered psychotropic meds?

The entire facility is designated as the receiving facility – not just the psychiatric unit. Wherever a person is held for psychiatric examination or treatment in the facility, all aspects of the Baker Act apply. The following can be found in chapter 395, Florida's hospital licensure statute:

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

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

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

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

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

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

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

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

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

Q. Can receiving facilities (CSU's and hospitals) use standing orders for new admissions? These are written orders to be followed by nursing staff based on their judgment for persons presented to the units, with no input by a physician. They include psychotropic medications from a pre-determined list as well as non-psychiatric medications and over-the-counter medications. Use of these PRN standing orders are to avoid calling a physician at night, although the physician may or may not be paid on-call fees.

The Baker Act requires a physical exam within 24 hours of arrival by an authorized health care practitioner, in addition to a nursing assessment required by rule. The CSU rules clearly prohibit standing orders for psychiatric medications. The Baker Act rules define an Emergency treatment order (ETO) to mean the written emergency order for psychotropic medications, seclusion, and restraints order by a physician in response to a person presenting an imminent danger to self or others, and as described in Rule 65E-5.1703, F.A.C., of this rule chapter. This must be based on a direct order of a physician and cannot be done on a PRN or standing order basis. Some other statutory and regulatory requirements are at the bottom of this message.

65E-5 Definitions

(11) PRN means an individualized order for the care of an individual person which is written after the person has been seen by the practitioner, which order sets parameters for attending staff to implement according to the circumstances set out in the order.

(15) Standing order means a broad protocol or delegation of medical authority that is generally applicable to a group of persons, hence not individualized. As limited by this chapter, it prohibits improper delegations of authority to staff that are not authorized by the facility, or not permitted by practice licensing laws, to independently make such medical decisions; such as decisions involving determination of need, medication, routes, dosages for psychotropic medication, or use of restraints or seclusion upon a person.

65E-5.170 Right to Express and Informed Consent.

(2) Authorization for Treatment.

(a) Express and informed consent, including the right to ask questions about the proposed treatment, to receive complete and accurate answers to those questions, and to negotiate treatment options, shall be obtained from a person who is competent to consent to treatment. If the person is incompetent to consent to treatment, such express and informed consent shall be obtained from the duly authorized substitute decision-maker for the person before any treatment is rendered, except where emergency treatment is ordered by a physician for the safety of the person or others.

(d) No facility or service provider shall initiate any mental health treatment, including psychotropic medication, until express and informed consent for psychiatric treatment is sought from a person legally qualified to give it, except in instances where emergency treatment is ordered by a physician to preserve the immediate safety of the person or others.

65E-12.106

(17)(c) Medication Orders. All orders for medications shall be issued by a Florida licensed physician.

(18)(a)3. The use of standing or routine orders for emergency treatment orders is prohibited.

(20) Nursing Services.

(a) Medical Prescription. Registered nurses shall ensure that each physician's or psychiatrist's orders are followed. When a determination is made that the orders have not been followed or were refused by the person being served pursuant to section 394.459(3), F.S., the physician or psychiatrist shall be notified within 24 hours. The registered nurse or nursing service shall substantiate this action through documentation in the individual's clinical record.

(b) Nursing Standards. Each CSU and SRT shall develop and maintain a standard manual of nursing services which shall address medications, treatments, diet, personal hygiene care and grooming, clean bed linens and environment, and protection from infection.

65E-12.107 Minimum Standards for Crisis Stabilization Units (CSUs).

In addition to sections 65E-12.104, 65E-12.105, and 65E-12.106, F.A.C., above, these standards apply to CSU programs.

(3) Medical Care.

(a) The development of medical care policies and procedures shall be the responsibility of the psychiatrist or physician. The policies and procedures for medical care shall include the procedures that may be initiated by a registered nurse in order to alleviate a life threatening situation. Medication or medical treatment shall be administered upon direct order from a physician or psychiatrist, and orders for medications and treatments shall be written and signed by the physician or psychiatrist.

(b) There shall be no standing orders for any medication used primarily for the treatment of mental illness.

(c) Every order given by telephone shall be received and recorded immediately only by a registered nurse with the physician's or psychiatrist's name, and signed by the physician or psychiatrist within 24 hours. Such telephone orders shall include a progress note that an order was made by telephone, the content of the order, justification, time and date.

Q. Does a patient with a legal guardian and history of psychiatric illness have to be seen face to face by a psychiatrist in the hospital before the initiation of psychotropic medications? Would a phone order be good enough? Can an ARNP do the evaluation?

No medications can be administered unless express and informed consent is first obtained from the person legally authorized to provide such consent (except in cases of imminent danger) and documented in the medical record. Your question refers to a guardian appointed by the court to make such decisions for the patient. This express and informed consent includes at a minimum:

- The reason for admission or treatment,
- Proposed treatment, including psychotherapeutic medications
- Purpose of treatment
- Alternative treatments
- Specific dosage range for medications
- Frequency and method of administration

- Common risks, benefits and short-term/long-term side effects
- Contraindications
- Clinically significant interactive effects with other medications,
- Similar information on alternative medication which may have less severe or serious side effects.
- Potential effects of stopping treatment
- Approximate length of care
- How treatment will be monitored, and that
- Any consent for treatment may be revoked orally or in writing before or during the treatment period by the person legally authorized to make health care decisions for the person

The Baker Act presumes that an examination occurs prior to medication administration, but it doesn't specifically require a physical examination until 24 hours after the patient's arrival. A physical examination can be performed by "a health practitioner authorized by law to give such examinations".

However, if the accepted standards for medical practice and the hospital's policies and procedures accept the prescribing and administering of psychotropic medications without prior examination and based solely on telephone orders, the Baker Act wouldn't specifically prohibit that practice. This is a question for the Department of Health/Medical Quality Assurance professionals to answer.

Q. When we admit an adult patient voluntarily to our psychiatric unit we have them sign the 3040 and the 3042a. We don't have them sign the 3042b. At the present time we are waiting until the psychiatrist evaluates the patient to determine competency to consent to psychotropic medications. It seems to me that if we are making the decision that they are competent to sign into the facility voluntarily then we should be able to have them consent for medications as well as psychotropic medications. I have looked at the statute but I am having difficulty finding a clear answer on this. Is there anything that states who can make this determination of competency and does it specify what decision can be made? Does this require an evaluation by a psychiatrist to determine competency to authorize psychotropic medications? Can this be completed by a licensed person such as an LCSW, LMHC, RN?

The Baker Act permits a competent adult to apply for voluntary admission, as follows:

394.4625, FS Voluntary admissions.--

(1) AUTHORITY TO RECEIVE PATIENTS.--

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

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

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

65E-5.170, FAC Right to Express and Informed Consent.

(1) Establishment of Consent.

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

65E-5.170, FAC Right to Express and Informed Consent.

(1) Establishment of Consent.

(c) If the admission is voluntary, the person's **competence to provide express and informed consent for admission shall be documented by the admitting physician.** Recommended form CF-MH 3104, Feb. 05, "Certification of Person's Competence to Provide Express and Informed Consent," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. The completed form or other documentation shall be retained in the person's clinical record. Facility staff monitoring the person's condition shall document any observations which suggest that a person may no longer be competent to provide express and informed consent to his or her treatment. In such circumstances, staff shall notify the physician and document in the person's clinical record that the physician was notified of this apparent change in clinical condition.

As you can see above, only the admitting physician is authorized to determine and document a person's competence to provide express and informed consent to treatment. The statutory definition of "express and informed consent" requires that a person be competent. The definition of "incompetent to consent to treatment" requires the physician to certify that the person has the capacity to make well-reasoned, willful, and knowing treatment decisions. One would presume that this capacity is sustained on an on-going basis and that staff hasn't noted any incidents where the person's statements or behaviors would indicate otherwise.

394.455 Definitions

(9) "**Express and informed consent**" means consent voluntarily given in writing, by a **competent** person, **after sufficient explanation and disclosure** of the subject matter involved to enable the person to make a knowing and willful

decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

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

Finally, with regard to your question about the difference between a general consent and specific consent for psychotropic medications, the Baker Act statute and the Florida Administrative Code below prescribes that any consent for medications be obtained only after full disclosure is provided to the competent adult patient.

65E-5.170, FAC Right to Express and Informed Consent.

(2) Authorization for Treatment.

(a) **Express and informed consent, including the right to ask questions about the proposed treatment, to receive complete and accurate answers to those questions, and to negotiate treatment options, shall be obtained from a person who is competent to consent to treatment.** If the person is

incompetent to consent to treatment, such express and informed consent shall be obtained from the duly authorized substitute decision-maker for the person before any treatment is rendered, except where emergency treatment is ordered by a physician for the safety of the person or others. Chapter 394, Part I, F.S., and this rule chapter govern mental health treatment. Medical treatment for persons served in receiving and treatment facilities and by other service providers are governed by other statutes and rules.

(b) A copy of information disclosed while attempting to obtain express and informed consent shall be given to the person and to any substitute decision-maker authorized to act on behalf of the person.

(c) When presented with an event or an alternative which requires express and informed consent, a competent person or, if the person is incompetent to consent to treatment, the duly authorized substitute decision-maker shall provide consent to treatment, refuse consent to treatment, negotiate treatment alternatives, or revoke consent to treatment. Recommended forms CF-MH 3042a, Feb. 05, "General Authorization for Treatment Except Psychotropic Medications," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, and CF-MH 3042b, Feb. 05, "Specific Authorization for Psychotropic Medications," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used as documentation of express and informed consent and any decisions made pursuant to that consent. If used, recommended form CF-MH 3042a, "**General Authorization for Treatment Except Psychotropic Medications,**" as **referenced in paragraph 65E-5.170(2)(c), F.A.C., shall be completed at the time of admission** to permit routine medical care, psychiatric assessment, and other assessment and treatment except psychotropic medications. **The more specific recommended form CF-MH 3042b, "Specific Authorization for Psychotropic Medications,**" as referenced in paragraph 65E-5.170(2)(c), F.A.C., or its equivalent, **shall be completed prior to the administration of any psychotropic medications,** except under an emergency treatment order. The completed forms, or equivalent documentation, shall be retained in the person's clinical record.

(d) No facility or service provider shall initiate any mental health treatment, including psychotropic medication, until express and informed consent for psychiatric treatment is sought from a person legally qualified to give it, except in instances where emergency treatment is ordered by a physician to preserve the immediate safety of the person or others.

394.459 Rights of patients.--

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

(a)2. **Before giving express and informed consent, the following information shall be provided and explained** in plain language to the patient, or to the patient's guardian if the patient is 18 years of age or older and has been adjudicated incapacitated, or to the patient's guardian advocate if the patient has been found to be incompetent to consent to treatment, or to both the patient and the guardian if the patient is a minor: the reason for admission or treatment; the proposed treatment; the purpose of the treatment to be provided; the common risks, benefits, and side effects thereof; the specific dosage range for the medication, when applicable; alternative treatment modalities; the approximate length of care; the potential effects of stopping treatment; how treatment will be monitored; and that any consent given for treatment may be revoked orally or in writing before or during the treatment period by the patient or by a person who is legally authorized to make health care decisions on behalf of the patient.

65E-5.170, FAC Right to Express and Informed Consent.

(4) **In addition to any other requirements, at least the following must be given to the person before express and informed consent will be valid:**

(a) Identification of the proposed psychotropic medication, together with a plain language explanation of the proposed dosage range, the frequency and method of administration, the recognized short-term and long-term side effects, any contraindications which may exist, clinically significant interactive effects with other medications, and similar information on alternative medications which may have less severe or serious side effects.

(b) A plain language explanation of all other treatments or treatment alternatives recommended for the person.

If the person conducting the admission is a clinically trained medical or nursing professional with expertise in all aspects of the required disclosure required to meet the conditions for "express and informed consent" above, both forms could be signed at the same time. However, it is unlikely that most facilities' policies and procedure authorize their non-medical staff to make diagnoses and provide / explain all the above required elements of express and informed consent.

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

No. There is no "implied consent" for psychotropic medications. Just because a person swallows the pills or has willingly taken the medications at a point prior to the hospitalization, the law prohibits the administration of medications unless "express and informed consent" has been obtained from the person or his/her substitute decision

maker. The only exception to this prohibition is when the physician has fully documented the nature and extent of the person's imminent dangerousness and has ordered emergency treatment -- this is limited to rapid response medications since it is for chemical restraints -- an issue controlled by federal regulations as well as state law/rules. Unless such an emergency exists, psychotropic medications cannot be administered unless the person or his/her substitute decision maker provides express and informed consent to the medications.

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

Q. If an involuntary placement petition was completed on the weekend and there is a proxy can we still medicate the patient before I file on the next business day.

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

Q. Can psychiatric treatment be initiated before informed consent is obtained?

NO. Unless the person is displaying uncontrolled symptoms and behaviors that are causing imminent danger, treatment cannot be initiated unless express and informed consent is first obtained from a competent adult or from a legally authorized substitute decision-maker.

At any time staff observes any reason why the person isn't making such well-reasoned decisions, treatment must stop except when the physician has documented imminent danger, in which case an emergency treatment order can be considered.

Q. Does a physician have to see a voluntary patient before ordering a PRN medication? If the person has been taking a certain medication and already knows about it or the physician talks to the person over the phone about the medication prior to seeing the person and it is clearly documented, would that suffice? Our physicians are concerned with any reference in the statutes and liability of ordering a PRN prior to seeing the person.

Use of PRN medications for non-psychiatric medications is quite common and is not addressed in the Baker Act. However, if the physician believes that it is safe to specifically order psychotropic medications based on a telephone call prior to examining the person, there is no prohibition in the Baker Act to this practice. However, the law and rules do require the person receive a full disclosure about each medication by a person who is qualified to provide this information – probably a physician or a nurse. This is the

basis of express and informed consent (well-reasoned, willful and knowing decision-making) that must be obtained before any medication is administered. In any case, the physician would have to document the person's capacity to provide express and informed consent within the first 24 hours after the person's arrival, if allowed to provide consent to his or her own treatment. If at any time staff thought the person didn't have this capacity, the medication should stop until the physician could perform the examination and until a substitute decision-maker could be found. Use of standing orders or PRN's for emergency medications or procedures is prohibited in the Baker Act rules.

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

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

Q. If a person is admitted on a 'voluntary' basis but before the physician has completed a competency exam, it is my understanding of the BA laws that the staff may administer psychotropic medications as long as the patient consents. The 'voluntary' presumes the patient is competent to consent unless they display thoughts or behaviors that would lead one to believe that they can not make well-reasoned, willful and knowing decisions. Is this correct?

If the adult on voluntary status consistently appears to be able to make well-reasoned, willful, and knowing decisions about his/her medical and mental health treatment, the Baker Act wouldn't prohibit a physician from ordering and staff administering medications. However, at any time the person's words or behaviors suggest an inability to make such well-reasoned decisions, medications must be stopped until a physician has certified competence after a face-to-face exam.

Q. If an individual with a legal guardian on involuntary status arrives at our facility, do we have to wait for a documentation of incompetence by the physician in order for the legal guardian to consent. What I believe is no because the courts have already made this determination that is why they have a legal guardian. Is this correct?

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

Once you have documentation through the court order and letters of guardianship, the person must have orders for medication. You would have to then get consent from the

court-appointed guardian. The Florida Administrative Code governing this issue is as follows:

65E-5.170 Right to Express and Informed Consent.

(1) Establishment of Consent.

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

Q. Does competency to consent to treatment have to be documented by a physician before consent can be sought and treatment administered?

NO. Chapter 65E-5.170(1), FAC requires that as soon as possible, but in no event longer than 24 hours from entering a designated receiving facility on a voluntary or involuntary basis, each person shall be examined by the admitting physician to determine the person's ability to provide express and informed consent to admission and treatment.

This doesn't require that the examination or completion of the form be done prior to administering psychotropic medications. However, the law is very clear that the person must be able to provide express and informed consent for any treatment rendered, after full disclosure of all the legally required information.

With regard to adults on **voluntary** status, one can presume the person is competent to consent to medications and other treatment prior to being certified so by a physician as long as staff notes that the person appears to be able to consistently make well-reasoned, willful, and knowing decisions about his/her medical and mental health treatment. However, at any time the person displays thoughts or behaviors that would lead one to believe that he or she is not able to make well-reasoned, willful and knowing decisions, the treatment must be discontinued until informed consent can be obtained from a legally authorized person, unless an emergency treatment order is issued because of imminent danger.

If a person is admitted on **involuntary** status and the block on the BA-52 form indicates the person was unable to determine a voluntary examination was needed is checked, a facility would have to presume the person is incompetent to consent to medications or other treatment. If the box marked "refusing voluntary exam" is checked instead, the

person on involuntary status might be capable of providing consent to his/her own treatment as long as staff noted that the person appeared to be consistently able to make well-reasoned, willful, and knowing decisions about his/her medical and mental health treatment.

At any time staff observes any reason why the person isn't making such well-reasoned decisions, treatment must stop except when the physician has documented imminent danger, in which case an emergency treatment order can be considered.

Mental Health Advance Directives

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

Yes. A Mental Health Advance Directive found at the end of Appendix C of the 2008 Baker Act Handbook. It is based on the 20 page Bazelon Center form, but condensed and adapted to Florida laws. It is recommended, but not mandatory. The #3122 form can be used by the physician to certify incompetence to consent and notify the surrogate/proxy, as well as the affidavit form (3123).

Q. I am trying to get clarification of exactly what the expectations are of our facility should one of our inpatients request to complete a Mental Health Advance Directive. Can psychiatric inpatients complete a MH Advance Directive?

Only a person who is considered competent may complete a valid advance directive, even one for mental health care.

765.101(8) "Incapacity" or "incompetent" means the patient is physically or mentally unable to communicate a willful and knowing health care decision...

Competence under the Baker Act has even a higher standard for competence::

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

If the patient is competent and there are two witnesses who attest "that at the time the advance directive was signed, the person was of sound mind and under no constraint or undue influence", he/she would be eligible to complete the form. Many facilities feel that the mere presence of a person in a receiving facility may suggest lack of competence and possibly some undue influence by staff.

You may want to select a health care proxy (relative or close personal friend) while the person is hospitalized if not competent to execute an advance directive and provide the

person the paperwork and assistance as part of their release from the hospital. That way the document is in place should he/she be re-hospitalized at some future time.

Q. I need information about mental health advance directives. At this time my facility asks patients if they have one on admission and, if they do, we get a copy. Can you please tell me exactly where in the statute it discusses mental health advance directives? The facility I work for try's to have all the same computer screens and protocols for all our sister facilities in Florida and we can not find where it discusses exactly what we are to do that would keep us in compliance.

The federal regulations require that any hospital inquire about a person's advance directives at the time of admission. In addition, the Florida Administrative Code governing the Baker Act requires that each receiving facility (hospital and CSU) also make such an inquiry.

The primary statute that governs advance directives in Florida is chapter 765, FS. It includes several references to mental health issues:

765.101(5) "Health care decision" means:

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

765.113 Restrictions on providing consent.-- ...or voluntary admission to a mental health facility.

765.202(5) A principal may designate a separate surrogate to consent to mental health treatment ...

765.204 Capacity of principal; procedure.--

However, the Baker Act (394, Part I, FS) also makes several references to advance directives and health care surrogates/proxies. As does the Florida Administrative Code (65E-5, FAC) governing the Baker Act.

Q. I am trying to gather information regarding the process for when consumers complete MH Advance Directives. If they are hospitalized, how does the person identify that they have a MH Advance Directive and how do hospitals enact it? How do they provide treatment within the person's specified directives?"

Each person entering a hospital or receiving facility must be asked if they have an advance directive. If the person has such a directive, he or she should have a copy brought or sent to the facility. It should be the basis for the individual's treatment plan. If no advance directive can be produced, it is a moot point as any Advance Directive completed when an individual is having a psychiatric crisis would be suspect.

The Surrogate named in the advance directive must exercise "substitute judgment", providing decisions he/she believes the individual would have made if competent to

make those decisions. The surrogate can only use a "best interest" standard of decision making if he/she doesn't know what the individual would have wanted.

In the absence of an advance directive or a health care surrogate named by the individual at a time when competent to do so, a health care proxy can be named by the facility from the list found in chapter 765, Part IV, F.S.. A proxy has the same authority as a surrogate named by the individual. A surrogate or proxy has the power to make any and all health care decisions including mental health with certain limitations. The individual must be held on involuntary status and appointment of a guardian advocate under the Baker Act must be sought. The person serving as surrogate / proxy will more likely than not be named by the court as the Guardian Advocate.

The person raising the question should review chapter 765, F.S. governing advance directives and Chapter 65E-5.2301, FAC that I've included at the end of this message.

Electroconvulsive Therapy

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

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

Consent to Medical Treatment

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

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

Q. A consumer has contacted me to ask whether a Baker Act receiving facility has the right to take blood or urine samples from an individual during the involuntary examination period without consent.

As Florida's Mental Health Act, the Baker Act doesn't address medical consent issues, with the very narrow exception below:

394.459 Rights of patients.—

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

(c) When the department is the legal guardian of a patient, or is the custodian of a patient whose physician is unwilling to perform a medical procedure, including an electroconvulsive treatment, based solely on the patient's consent and whose guardian or guardian advocate is unknown or unlocatable, the court shall hold a

hearing to determine the medical necessity of the medical procedure. The patient shall be physically present, unless the patient's medical condition precludes such presence, represented by counsel, and provided the right and opportunity to be confronted with, and to cross-examine, all witnesses alleging the medical necessity of such procedure. In such proceedings, the burden of proof by clear and convincing evidence shall be on the party alleging the medical necessity of the procedure.

(d) The administrator of a receiving or treatment facility may, upon the recommendation of the patient's attending physician, authorize emergency medical treatment, including a surgical procedure, if such treatment is deemed lifesaving, or if the situation threatens serious bodily harm to the patient, and permission of the patient or the patient's guardian or guardian advocate cannot be obtained.

Other state laws addressing medical consent are as follows:

766.103 Florida Medical Consent Law.--

(1) This section shall be known and cited as the "Florida Medical Consent Law."

(3) No recovery shall be allowed in any court in this state against any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractic physician licensed under chapter 460, podiatric physician licensed under chapter 461, dentist licensed under chapter 466, advanced registered nurse practitioner certified under s. 464.012, or physician assistant licensed under s. 458.347 or s. 459.022 in an action brought for treating, examining, or operating on a patient without his or her informed consent when:

(a)1. The action of the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community as that of the person treating, examining, or operating on the patient for whom the consent is obtained; and

2. A reasonable individual, from the information provided by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant, under the circumstances, would have a general understanding of the procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures, which are recognized among other physicians, osteopathic physicians, chiropractic physicians, podiatric physicians, or dentists in the same or similar community who perform similar treatments or procedures; or

(b) The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure had he or she been advised by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant in accordance with the provisions of paragraph (a).

(4)(a) A consent which is evidenced in writing and meets the requirements of subsection (3) shall, if validly signed by the patient or another authorized person, raise a rebuttable presumption of a valid consent.

(b) A valid signature is one which is given by a person who under all the surrounding circumstances is mentally and physically competent to give consent.

765.101 Definitions (Advance Directive Statute)

(9) "Informed consent" means consent voluntarily given by a person after a sufficient explanation and disclosure of the subject matter involved to enable that person to have a general understanding of the treatment or procedure and the medically acceptable alternatives, including the substantial risks and hazards inherent in the proposed treatment or procedures, and to make a knowing health care decision without coercion or undue influence.

415.102 (Adult Protective Services) Definitions of terms used in ss. 415.101-415.113.--As used in ss. 415.101-415.113, the term:

(3) "Capacity to consent" means that a vulnerable adult has sufficient understanding to make and communicate responsible decisions regarding the vulnerable adult's person or property, including whether or not to accept protective services offered by the department.

401.445 (EMS Transport & ER) Emergency examination and treatment of incapacitated persons.--

(1) No recovery shall be allowed in any court in this state against any emergency medical technician, paramedic, or physician as defined in this chapter, any advanced registered nurse practitioner certified under s. 464.012, or any physician assistant licensed under s. 458.347 or s. 459.022, or any person acting under the direct medical supervision of a physician, in an action brought for examining or treating a patient without his or her informed consent if:

(a) The patient at the time of examination or treatment is intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent as provided in s. 766.103;

(b) The patient at the time of examination or treatment is experiencing an emergency medical condition; and

(c) The patient would reasonably, under all the surrounding circumstances, undergo such examination, treatment, or procedure if he or she were advised by the emergency medical technician, paramedic, physician, advanced registered nurse practitioner, or physician assistant in accordance with s. 766.103(3)

Examination and treatment provided under this subsection shall be limited to reasonable examination of the patient to determine the medical condition of the patient and treatment reasonably necessary to alleviate the emergency medical condition or to stabilize the patient.

There is a presumption that a person who is undergoing an emergency medical condition and unable to provide consent would have consented to life-saving interventions if he/she had been competent to do so, absent an advance directive or DNR reflecting otherwise. Short of a medical emergency, I doubt that a facility has the right to take blood or urine samples from an individual during the involuntary examination period without consent by a person authorized by law to provide such consent (competent adult, guardian, health care surrogate/proxy, etc.)

Q. My question is about a person's competence to consent for medical medications if the psychiatrist has deemed the person incompetent to consent for

treatment. Does the doctor's finding of incompetent to consent to treatment under the Baker Act relate to psychiatric treatment, including psychotropic medication only or does this also include any medical medication that the patient may be on prior to being admitting to the CSU? We frequently have individuals admitted who come on routine diabetic medication, heart medication, medication for COPD or other respiratory problems and other chronic conditions. To stop these medications can be life threatening and it may take us two or three days to find a health care surrogate or proxy due to the fact we admit from such a large geographic area and often family is very difficult to contact. Thus, for the welfare of the patient we have allowed the patient to sign consent for non psychotropic medications if the person were not too psychotic to do so. Please clarify.

The Baker Act is merely the state's mental health law and doesn't affect medical treatment. The Baker Act is silent on this issue. For medical treatment, a provider would follow whatever laws govern informed consent for medical care – it seems to be much less stringent than for mental health.

More to the point is that denial of antihypertensive medications, insulin, and the entire range of other medications for non-psychiatric conditions would probably represent medical neglect on the part of a provider. Most receiving facilities will attempt to get a proxy to provide consent, but if no proxy is available, they will administer these drugs anyway. Given that the patient was taking the medications prior to admission, an implied consent might be acceptable where it is not sufficient for psychotropic medications.

Q. If a psychiatrist has deemed a person incompetent to consent to treatment, does this relate to psychiatric treatment only or does this also include any medical medication that the patient may be on prior to being admitted? We frequently have individuals admitted who come on routine diabetic medication, heart medication, medication for COPD or other respiratory problems and other chronic conditions. To stop these medications can be life threatening and it may take us two or three days to find a health care surrogate or proxy. We have allowed patients to sign consent for non-psychotropic medications if the person were not too psychotic to do so. Please clarify.

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Q. If a person in a medical facility under an involuntary exam is awaiting medical stabilization before transfer to a BA Receiving facility and has refused a CT scan ordered by a physician. Once the person arrives at a receiving facility, can a proxy consent to a CT scan or other diagnostic procedures on behalf of the person?

The Baker Act only governs mental health issues, while other statutes govern consent for medical care. However, chapter 765, FS is the Advance Directive statute for Florida and can be used for medical or mental health decisions. Part IV of that statute governs the issue of proxies when a person has not executed an advance directive or the surrogate named in an advance directive is no longer able or willing to serve. Proxies and surrogates have the power to make any and all health care decisions that persons who lack competence would have made for themselves if they had been capable of doing so. The only exception to the authority relates to ECT, psychosurgery, experimental treatments, abortion and sterilization -- these must be specifically allowed in a written advance directive for a Surrogate to provide consent. The only other restriction is the Surrogate/Proxy cannot consent to voluntary admission of the person for psychiatric care or provide consent to treatment for a person on voluntary status in a psychiatric facility. A surrogate or proxy can provide consent at the ER as well as later at a Baker Act receiving facility.

Q. We have a patient on our unit on a BA-8 for up to 30 days. He was originally deemed competent and the court did not appoint a guardian advocate. Just recently we found out that he has a malignant melanoma that needs immediate surgery ASAP but he is refusing to have it done at this Hospital due to his fixed paranoia about this hospital and his last stay here he ended up being sent to the State Hospital. What legal procedures do we need to go through to get this man his needed surgery? The psychiatrist now feels the man is incompetent. Do we need to go back to court to get a guardian advocate appointed? Can a guardian advocate sign the papers for a patient to get surgery or do we need to do something else?

You have several alternatives.

1. If the doctor believes the man lacks competence, this can be documented in the chart and a health care proxy can be designated from the list found in Chapter 765, Part IV. The proxy can immediately exercise substitute judgment, consenting to treatment that he/she believes the person would have consented to if competent to do so.
2. You can file a petition (CF-MH 3106) for Adjudication of Incompetence to Consent to treatment and Appointment of a Guardian Advocate with the circuit court. The boxes for medical and for mental health treatment should be checked. While surgery isn't one of the procedures requiring a specialized separate hearing before consent for extraordinary procedures can be authorized, it might be wise to be sure the judge is aware of the circumstances. It's possible that the court will provide an expedited hearing.
3. You can file a petition for Expedited Judicial Intervention for Medical Treatment (Probate Rule 5.900) with the circuit court.

Q. An adult male visiting Florida stabbed himself multiple times while in a psychotic episode. He was taken to the hospital for medical treatment and the BA is under the medical interruption. The man is psychotic and not competent to make psychiatric treatment decisions. The family is requesting that he be medically stabilized to travel home to his home state for continued medical care and the initiation of psychiatric care. Can a family member legally request this transfer? Can our hospital legally transfer him to another state with the BA "suspended" under medical interruption---just to expire by virtue of leaving the state? Can we provide the psychiatric evaluation while he under the medical interruption, discontinue the BA status in Florida and transfer him to an out-of-state hospital for medical and psych follow up?

Your hospital's legal counsel should be involved in this matter. However, the physician can document the young man's incompetence/incapacity and designate the parents as his health care proxy under chapter 765. Since he is on an involuntary status, they can consent to his medical and his psychiatric treatment, assuming that full disclosure of the risks/benefits have been made and that they believe their son would have consented if able to do so. Besides making medical and psychiatric treatment decisions, they can access his clinical record and release information from the record, apply for public benefits on his behalf, and authorize transfers. The logistics of the transfer may be difficult unless the family can arrange private secured air transport with a couple of escorts. An airline may not accept him with such acute mental health issues. The Interstate transfer provisions in 394 Part II, FS are limited to transfers between state hospitals.

It's clear that he needs to be back home close to family and his support system. An attorney may need to be appointed to ensure that the man's due process rights are protected in the process. If this doesn't work, another possibility might be for the hospital attorney to file a petition with the circuit court for "expedited judicial intervention concerning medical treatment procedures" under Probate Rule 5.900.

Q. Can a med/surg patient taking psychotropic medications (but not hospitalized for psychiatric purposes) would have to go through the more extensive consent procedures required by the Baker Act statute and rules.

Not necessarily. The patient should be treated like any other med/surg patient with the consent required of those, rather than under the Baker Act. However, if the person didn't appear to be able to give informed consent to med/surg procedures, consent from a substitute decision-maker may need to be sought.

Q. I am somewhat confused because the statute and the regulations do not distinguish between competence to consent to medical and psychiatric treatment. Form 3104 certifies a patient as either competent or incompetent, but doesn't distinguish between medical and psychiatric treatment. However, form 3106 (request for GA) has the facility select either mental , medical, or both. The ability to select suggests that there is a difference. Can I get DCF's position clarified?

DCF has always taken the position that the Baker Act only applies to mental health treatment as it is the state's Mental Health Act. The only references to medical issues,

other than for Guardian Advocates, are under 394.459 governing rights of persons, as follows:

(2) Right To Treatment.--

(c) Each person who remains at a receiving or treatment facility for more than 12 hours shall be given a physical examination by a health practitioner authorized by law to give such examinations, within 24 hours after arrival at such facility.

(3) Right To Express And Informed Patient Consent.--

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

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

(d) The administrator of a receiving or treatment facility may, upon the recommendation of the patient's attending physician, authorize emergency medical treatment, including a surgical procedure, if such treatment is deemed lifesaving, or if the situation threatens serious bodily harm to the patient, and permission of the patient or the patient's guardian or guardian advocate cannot be obtained.

The Advance Directive statute [s.765.101(9), FS] defines informed consent as follows:

(9) "Informed consent" means consent voluntarily given by a person after a sufficient explanation and disclosure of the subject matter involved to enable that person to have a general understanding of the treatment or procedure and the medically acceptable alternatives, including the substantial risks and hazards inherent in the proposed treatment or procedures, and to make a knowing health care decision without coercion or undue influence.

The above definition is much less stringent than the statutory definition for "express and informed consent" in the Baker Act, considering the required disclosures that must be provided to the decision-maker. Most people served in receiving facilities have some relative or close personal friend who could give interim consent (under 765) to medical interventions until appointed as Guardian Advocate under the Baker Act. The surrogate or proxy can make such decisions at any point after a physician determines the person lacks capacity or competence, as follows:

(8) "Incapacity" or "incompetent" means the patient is physically or mentally unable to communicate a willful and knowing health care decision. For the purposes of making an anatomical gift, the term also includes a patient who is deceased.

Some people use the phrase "implied consent" to mean the person has agreed to take certain medications in the past or ingests medications without any acknowledgment of understanding or agreement. This is clearly inadequate to meet the requirements for psychiatric decision-making under the Baker Act.

Further, DCF has also taken the position that denial of medically necessary drugs (HBP, diabetes, heart, etc.) for persons in hospitals or other receiving facilities could constitute medical neglect under 415.102(15), FS

"Neglect" means the failure or omission on the part of the caregiver or vulnerable adult to provide the care, supervision, and services necessary to maintain the physical and mental health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, which a prudent person would consider essential for the well-being of a vulnerable adult. The term "neglect" also means the failure of a caregiver or vulnerable adult to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness which produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death.

The Baker Act 394.4598(6), FS governing Guardian Advocates is clear that any GA is authorized to consent to psychiatric treatment (with some exceptions listed below), but only has authority to consent to medical treatment if authorized by the court:

If a guardian with the authority to consent to medical treatment has not already been appointed or if the patient has not already designated a health care surrogate, the court may authorize the guardian advocate to consent to medical treatment, as well as mental health treatment. Unless otherwise limited by the court, a guardian advocate with authority to consent to medical treatment shall have the same authority to make health care decisions and be subject to the same restrictions as a proxy appointed under part IV of chapter 765.

Chapter 65E-5.230(1), FAC establishes the 3106 form or its equivalent as the method of seeking appropriate range of authority for the Guardian Advocate. Facilities should routinely request authority from the court for Guardian Advocates to be able to provide both psychiatric and medical consent because many of the lab and diagnostic tests required for persons in psychiatric facilities may be considered medical in nature.

Q. Can Baker Act patients refuse to provide blood, urine or other tests needed for medical clearance? We understand that a patient can refuse those tests/interventions? It is the hospital's goal to provide the needed medical information to another Receiving Facility for them to assess their facility's ability to manage and care for the patient. However, if our ED physician deems a patient to no longer have an emergency medical condition, can that Receiving Facility

deny acceptance of the patient because the hospital has no labwork to provide due to the patient's refusal? Some staff feel we can be charged with assault if we draw blood on Baker Act patients after they have refused care, Is this true?

A person has the right to refuse medical treatment, if competent to do so. The Baker Act as Florida's Mental Health Act, provides no authority to perform any medical examination or treatment – other statutes must be relied upon for lab and other diagnostic tests deemed medically necessary. Chapter 401 is the EMS statute, but it has considerable information about dealing with persons with emergency conditions who cannot provide consent. Some sections apply to hospital ED's as well, as follows:

401.445 Emergency examination and treatment of incapacitated persons.--

(1) No recovery shall be allowed in any court in this state against any emergency medical technician, paramedic, or physician as defined in this chapter, any advanced registered nurse practitioner certified under s. 464.012, or any physician assistant licensed under s. 458.347 or s. 459.022, or any person acting under the direct medical supervision of a physician, in an action brought for examining or treating a patient without his or her informed consent if:

(a) The patient at the time of examination or treatment is intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent as provided in s. 766.103;

(b) The patient at the time of examination or treatment is experiencing an emergency medical condition; and

(c) The patient would reasonably, under all the surrounding circumstances, undergo such examination, treatment, or procedure if he or she were advised by the emergency medical technician, paramedic, physician, advanced registered nurse practitioner, or physician assistant in accordance with s. 766.103(3).

Examination and treatment provided under this subsection shall be limited to reasonable examination of the patient to determine the medical condition of the patient and treatment reasonably necessary to alleviate the emergency medical condition or to stabilize the patient.

(2) In examining and treating a person who is apparently intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent, the emergency medical technician, paramedic, physician, advanced registered nurse practitioner, or physician assistant, or any person acting under the direct medical supervision of a physician, shall proceed wherever possible with the consent of the person. If the person reasonably appears to be incapacitated and refuses his or her consent, the person may be examined, treated, or taken to a hospital or other appropriate treatment resource if he or she is in need of emergency attention, without his or her consent, but unreasonable force shall not be used.

(3) This section does not limit medical treatment provided pursuant to court order or treatment provided in accordance with chapter 394 or chapter 397.

401.45 Denial of emergency treatment; civil liability.--

(1)(a) Except as provided in subsection (3), a person may not be denied needed prehospital treatment or transport from any licensee for an emergency medical condition.

(b) A person may not be denied treatment for any emergency medical condition that will deteriorate from a failure to provide such treatment at any general hospital licensed under chapter 395 or at any specialty hospital that has an emergency room.

(2) A hospital or its employees or any physician or dentist responding to an apparent need for emergency treatment under this section is not liable in any action arising out of a refusal to render emergency treatment or care if reasonable care is exercised in determining the condition of the person and in determining the appropriateness of the facilities and the qualifications and availability of personnel to render such treatment.

Another statute of note is:

766.103 Florida Medical Consent Law.--

(1) This section shall be known and cited as the "Florida Medical Consent Law."

(2) In any medical treatment activity not covered by s. 768.13, entitled the "Good Samaritan Act," this act shall govern.

(3) No recovery shall be allowed in any court in this state against any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractic physician licensed under chapter 460, podiatric physician licensed under chapter 461, dentist licensed under chapter 466, advanced registered nurse practitioner certified under s. 464.012, or physician assistant licensed under s. 458.347 or s. 459.022 in an action brought for treating, examining, or operating on a patient without his or her informed consent when:

(a)1. The action of the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community as that of the person treating, examining, or operating on the patient for whom the consent is obtained; and

2. A reasonable individual, from the information provided by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant, under the circumstances, would have a general understanding of the procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures, which are recognized among other physicians, osteopathic physicians, chiropractic physicians, podiatric physicians, or dentists in the same or similar community who perform similar treatments or procedures; or

(b) The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure had he or she been advised by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant in accordance with the provisions of paragraph (a).

Whenever a person has an adult relative or close personal friend, that person could serve as the person's proxy and provide consent for the procedure once your doctor had determined the person lacked capacity to make his/her own medical decisions.

While the designated receiving facility can't require your ED physician to perform lab tests, it can refuse to accept transfer of a person for whom it may have insufficient information to ensure it can manage the person's medical condition. Since the

emergency psychiatric condition is an emergency medical condition per CMS, EMTALA would prevent your hospital ER from transferring the person without the prior approval of the destination facility.

Q. If a person under involuntary examination status is on a medical floor, does the person have the right to refuse medications/treatment, including life saving treatment?

The Baker Act is Florida's Mental Health Act -- nothing more or less than that. It doesn't address issues of medical care and can not be used as the basis for providing medical examination or treatment. Other laws must be used instead, such as 395 that governs hospitals or 415 that governs the abuse, neglect, or exploitation of vulnerable adults (self neglect by a person who lacks capacity). If a person has a life threatening condition and is unable (not the same as refusing) to provide informed consent to necessary treatment, one can usually presume the person would have consented to such treatment if able to do so. However, a person who is competent to make such decisions but refuses the treatment has this right to do so. If the medical treatment needed by a person who isn't competent to consent isn't related to a life threatening condition, one needs to obtain a substitute decision-maker such as a health care surrogate or proxy to obtain the necessary authorization. The hospital's attorney and/or risk manager may need to consult on issues such as this.

Q. A person for whom an involuntary examination has been initiated was recently taken to an emergency room by a law enforcement officer and the person was verbally threatening, removing his clothing, and attempting to leave the ER and police were unsure if the person was under the influence of substances that may have induced the behavior or if the behavior was based in a pre-existing psychiatric condition. The person refused all lab work and refused all medications, ultimately escalating to the point of requiring 4 point restraints. Can the ER Physician order a medication ETO or draw blood without consent for the purposes of medical safety?

The Baker Act doesn't specifically address this issue. However, the medication would be considered a chemical restraint under the behavioral restraint standards governed by the federal conditions of participation. A physician can order an ETO for psychotropic medications or restraints at any time there is imminent danger because of a person's condition, whether the person is at a receiving facility or a medical hospital preceding transfer. This presumes that the ETO is the least restrictive intervention possible under the circumstances. It is essential that the physician's signed order in the progress notes and order describe the specific behavior which constitutes a danger to the person or to others, and the nature and extent of the danger posed. In this circumstance,

Q. Can an involuntary Baker Act pt while in an acute care hospital can make his/her own healthcare decisions ie surgery, blood products, etc?

The Baker Act, as Florida's Mental Health Act, doesn't govern medical examinations and medical treatment. You would rely on Florida's Medical Consent Act for that purpose. In any case, you'll want to obtain a health care surrogate or proxy to provide consent for a

person who is unable to consent to his/her own medical treatment. Of course, if the person has a life-threatening condition, other laws provide for that medical treatment to be done on the presumption the person would have consented if able to do so.

Q. When a patient has medical problems superseding their psychiatric issues is admitted to a Med Surg or ICU floor, then medically stabilizes and is pending transfer to a psychiatric bed, should that floor request the patient sign the 42b consent form for Psychotropic Medications since the 72 hour time clock is now ticking? What about before they are medically cleared - during the time their primary interventions are medical? Should a med floor ever obtain express and informed written consent for psychotropics? In general, individualized written consent isn't required for other medications like antibiotics, heart meds etc. If they don't need to have them sign, do you see any increased liability if they choose to have the patient sign?

Regarding your question about consent for treatment prior to a patient's transfer from a medical floor to a psychiatric unit, the Baker Act is just the Florida Mental Health Act and doesn't govern medical (non-psychiatric) treatment. Therefore, any medical treatment before or after transfer to the psychiatric unit should comply with other laws governing informed consent.

However, "express and informed consent", a higher level of disclosure and consent is required for psychiatric care, including medications. Given that the entire facility at the address on the designation letter is considered the "receiving facility", any psychotropic medications given to persons held under the voluntary or involuntary provisions of the Baker Act would have to conform to the requirements of the law. Even non-designated hospitals that are medically treating persons prior to transfer to a receiving facility would be required as a condition of licensure to comply with all

The hospital's risk manager or attorney would probably agree that obtaining express and informed consent from a legally authorized individual (competent adult, guardian, health care surrogate/proxy, etc.) after provision of required disclosure would not only comply with the law, but reduce the liability of the hospital and the physician.