

Marchman Act
(Florida's Substance Abuse Impairment Act)

General

Q. How do I obtain a copy of the Marchman Act Handbook?

The Marchman Act Handbook (2003) was never printed for distribution. Anyone can download it from the DCF web site to a disk and keep the disk on hand for reference. There is nothing copyrighted or proprietary about the material, so the disk can be sent to a printer for reproduction. It is possible that someone might only want portions of the Handbook, which is why it was prepared with each section in a separate file.

Q. Could you please provide me with the list of receiving facilities regarding the Marchman Act?

As required by the Marchman Act [chapter 397.6744], DCF maintains a current list of licensed facilities.

Q. Can the Marchman Act forms be changed or are the model forms mandated?

The Marchman Act forms are recommended forms – not mandatory. As long as the user doesn't make changes that are inconsistent with the law, addition of other information or change in format is entirely discretionary.

Minors

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

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

397.601 Voluntary admissions.

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

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

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

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

(b)Except for purposes of law enforcement activities in connection with protective custody, the disability of minority is not removed if there is an involuntary admission for substance abuse services, in which case parental participation may be required as the court finds appropriate.

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

397.311 Definitions.

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

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

397.405 Exemptions from licensure.

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

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

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

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

Involuntary Admissions – Marchman Act

Q. How is an involuntary admission under the Marchman Act initiated?

The Marchman Act offers four methods of initiating an involuntary admission. These include:

- Protective Custody by a law enforcement officer
- An emergency admission with a certificate of a physician
- An Alternative involuntary admission for a minor by the minor's guardian
- Court-ordered assessment

If the assessment conducted in accord with one of the above by a "Qualified Professional" documents that the criteria is indeed met, a petition for involuntary treatment can then be filed with the court.

Protective Custody – Law Enforcement

Q. Where can a law enforcement officer take a person under the involuntary provisions of the Marchman Act?

Under Marchman Act Protective Custody initiated by law enforcement, the officer is only permitted to take the person to home, hospital, or detox with the person's consent, whichever the officer believes is the most appropriate setting for the person. If the person doesn't give such consent, it is limited to hospital or detox, unless the person is taken to jail. Other licensed substance abuse providers that are not licensed as detox facilities, addiction receiving facilities (ARF), or hospitals wouldn't be eligible to accept a person under protective custody.

Any licensed hospital (general or specialty hospital) must accept any person brought to its emergency department and conduct a medical screening. If found to have an "emergency medical condition" even if only related to a psychiatric or substance abuse emergency, the hospital ED must follow rigorous standards established by the federal government under EMTALA before any transfer to another facility can take place.

Q. I am the Chief of Police at a VA Hospital. Can you define who is a "law enforcement officer" under the Baker and Marchman Acts?

Florida law defines a law enforcement officer for purposes of the Baker Act and Marchman Act as follows:

- **Baker Act:** 394.455(16) "Law enforcement officer" means a law enforcement officer as defined in s. 943.10.
- **Marchman Act:** 97.311(17) "Law enforcement officer" means a law enforcement officer as defined in s. 943.10(1).

Chapter 943.10, FS referenced in the above definitions reads as follows:

943.10 Definitions; ss. 943.085-943.255.--The following words and phrases as used in ss. 943.085-943.255 are defined as follows:

(1) "Law enforcement officer" means any person who is elected, appointed, or employed full time by any municipality or the state or any political subdivision thereof; who is vested with authority to bear arms and make arrests; and whose primary responsibility is the prevention and detection of crime or the enforcement of the penal, criminal, traffic, or highway laws of the state. This definition includes all certified supervisory and command personnel whose duties include, in whole or in part, the supervision, training, guidance, and management responsibilities of full-time law enforcement officers, part-time law enforcement officers, or auxiliary law enforcement officers but does not include support personnel employed by the employing agency.

The Florida Attorney General Opinion Number: AGO 99-68, dated November 8, 1999, regarding the Baker Act and federal law enforcement officers also applies. The AG opinion simply said that a VA officer couldn't initiate or provide primary transportation of a person under the Baker Act to a receiving facility. While this AGO doesn't specifically mention the Marchman Act, one could assume the same opinion would apply because state law defines a law enforcement officer the same in both the Baker Act and the Marchman Act.

Even if a VA law enforcement officer can't initiate an involuntary examination under the Baker Act, either a circuit court judge or any number of mental health professionals are also authorized to initiate instead. Just because the VA police can't initiate doesn't mean all the other mental health professionals on the campus can't initiate. The AG Opinion also didn't mention the secondary transfer of a person from a hospital setting that has certain responsibilities under the federal EMTALA law.

The Marchman Act has some differing provisions governing involuntary admission. Such involuntary admission for an adult can be initiated by a circuit court judge, an array of folks as long as there is a certificate of a physician attached, or by a law enforcement officer. A law enforcement officer is the only one who can initiate "protective custody" and the officer may take the person in protective custody to home, a hospital, a detox center or to jail – whichever the officer determines is most appropriate.

Q. As a law enforcement officer, I placed a man in "protective custody" under the Marchman Act because he was substance impaired and otherwise meeting the criteria under the law. He was transported to the hospital. Once the officer arrived he was told that the person could not be accepted (he met the criteria) in under the Marchman act without a court order. After phone calls back and forth the individual was Baker Acted. Could you clarify?

It's obvious that the hospital staff need training in the state's Marchman Act as well as in the federal EMTALA law.

With regard to the EMTALA law, a hospital must accept any person brought and conduct a medical screening examination to determine if the person has an emergency medical condition, which can be of a psychiatric or substance abuse nature even absent any other medical conditions. Failure to comply has serious financial and administrative consequences to the hospital if reported to AHCA.

The state's Marchman Act has a number of ways in which an involuntary admission to a hospital can be initiated, only one of which is via a court order. The other ones are through Protective Custody of a law enforcement officer or an Emergency Admission with a physician's certificate. It is unfortunate that the hospital staff failed to understand this and as a result, put the officer through such a delay.

The Protective Custody provisions of the law are included in the following:

397, Part V, FS Involuntary Admission Procedures

- A. General Provisions
- B. Noncourt Involved Admissions: Protective Custody
- C. Noncourt Involved Admissions; Emergency
- D. Noncourt Involved Admissions; Alternative Involuntary Assessment for Minors
- E. Court Involved Admissions, Civil Involuntary Proceedings; Generally
- F. Court Involved Admissions; Involuntary Assessment; Stabilization
- G. Court Involved Admissions; Involuntary Treatment

A. General Provisions

397.675 Criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment.

397.6751 Service provider responsibilities regarding involuntary admissions.

397.6752 Referral of involuntarily admitted client for voluntary treatment.

397.6758 Release of client from protective custody, emergency admission, involuntary assessment, involuntary treatment, and alternative involuntary assessment of a minor.

397.6759 Parental participation in treatment.

397.675 Criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment.--A person meets the criteria for involuntary admission if there is good faith reason to believe the person is substance abuse impaired and, because of such impairment:

(1) Has lost the power of self-control with respect to substance use; and either

(2)(a) Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; or

(b) Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto; however, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services.

397.677 Protective custody; circumstances justifying.--A law enforcement officer may implement protective custody measures as specified in this part when a minor or an adult who appears to meet the involuntary admission criteria in s.

397.675 is:

(1) Brought to the attention of law enforcement; or

(2) In a public place.

397.6771 Protective custody with consent.--A person in circumstances which justify protective custody, as described in s. 397.677, may consent to be assisted by a law enforcement officer to his or her home, to a hospital, or to a licensed detoxification or addictions receiving facility, whichever the officer determines is most appropriate.

397.6772 Protective custody without consent.--

(1) If a person in circumstances which justify protective custody as described in s. 397.677 fails or refuses to consent to assistance and a law enforcement officer has determined that a hospital or a licensed detoxification or addictions receiving facility is the most appropriate place for the person, the officer may, after giving due consideration to the expressed wishes of the person:

- (a) Take the person to a hospital or to a licensed detoxification or addictions receiving facility against the person's will but without using unreasonable force; or
- (b) In the case of an adult, detain the person for his or her own protection in any municipal or county jail or other appropriate detention facility.

Such detention is not to be considered an arrest for any purpose, and no entry or other record may be made to indicate that the person has been detained or charged with any crime. The officer in charge of the detention facility must notify the nearest appropriate licensed service provider within the first 8 hours after detention that the person has been detained. It is the duty of the detention facility to arrange, as necessary, for transportation of the person to an appropriate licensed service provider with an available bed. Persons taken into protective custody must be assessed by the attending physician within the 72-hour period and without unnecessary delay, to determine the need for further services.

(2) The nearest relative of a minor in protective custody must be notified by the law enforcement officer, as must the nearest relative of an adult, unless the adult requests that there be no notification.

397.6773 Dispositional alternatives after protective custody.--

(1) A client who is in protective custody must be released by a qualified professional when:

- (a) The client no longer meets the involuntary admission criteria in s. 397.675(1);
- (b) The 72-hour period has elapsed; or
- (c) The client has consented to remain voluntarily at the licensed service provider.

(2) A client may only be retained in protective custody beyond the 72-hour period when a petition for involuntary assessment or treatment has been initiated. The timely filing of the petition authorizes the service provider to retain physical custody of the client pending further order of the court.

397.6774 Department to maintain lists of licensed facilities.--The department shall provide each municipal and county public safety office with a list of licensed hospitals, detoxification facilities, and addictions receiving facilities, including the name, address, and phone number of, and the services offered by, the licensed service provider.

397.6775 Immunity from liability.--A law enforcement officer acting in good faith pursuant to this part may not be held criminally or civilly liable for false imprisonment.

Law enforcement officers are not expected to be diagnosticians. A person may be severely intoxicated with or without a co-occurring serious mental illness. The officer simply has to have reason to believe the person meets one law or the other. If the clinical staff conducting an examination believe that a Marchman Act Protective Custody isn't appropriate because the person isn't substance abuse impaired and instead believe that a Baker Act involuntary examination is the more correct method, the hospital or receiving facility clinical staff can remedy this – not the law enforcement officer.

The recommended Marchman Act Protective Custody form for law enforcement use is posted on the DCF website. It is not a required form if different form has been locally adopted. Your law enforcement agency should contact DCF to arrange training for hospital staff to ensure they don't expose themselves to liability while creating serious problems for law enforcement personnel and consumers.

Q. The manual states that you can take someone to jail for detox and not arrest. Is this correct?

Regarding placing persons on protective custody status in jail instead of a detox center, the Marchman Act states the following:

397.677 Protective custody; circumstances justifying.--A law enforcement officer may implement protective custody measures as specified in this part when a minor or an adult who appears to meet the involuntary admission criteria in s. 397.675 is:

- (1) Brought to the attention of law enforcement; or
- (2) In a public place.

397.6771 Protective custody with consent.--A person in circumstances which justify protective custody, as described in s. 397.677, may consent to be assisted by a law enforcement officer to his or her home, to a hospital, or to a licensed detoxification or addictions receiving facility, whichever the officer determines is most appropriate.

397.6772 Protective custody without consent.--

(1) If a person in circumstances which justify protective custody as described in s. 397.677 fails or refuses to consent to assistance and a law enforcement officer has determined that a hospital or a licensed detoxification or addictions receiving facility is the most appropriate place for the person, the officer may, after giving due consideration to the expressed wishes of the person:

- (a) Take the person to a hospital or to a licensed detoxification or addictions receiving facility against the person's will but without using unreasonable force; or
- (b) In the case of an adult, detain the person for his or her own protection in any municipal or county jail or other appropriate detention facility. Such detention is not to be considered an arrest for any purpose, and no entry or other record may be made to indicate that the person has been detained or charged with any crime. The officer in charge of the detention facility must notify the nearest

appropriate licensed service provider within the first 8 hours after detention that the person has been detained. It is the duty of the detention facility to arrange, as necessary, for transportation of the person to an appropriate licensed service provider with an available bed. Persons taken into protective custody must be assessed by the attending physician within the 72-hour period and without unnecessary delay, to determine the need for further services.

(2) The nearest relative of a minor in protective custody must be notified by the law enforcement officer, as must the nearest relative of an adult, unless the adult requests that there be no notification.

397.6773 Dispositional alternatives after protective custody.--

(1) A client who is in protective custody must be released by a qualified professional when:

- (a) The client no longer meets the involuntary admission criteria in s. 397.675(1);
- (b) The 72-hour period has elapsed; or
- (c) The client has consented to remain voluntarily at the licensed service provider.

(2) A client may only be retained in protective custody beyond the 72-hour period when a petition for involuntary assessment or treatment has been initiated. The timely filing of the petition authorizes the service provider to retain physical custody of the client pending further order of the court.

397.6774 Department to maintain lists of licensed facilities.--The department shall provide each municipal and county public safety office with a list of licensed hospitals, detoxification facilities, and addictions receiving facilities, including the name, address, and phone number of, and the services offered by, the licensed service provider.

397.6775 Immunity from liability.--A law enforcement officer acting in good faith pursuant to this part may not be held criminally or civilly liable for false imprisonment.

A person is taken to the jail for protective custody – not detox. They may go through withdrawal while in the jail, but detox would require specialty licensure from DCF.

Public intoxication is not a crime and a person can't be arrested for it. On the other hand, there are other offenses such as disorderly intoxication, open container laws, etc for which a person can be lawfully arrested.

Q. If an Addiction Receiving Facility (ARF) is full, is the jail is the right destination or a hospital?

Chapter 397 (Marchman Act) permits the use of jails. While a jail is a permissible option for a law enforcement officer under Protective Custody, preferable options such as a detox program or hospital exist.

Q. My understanding is that people placed in jail under Marchman Act protective custody must be assessed by a physician within 72 hours to be released. Is this happening?

You are correct that the Protective Custody provisions of the Marchman Act require such a physician to perform an assessment, as follows:

397.6772 Protective custody without consent.--

(1) If a person in circumstances which justify protective custody as described in s. 397.677 fails or refuses to consent to assistance and a law enforcement officer has determined that a hospital or a licensed detoxification or addictions receiving facility is the most appropriate place for the person, the officer may, after giving due consideration to the expressed wishes of the person:

(a) Take the person to a hospital or to a licensed detoxification or addictions receiving facility against the person's will but without using unreasonable force; or

(b) In the case of an adult, detain the person for his or her own protection in any municipal or county jail or other appropriate detention facility.

Such detention is not to be considered an arrest for any purpose, and no entry or other record may be made to indicate that the person has been detained or charged with any crime. The officer in charge of the detention facility must notify the nearest appropriate licensed service provider within the first 8 hours after detention that the person has been detained. It is the duty of the detention facility to arrange, as necessary, for transportation of the person to an appropriate licensed service provider with an available bed. Persons taken into protective custody must be assessed by the attending physician within the 72-hour period and without unnecessary delay, to determine the need for further services.

Usually persons held under the civil Marchman Act provisions in a jail are assessed by nurses instead of physicians. It is also possible that if the person is taken by law enforcement to an ED for medical clearance before being taken to jail for protective custody, would have undergone the medical screening required under the federal EMTALA law.

Q. I received a call from our law enforcement agency in regards to getting a useable on-line form for the Marchman Act. Presently the form is attached to numerous other information and is not in a one page format like the Baker Act on-line form. They were wondering if they could reproduce the form themselves since it does not have an official form # on it. If not, do you know of a better way they can get this form on-line in user friendly format?

The form developed in 2003 for law enforcement protective custody as part of the Marchman Act Handbook is on the DCF website. All the Marchman Act forms are recommended - not required. Law enforcement agencies can reproduce the form as it is recommended or could modify it to meet local needs, as long as the information remains consistent with statute.

Q. Law enforcement is having some Marchman Act problems in our community regarding medical clearance prior to jail or going back to an ER to pick up a person who has been cleared. Can you give us some guidance on how Protective Custody should work?

Under the Marchman Act, law enforcement officers are permitted to take a person under Protective Custody (with consent) to his or her home, to a hospital, or to a licensed detoxification or addictions receiving facility, whichever the officer determines is most appropriate. It is one of the above. One of the above choices – not more than one in sequence. See the bottom of this message for the statutory language from the Marchman Act.

Without consent, the officer can take a person to a hospital or a licensed detoxification or addictions receiving facility or in the case of an adult, detain the person for his or her own protection in any municipal or county jail or other appropriate detention facility.

Again, it appears to me that the officer takes the person to the one place that appears to the officer to be most appropriate – only one bite from the apple.

What has happened is that some jails are requiring officers to take any person to a hospital ER for “medical clearance” prior to bringing the person to jail under the Marchman Act. This can be a problem because once a person is presented to a hospital ER for the medical screening examination required under the federal EMTALA law, the responsibility for the person becomes that of the hospital. If the person is found to have a substance abuse emergency, it is considered to be an emergency medical condition even absent any other medical condition. The hospital has to either admit or transfer such a person to another appropriate medical provider with the capacity and capability of managing the condition. However, if the person has no substance abuse emergency, the person is considered to be “stable for discharge”. At this point, what is the purpose of sending the person to the jail other than to relieve the ER physicians of some potential liability and transfer that liability to the Sheriff? Some hospitals have allegedly insisted on transfer from the ER to the jail even when persons wanted to called a friend or family member to take them home.

Law enforcement question why they should be held at the ER or called back to the ER for purposes of transport to the jail when they had already taken the person to one of the destinations permitted in the Marchman Act.

Marchman Act/Protective Custody

397.677 Protective custody; circumstances justifying.--A law enforcement officer may implement protective custody measures as specified in this part when a minor or an adult who appears to meet the involuntary admission criteria in s. 397.675 is:

- (1) Brought to the attention of law enforcement; or
- (2) In a public place.

397.6771 Protective custody with consent.--A person in circumstances which justify protective custody, as described in s. 397.677, may consent to be assisted by a law enforcement officer to his or her home, to a hospital, or to a licensed detoxification or addictions receiving facility, whichever the officer determines is most appropriate.

397.6772 Protective custody without consent.--

- (1) If a person in circumstances which justify protective custody as described in s. 397.677 fails or refuses to consent to assistance and a law enforcement officer has determined that a hospital or a licensed detoxification or addictions receiving

facility is the most appropriate place for the person, the officer may, after giving due consideration to the expressed wishes of the person:

- (a) Take the person to a hospital or to a licensed detoxification or addictions receiving facility against the person's will but without using unreasonable force; or
- (b) In the case of an adult, detain the person for his or her own protection in any municipal or county jail or other appropriate detention facility.

Such detention is not to be considered an arrest for any purpose, and no entry or other record may be made to indicate that the person has been detained or charged with any crime. The officer in charge of the detention facility must notify the nearest appropriate licensed service provider within the first 8 hours after detention that the person has been detained. It is the duty of the detention facility to arrange, as necessary, for transportation of the person to an appropriate licensed service provider with an available bed. Persons taken into protective custody must be assessed by the attending physician within the 72-hour period and without unnecessary delay, to determine the need for further services.

(2) The nearest relative of a minor in protective custody must be notified by the law enforcement officer, as must the nearest relative of an adult, unless the adult requests that there be no notification.

397.6773 Dispositional alternatives after protective custody.--

(1) A client who is in protective custody must be released by a qualified professional when:

- (a) The client no longer meets the involuntary admission criteria in s. 397.675(1);
- (b) The 72-hour period has elapsed; or
- (c) The client has consented to remain voluntarily at the licensed service provider.

(2) A client may only be retained in protective custody beyond the 72-hour period when a petition for involuntary assessment or treatment has been initiated. The timely filing of the petition authorizes the service provider to retain physical custody of the client pending further order of the court.

397.6774 Department to maintain lists of licensed facilities.--The department shall provide each municipal and county public safety office with a list of licensed hospitals, detoxification facilities, and addictions receiving facilities, including the name, address, and phone number of, and the services offered by, the licensed service provider.

397.6775 Immunity from liability.--A law enforcement officer acting in good faith pursuant to this part may not be held criminally or civilly liable for false imprisonment.

Q. I am a police Lt. Obviously an officer can initiate a Marchman Act and complete form MA-3 and take the person to the nearest receiving facility or jail when that person meets the criteria and is brought to the attention of a law enforcement officer or found in a public place. Often times the jail staff will require the detaining officer to have the person medically cleared at the emergency room and then the officer transports that individual to back to the jail or receiving facility. However if a person finds their way to a doctor's office or the emergency room not via law enforcement and a physician determines this person needs to be evaluated in accordance with the Marchman Act, it is my

understanding that the recommending physician may initiate the Marchman Act (Chapter 397.675) and complete form MA-5 and other related forms under the Emergency Admission clause without involving law enforcement. Is this correct?

You are absolutely correct in your understanding of the Marchman Act. However, a summary is below. Only a law enforcement officer can initiate “protective custody”. One of the options the officer has is to take the individual to jail, if one of the other options (home, detox, or hospital) isn’t available or appropriate.

- If the officer opts to take the individual to the jail and is then required by jail staff to get “medical clearance” before the person can be accepted, this results in taking the person to the hospital instead. The officer’s responsibility is over because he/she has taken the person to one of the other legally acceptable options under protective custody. EMTALA applies to the hospital.
- If the officer instead takes the individual directly to a hospital ED requesting medical examination or treatment, the federal EMTALA law intervenes and controls the options of the ED physician and hospital. The officer is not required to stay for the purpose of providing security/stabilization or to provide secondary transfer to any other setting. When the doctor finds that the person has no emergency medical condition (including any psychiatric or substance abuse emergency, absent any other medical condition), the doctor can release the person from the ED. There is no purpose served in sending the individual from the ED to jail under the Marchman Act unless criminal charges are pending. However, if the doctor believes such an emergency substance abuse condition exists and needs transfer to another hospital, the responsibility for arranging safe and appropriate transportation lies with the sending hospital – not law enforcement.

With regard to the scenario of when law enforcement isn’t involved at all because the person ends up at the hospital ED on his/her own, protective custody is not even an option. Emergency Admission provisions of the Marchman Act then prevail instead of protective custody and there is no role for law enforcement. A person meeting involuntary admission criteria may be admitted to a hospital or a licensed detox program for emergency assessment and stabilization upon receipt of a physician’s certificate and completion of an application. An application for emergency admission may be initiated: for adults by:

- Certifying physician
- Spouse or guardian
- Any relative
- Any other responsible adult who has personal knowledge of the person’s substance abuse impairment.

Marchman Act and Emergency Medical Conditions

Q. Our psychiatrist was on call for a voluntary patient who was in pretty severe alcohol withdrawal and who needed & received a high dose of Ativan. On the 3rd day, the patient wanted to leave AMA so the doctor held him the 24 hours; he wasn’t in active withdrawal due to the medications administered. Obviously, he still needed tapering from this dose of Ativan but insisted on leaving anyway.

Without a proper taper, he could face severe withdrawal, including seizures, DT's, death. We wondered if he could have Marchman Acted him and transferred him to a Marchman Act receiving facility. We weren't sure this would work. Outside of detailed documentation and counseling on the risk the patient was taking, what would have been the doctor's alternatives? He knew the patient was going to use when he left, which he did and ended up in the ER after OD'ing on Listerine. Was this someone, while already a psychiatric inpatient, that we could have signed a Marchman Act on, and forced him to stay in the hospital, knowing the severe risk he would be taking if he left AMA? And if so, since our facility is not a Marchman receiving facility, then we would have to transfer him to another facility, right?

This is a complex situation dealing with Baker Act, Marchman Act and a medical emergency concurrently. This answer won't be as clear as you may need.. DCF/HQ takes the position that a person without a psychiatric diagnosis can't be admitted to a Baker Act receiving facility. The Baker Act requires a person on voluntary and on involuntary status to have a mental illness diagnosis – the legal definition specifically excludes intoxication and substance abuse impairment because those issues are governed by the Marchman Act. The Baker act definition is:

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

Co-existing diagnoses of mental illness and substance abuse impairment would be appropriate for a Baker Act facility.

The Marchman Act requires a person to have a “substance Abuse Impairment” as defined in Chapter 397(14), FS as follows:

“Impaired” or “substance abuse impaired” means a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behavior.

These two definitions are mutually exclusive. However, there isn't any reason why a person who may be hospitalized for a psychiatric diagnosis in a Baker Act facility may be found through expert evaluation to have a substance abuse impairment instead. The Baker Act and the Marchman Act each have provisions in which court can transfer a person between the Baker Act and the Marchman Act when it is determined that the other law would be more appropriate.

The Marchman Act involuntary admission criteria can be based on impaired judgment as well as active danger. If the request for AMA was based on impaired judgment due to substance abuse or was he just making a decision (to leave AMA) that was medically unadvisable? If the clinical judgment is that the individual was leaving AMA in order to obtain alcohol, because he was addicted to alcohol, that would meet criteria. But if he just didn't want to be in the hospital or get detox treatment, he would not meet criteria.

Clinical judgment would generally err on the side of assuming that the individual was leaving for substance abuse reasons.

Unless the person is actively dangerous due to the impairment -- the criteria in the message has the word "or" between the active danger and the impaired judgment. A "mere refusal" is tied to the impaired judgment paragraph, not the active danger paragraph.

397.675 Criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment.

A person meets the criteria for involuntary admission if there is good faith reason to believe the person is substance abuse impaired and, because of such impairment:

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

In any case the person would have to meet the criteria for substance abuse impairment and have lost the power of self-control with respect to substance abuse as well as one of the two other criteria.

394 467(6) HEARING ON INVOLUNTARY INPATIENT PLACEMENT.—

(c) If at any time prior to the conclusion of the hearing on involuntary inpatient placement it appears to the court that the person does not meet the criteria for involuntary inpatient placement under this section, but instead meets the criteria for involuntary outpatient placement, the court may order the person evaluated for involuntary outpatient placement pursuant to s. 394.4655. The petition and hearing procedures set forth in s. 394.4655 shall apply. **If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to s. 397.675, then the court may order the person to be admitted for involuntary assessment for a period of 5 days pursuant to s. 397.6811. Thereafter, all proceedings shall be governed by chapter 397.**

397.6818 Court determination.

(1) Based on its determination, the court shall either dismiss the petition or immediately enter an order authorizing the involuntary assessment and stabilization of the respondent; **or, if in the course of the hearing the court has reason to believe that the respondent, due to mental illness other than or in addition to substance abuse impairment, is likely to injure himself or herself or another if allowed to remain at liberty, the court may initiate involuntary proceedings under the provisions of part I of chapter 394.**

A hospital was sued in a civil case in which a man was brought to the hospital (a designated receiving facility) and assessed under the involuntary examination provisions of the Baker Act. It was determined within the 72-hour examination period that his condition resulted from serious substance abuse impairment and an involuntary admission under the Marchman Act was then initiated. The man sued the hospital for battery and false imprisonment since he had been detained involuntarily beyond a 72-hour period. It was documented that the time frames allowed in each law were not exceeded when one was added on top of the other. The court ruled for the defense with a summary judgment without even allowing the case to go to trial – something that is unusual for courts to do if there is any possible question of fact for a jury to decide.

As a result of all the above, the doctor could have initiated a Marchman Act Emergency Admission pursuant to chapter 397679, FS with the application and the physician's certificate completed by the psychiatrist at your facility. The criteria is as follows:

397.675 Criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment.

A person meets the criteria for involuntary admission if there is good faith reason to believe the person is substance abuse impaired and, because of such impairment:

(1) Has lost the power of self-control with respect to substance use; **and either**

(2)(a) Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; **or**

(b) Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto; however, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services.

You would have to transfer to a licensed substance abuse facility if the man didn't have a co-occurring psychiatric disorder. The one other complicating factor in this case is whether the man had an emergency medical condition and lacked the capacity to provide informed consent to medical care. In that case, other laws and court rules apply.

Q. When our CSU physicians initiate a Marchman Act, are they only required to fill out the "physician certificate for emergency admission" or do they also have to complete the "application for involuntary emergency admission"?

Below is the applicable provisions of the Marchman Act that specifically state there must be an application for emergency admission in addition to a physician's certificate. Other people besides the physician are authorized to complete the application, including the spouse, guardian, any relative, or any other responsible adult who has personal knowledge of the person's substance abuse impairment.

397.679 Emergency admission; circumstances justifying.

A person who meets the criteria for involuntary admission in s. 397.675 may be admitted to a hospital or to a licensed detoxification facility or addictions receiving facility for emergency assessment and stabilization, or to a less intensive component of a licensed service provider for assessment only, upon receipt by the facility of **the physician's certificate and the completion of an application for emergency admission.**

397.6791 Emergency admission; persons who may initiate.

The following persons may request an emergency admission:

- (1) In the case of an adult, **the certifying physician**, the person's spouse or guardian, any relative of the person, or any other responsible adult who has personal knowledge of the person's substance abuse impairment.
- (2) In the case of a minor, the minor's parent, legal guardian, or legal custodian.

397.6793 Physician's certificate for emergency admission.

(1) The physician's certificate must include the name of the person to be admitted, the relationship between the person and the physician, the relationship between the applicant and the physician, any relationship between the physician and the licensed service provider, and a statement that the person has been examined and assessed within 5 days of the application date, and must include factual allegations with respect to the need for emergency admission, including:

- (a) The reason for the physician's belief that the person is substance abuse impaired; and
- (b) The reason for the physician's belief that because of such impairment the person has lost the power of self-control with respect to substance abuse; and either
- (c) 1. The reason the physician believes that the person has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or
2. The reason the physician believes that the person's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the person is incapable of appreciating his or her need for care and of making a rational decision regarding his or her need for care.

(2) The physician's certificate must recommend the least restrictive type of service that is appropriate for the person. The certificate must be signed by the physician.

(3) A signed copy of the physician's certificate shall accompany the person, and shall be made a part of the person's clinical record, together with a signed copy of the application. The application and physician's certificate authorize the involuntary admission of the person pursuant to, and subject to the provisions of ss. 397.679-397.6797.

(4) The physician's certificate must indicate whether the person requires transportation assistance for delivery for emergency admission and specify, pursuant to s. 397.6795, the type of transportation assistance necessary.

Q. This question comes from one of our psychiatrists who is frustrated by our revolving door of alcoholics & addicts. Our rural community hospital has a CSU & Detox and there's very little treatment and referral options. His question is – can he Marchman Act a revolving door patient to long term treatment? I thought only family members usually did this and it was a court process & since we aren't a

Marchman Act receiving facility, they wouldn't be able to stay here...etc etc. Is this correct?

There are multiple ways of initiating an involuntary admission under the Marchman Act:

1. Protective Custody by law enforcement
2. Emergency Admission by an array of folks but it requires a physician's certificate
3. Alternative method for parents of minors to a juvenile addiction receiving facility (you don't have one in the Keys)
4. Court order (ex parte or scheduled hearing)

Licensed hospitals are exempt from licensing as substance abuse providers, but are subject to the federal EMTALA law that defines a substance abuse emergency as an emergency medical condition. A hospital would have to accept the person and perform the required medical screening exam. Once that emergency is over, EMTALA no longer applies.

In the situation your physician suggested, he can apply for the person's emergency admission as well as being the certifying physician. This allows for the assessment to be done and then you can file a petition with the court for involuntary treatment that could potentially result in a court order of up to 60 days of treatment.

397.675 Criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment.

A person meets the criteria for involuntary admission if there is good faith reason to believe the person is substance abuse impaired and, because of such impairment:

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

397.679 Emergency admission; circumstances justifying.

A person who meets the criteria for involuntary admission in s. 397.675 may be admitted to a hospital or to a licensed detoxification facility or addictions receiving facility for emergency assessment and stabilization, or to a less intensive component of a licensed service provider for assessment only, upon receipt by the facility of the physician's certificate and the completion of an application for emergency admission.

397.6791 Emergency admission; persons who may initiate.

The following persons may request an emergency admission:

- (1) In the case of an adult, **the certifying physician**, the person's spouse or guardian, any relative of the person, or any other responsible adult who has personal knowledge of the person's substance abuse impairment.
- (2) In the case of a minor, the minor's parent, legal guardian, or legal custodian.

397.6793 Physician's certificate for emergency admission.

- (1) The physician's certificate must include the name of the person to be admitted, the relationship between the person and the physician, the relationship between the applicant and the physician, any relationship between the physician and the licensed service provider, and a statement that the person has been examined and assessed within 5 days of the application date, and must include factual allegations with respect to the need for emergency admission, including:
- (a) The reason for the physician's belief that the person is substance abuse impaired; and
- (b) The reason for the physician's belief that because of such impairment the person has lost the power of self-control with respect to substance abuse; and either
- (c) 1. The reason the physician believes that the person has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or
2. The reason the physician believes that the person's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the person is incapable of appreciating his or her need for care and of making a rational decision regarding his or her need for care.
- (2) The physician's certificate must recommend the least restrictive type of service that is appropriate for the person. The certificate must be signed by the physician.
- (3) A signed copy of the physician's certificate shall accompany the person, and shall be made a part of the person's clinical record, together with a signed copy of the application. The application and physician's certificate authorize the involuntary admission of the person pursuant to, and subject to the provisions of ss. 397.679-397.6797.
- (4) The physician's certificate must indicate whether the person requires transportation assistance for delivery for emergency admission and specify, pursuant to s. 397.6795, the type of transportation assistance necessary.

397.6795 Transportation-assisted delivery of persons for emergency assessment.

An applicant for a person's emergency admission, or the person's spouse or guardian, a law enforcement officer, or a health officer may deliver a person named in the physician's certificate for emergency admission **to a hospital or a licensed detoxification facility or addictions receiving facility for emergency assessment and stabilization.**

397.6797 Dispositional alternatives after emergency admission.

Within 72 hours after an emergency admission to a hospital or a licensed detoxification or addictions receiving facility, the individual must be assessed by the attending physician to determine the need for further services. Within 5 days after an emergency admission to a nonresidential component of a licensed service provider, the individual must be assessed by a qualified professional to determine the need for further services. Based upon that assessment, a qualified

professional of the hospital, detoxification facility, or addictions receiving facility, or a qualified professional if a less restrictive component was used, must either:

- (1) Release the individual and, where appropriate, refer the individual to other needed services; or
- (2) Retain the individual when:
 - (a) The individual has consented to remain voluntarily at the licensed provider; or
 - (b) A petition for involuntary assessment or treatment has been initiated, the timely filing of which authorizes the service provider to retain physical custody of the individual pending further order of the court.

397.693 Involuntary treatment.

A person may be the subject of a petition for court-ordered involuntary treatment pursuant to this part, if that person meets the criteria for involuntary admission provided in s. 397.675 and:

- (1) Has been placed under protective custody pursuant to s. 397.677 within the previous 10 days;

- (2) Has been subject to an emergency admission pursuant to s. 397.679 within the previous 10 days;**

- (3) Has been assessed by a qualified professional within 5 days;

- (4) Has been subject to involuntary assessment and stabilization pursuant to s. 397.6818 within the previous 12 days; or

- (5) Has been subject to alternative involuntary admission pursuant to s. 397.6822 within the previous 12 days.

397.695 Involuntary treatment; persons who may petition.

- (1) If the respondent is an adult, a petition for involuntary treatment may be filed by the respondent's spouse or guardian, any relative, **a service provider**, or any three adults who have personal knowledge of the respondent's substance abuse impairment and his or her prior course of assessment and treatment.

- (2) If the respondent is a minor, a petition for involuntary treatment may be filed by a parent, legal guardian, or service provider.

397.6951 Contents of petition for involuntary treatment.

A petition for involuntary treatment must contain the name of the respondent to be admitted; the name of the petitioner or petitioners; the relationship between the respondent and the petitioner; the name of the respondent's attorney, if known, and a statement of the petitioner's knowledge of the respondent's ability to afford an attorney; the findings and recommendations of the assessment performed by the qualified professional; and the factual allegations presented by the petitioner establishing the need for involuntary treatment, including:

- (1) The reason for the petitioner's belief that the respondent is substance abuse impaired; and

- (2) The reason for the petitioner's belief that because of such impairment the respondent has lost the power of self-control with respect to substance abuse; and either

- (3)(a) The reason the petitioner believes that the respondent has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or

- (b) The reason the petitioner believes that the respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.

397.6955 Duties of court upon filing of petition for involuntary treatment.

Upon the filing of a petition for the involuntary treatment of a substance abuse impaired person with the clerk of the court, the court shall immediately determine whether the respondent is represented by an attorney or whether the appointment of counsel for the respondent is appropriate. The court shall schedule a hearing to be held on the petition within 10 days. A copy of the petition and notice of the hearing must be provided to the respondent; the respondent's parent, guardian, or legal custodian, in the case of a minor; the respondent's attorney, if known; the petitioner; the respondent's spouse or guardian, if applicable; and such other persons as the court may direct, and have such petition and order personally delivered to the respondent if he or she is a minor. The court shall also issue a summons to the person whose admission is sought.

397.6957 Hearing on petition for involuntary treatment.

(1)At a hearing on a petition for involuntary treatment, the court shall hear and review all relevant evidence, including the review of results of the assessment completed by the qualified professional in connection with the respondent's protective custody, emergency admission, involuntary assessment, or alternative involuntary admission. The respondent must be present unless the court finds that his or her presence is likely to be injurious to himself or herself or others, in which event the court must appoint a guardian advocate to act in behalf of the respondent throughout the proceedings.

(2)The petitioner has the burden of proving by clear and convincing evidence:

(a)The respondent is substance abuse impaired, and

(b)Because of such impairment the respondent has lost the power of self-control with respect to substance abuse; and either

1.The respondent has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or

2.The respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.

(3)At the conclusion of the hearing the court shall either dismiss the petition or order the respondent to undergo involuntary substance abuse treatment, with the respondent's chosen licensed service provider to deliver the involuntary substance abuse treatment where possible and appropriate.

397.697 Court determination; effect of court order for involuntary substance abuse treatment.

(1)When the court finds that the conditions for involuntary substance abuse treatment have been proved by clear and convincing evidence, it may order the respondent to undergo involuntary treatment by a licensed service provider for a period not to exceed 60 days. If the court finds it necessary, it may direct the sheriff to take the respondent into custody and deliver him or her to the licensed service provider specified in the court order, or to the nearest appropriate licensed service provider, for involuntary treatment. When the conditions justifying involuntary treatment no longer exist, the individual must be released as provided in s. 397.6971. When the conditions justifying involuntary treatment are expected to exist after 60 days of treatment, a renewal of the involuntary

treatment order may be requested pursuant to s. 397.6975 prior to the end of the 60-day period.

(2) In all cases resulting in an order for involuntary substance abuse treatment, the court shall retain jurisdiction over the case and the parties for the entry of such further orders as the circumstances may require. The court's requirements for notification of proposed release must be included in the original treatment order.

(3) An involuntary treatment order authorizes the licensed service provider to require the individual to undergo such treatment as will benefit him or her, including treatment at any licensable service component of a licensed service provider.

The biggest issue here is that no drug treatment program is required to accept a person if it doesn't think the person meets the criteria, or that it isn't the least restrictive and most appropriate setting, would cause the program to go over census, that it can't meet the medical and behavioral needs of the person or if the person cannot pay for care. If the provider has vacancies fully funded by state DCF appropriated dollars, it can't discriminate based on inability to pay. The lack of secure drug treatment facilities and the lack of funded residential treatment programs are the biggest barriers to arranging care.

Q. I'm an ER nurse. Can a patient be Baker Acted over a Marchman Act? If a patient is sent from one facility to a hospital for medical clearance, is pregnant, abusing heroin, has been medically cleared and was then Baker Acted-Certificate of Professional was completed - is that legal? We are not a Marchman Act facility but her medical state was the concern and thus she was sent to our ER. The facility that sent her will not accept patients on heroin due to withdrawal concerns and I don't think they take pregnant patients either, so now, they want to admit her to our unit.

There is no legal prohibition against instituting a Baker Act involuntary examination after a Marchman Act involuntary admission has been first instituted. While this is an unusual practice, a circuit court in the Gainesville area ruled that such a practice didn't constitute "false imprisonment" even when the time the individual was detained exceeded a total of 72 hours for sequential examinations under the two laws.

Both the Baker Act and the Marchman Act permit a judge to switch from one law to the other if, at the time of a hearing, it appears the basis of an individual's problems are different than had been initially thought.

It is very typical for an individual to experience co-existing diagnoses of mental illness and substance abuse impairment and it isn't always easy to determine which is the primary diagnosis. Once an individual is in a facility with experienced clinicians, a proper diagnosis can more often be identified -- it may well be different than the one first noted.

Q. Our addiction director states It may be a violation to send a patient from one ED to another ED even if a Marchman Act is in place without stabilizing the patient first. When I asked him further if he meant a patient needing detoxification was not stable, he answered "yes--they can die in the process." Would you comment

on whether a patient needing detoxification may be transferred under the Marchman Act? We do have an inpatient unit with licensed substance abuse beds, but what if they were full or the patient was indigent? (We do accept no-pays, but I want to pose the question anyway.)

Your Addiction's Director is correct. If a person is in a life-threatening medical condition due to withdrawal from substances, this isn't really a Marchman Act situation. It is handled under the medical consent laws of Florida and the federal EMTALA law. This could be anything from overdose, withdrawal, or various conditions of the liver, stomach, esophagus, CNS, and other organs affected by the substances.

Once the imminent medical conditions are stabilized and a transfer of a person for the purpose of substance abuse treatment is considered appropriate, the Marchman Act should be considered. Non-hospital detoxification programs are prepared to handle simple intoxication that aren't exacerbated by medical complications.

With regard to hypothetical questions involving capacity and indigency, you'd be required to go over census for an indigent patient if you have ever done so for a non-indigent patient. You would also have to admit a person if you couldn't locate a willing hospital with the capability and capacity to serve the patient, even if the patient was indigent. It would probably be to a med/surg bed in the hospital rather than to the specific addictions unit.

Q. If law enforcement has initiated a Marchman Act (protective custody) and persons are brought to the ER for medical attention, what is the scope of our authority to "detain" or restrain patients if necessary to ensure that they are safe and receive appropriate care. Our officers are Proprietary Security Officers (Non-Sworn), employed full-time by the hospital. As such, we can detain perpetrators of violent crimes until the arrival of law enforcement, and have as a normal operating procedure, participated in the detention of Baker Act patients at our facility. We do not have arrest authority. Our question goes to Marchman Act Patients, and our right or authority to detain them for their own (or public) safety.

There are two issues here – State Marchman Act and federal EMTALA law.

Under the Marchman Act **involuntary admission** provisions, a law enforcement officer can initiate protective custody or a physician can initiate emergency admission if there is good faith reason to believe person is substance abuse impaired and because of the impairment:

- Has lost power of self-control over substance use; **and either**:
- Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on self or others, **or**
- Is in need of substance abuse services and, by reason of substance abuse impairment, his/her judgment has been so impaired the person is incapable of appreciating the need for services and of making a rational decision in regard thereto. (Mere refusal to receive services is not evidence of lack of judgment)

You can keep the person until:

- The 72-hour period has elapsed;

- Client no longer meets the involuntary admission criteria, or
- Client has consented to remain voluntarily, or
- Petition for involuntary assessment or treatment has been initiated. Timely filing of petition authorizes retention of client pending further order of the court.

As long as the person meets criteria for involuntary admission, you can keep him up to 72 hours. The person can be released by a “qualified professional”, including any physician licensed under 458 or 459.

With regard to EMTALA, a substance abuse emergency is considered equal to any other emergency medical condition and the hospital must perform all its duties for medical screening and stabilization, as well as arranging for an appropriate transfer if it doesn’t have the capability/capacity to manage the person’s condition.

There is no reason why security officers trained and authorized by your facility can’t detain persons against their will under Marchman Act involuntary admission status – that’s why they call it involuntary. There shouldn’t be any risk of “false imprisonment” in following state and federal law. There should be no difference in your rights between the managing of Marchman Act patients from the Baker Act patients under the state’s protective laws or the federal EMTALA law.

These protective laws are based on the premise that these patients aren’t capable of making well-reasoned decisions at the time and staff of the facilities must do what is necessary to maintain their safety. Sometimes it comes down to a weighing of facility liability for battery/false imprisonment in retaining a patient against the liability for a wrongful death if the person gets away from you. The hospital staff should document the risk the patient represents and use the least restrictive intervention as the circumstances permit.

Your staff has a significant duty under the federal EMTALA to retain the patient until either the required medical screening can be performed or a doctor determines that the person is competent to refuse the screening. If found to have an emergency medical condition, include an emergency psychiatric or substance abuse condition, the patient can’t be released or transferred until stabilized.

Q. Can an emergency admitted Marchman Act patient leave AMA? Do we need to call the police? This is the only thing I could find in the statute. Thanks.

The Marchman Act permits a person to be held against their will for up to 72 hours if under the Emergency admission provisions of the Marchman Act. This means that they don’t have the right to leave AMA if your physician believes the person still meets the involuntary admission criteria specified in the Marchman Act.

The 72-hour period is a maximum period – the provisions of law you’ve cited in your question clearly indicate that once the criteria no longer exist, the person could then request an AMA discharge even if not in his/her best interest.

Use of restraints to prevent elopements can only be used by a hospital if consistent with Conditions of Participation for behavioral restraints -- including imminent risk. However,

the hospital staff must always measure the risk of a wrongful death suit against the risk of an allegation of false imprisonment or a regulatory citation. Most attorneys and risk managers would prefer the latter to the former, especially if clinical staff had clearly documented the danger presented by the patient and why less restrictive alternatives had been considered but rejected.

You do need to ensure that patients aren't able to exit your hospital until a physician has documented that they are competent to refuse the medical screening examination required by EMTLA and, if found to have a psychiatric or substance abuse emergency (this is an emergency medical condition), that they not be able to leave until stabilized.

Hospitals have not always taken sufficient advantage of health care proxies for persons determined by a physician to lack capacity to make treatment decisions. In such cases, the proxy can consent to a treatment plan, including psychotropic medications, even in an ED situation. Of course, not everyone will have a surrogate or proxy available in person or by phone to make such decisions. In those cases, emergency treatment orders for medication may be required under certain danger situation; possible mechanical restraints might also be justified. In any case, the federal CMS conditions of participation and JCAHO standards will probably apply to your hospital.

In a worse case scenario where a person who clearly meets the criteria for emergency admission under the Marchman Act elopes from your facility, a call to your local law enforcement agency would be entirely appropriate.

It is suggested that you work with your risk manager and with your hospital attorney to weigh the risks vs. the benefits of various alternatives for ensuring the safety of your patients. There isn't an absolute answer on this issue because each situation is different, requiring a different set of alternatives to ensure the safety of patients.

Q. I am researching the process for involuntary admission for patients who are a danger to themselves due to substance abuse issues. We are investigating MD alternatives in managing emergency room patients who are not expressing suicidal ideation and plan, however present too acutely intoxicated to leave the ED safely, and try to walk out. I have reviewed the Florida Statutes Title XXIX, Chapter 397 Substance Abuse Services, C. Non-court Involved Emergency Admissions, and found a Marchman Act Power Point and Guide online which seem to be very informative.

<http://www.dcf.state.fl.us/mentalhealth/marchman/index.shtml>

Would you suggest any specific information on how we might use this information to establish a new way of managing these patients while maintaining ethical and legal guidelines for using the Marchman Act in our emergency room? Is there another resource I might use that would prove more useful?

You and your hospital for attempting to intervene in the lives of persons with addiction issues—it's good that you're using the DCF website for reference materials and found the PowerPoint Presentation to be helpful.

As you've found, a physician can be both the applicant for a person's emergency admission as well as the certifying physician if the person meets the involuntary admission criteria. These forms are found in the Marchman Act User Reference Guide

at the website pages 259-262 and Appendix E governs Emergency Substance Abuse Admissions and Persons with Emergency Medical Conditions (pages 78-87).

397.675 Criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment.--A person meets the criteria for involuntary admission if there is good faith reason to believe the person is substance abuse impaired and, because of such impairment:

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

The Marchman Act doesn't authorize provision of medical care – you have to look to the medical consent statute or s.401, FS.

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.

The DCF website is the comprehensive site for information about the Marchman Act.

Q. Our frustration with the Marchman Act is our impression (maybe incorrect) that the family had to go to Probate Court to sign a petition, perhaps for an ex-parte order. I learned this week that our sister hospital, has drafted a policy for Marchman Act in the Emergency Department. There is an associated form for the physician to complete. The implication is that after the physician completes the form, the patient can be sent to a substance abuse facility. That leads to questions as to what facilities would take a patient in these circumstances. Would they have to be a locked facility? Are we able to place a Marchman Act patient on the strength of the ED doctor's form?

There are multiple ways for an involuntary admission to be initiated other than by court order. A law enforcement officer can initiate protective custody (home, hospital, detox, addiction receiving facility or jail) and a parent can initiate assessment/stabilization of a minor child at a juvenile addiction receiving facility (locked facility). A number of folks are eligible to apply for an emergency admission as long as a physician has executed a certificate containing certain information. It is this option that your ER physicians would probably want to pursue. This section of the law is as follows:

397.679 Emergency admission; circumstances justifying.--A person who meets the criteria for involuntary admission in s. 397.675 may be admitted to a hospital or to a licensed detoxification facility or addictions receiving facility for emergency assessment and stabilization, or to a less intensive component of a licensed service provider for assessment only, upon receipt by the facility of the physician's certificate and the completion of an application for emergency admission.

397.6791 Emergency admission; persons who may initiate.--The following persons may request an emergency admission:

(1) In the case of an adult, the certifying physician, the person's spouse or guardian, any relative of the person, or any other responsible adult who has personal knowledge of the person's substance abuse impairment.

(2) In the case of a minor, the minor's parent, legal guardian, or legal custodian.

397.6793 Physician's certificate for emergency admission.--

(1) The physician's certificate must include the name of the person to be admitted, the relationship between the person and the physician, the relationship between the applicant and the physician, any relationship between the physician and the licensed service provider, and a statement that the person has been examined and assessed within 5 days of the application date, and must include factual allegations with respect to the need for emergency admission, including:

(a) The reason for the physician's belief that the person is substance abuse impaired; and

(b) The reason for the physician's belief that because of such impairment the person has lost the power of self-control with respect to substance abuse; and either

(c)1. The reason the physician believes that the person has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or

2. The reason the physician believes that the person's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the person is incapable of appreciating his or her need for care and of making a rational decision regarding his or her need for care.

(2) The physician's certificate must recommend the least restrictive type of service that is appropriate for the person. The certificate must be signed by the physician.

(3) A signed copy of the physician's certificate shall accompany the person, and shall be made a part of the person's clinical record, together with a signed copy of the application. The application and physician's certificate authorize the involuntary admission of the person pursuant to, and subject to the provisions of ss. 397.679-397.6797.

(4) The physician's certificate must indicate whether the person requires transportation assistance for delivery for emergency admission and specify, pursuant to s. 397.6795, the type of transportation assistance necessary.

397.6795 Transportation-assisted delivery of persons for emergency assessment.--An applicant for a person's emergency admission, or the person's spouse or guardian, a law enforcement officer, or a health officer may deliver a person named in the physician's certificate for emergency admission to a hospital or a licensed detoxification facility or addictions receiving facility for emergency assessment and stabilization.

397.6797 Dispositional alternatives after emergency admission.--Within 72 hours after an emergency admission to a hospital or a licensed detoxification or addictions receiving facility, the client must be assessed by the attending physician to determine the need for further services. Within 5 days after an emergency admission to a nonresidential component of a licensed service provider, the client must be assessed by a qualified professional to determine the need for further services. Based upon that assessment, a qualified professional of the hospital, detoxification facility, or addictions receiving facility, or a qualified professional if a less restrictive component was used, must either:

(1) Release the client and, where appropriate, refer the client to other needed services; or

(2) Retain the client when:

- (a) The client has consented to remain voluntarily at the licensed provider; or
- (b) A petition for involuntary assessment or treatment has been initiated, the timely filing of which authorizes the service provider to retain physical custody of the client pending further order of the court.

An addiction receiving facility (ARF) is locked, but a detox facility is not. Either is acceptable for involuntary admission under the Marchman Act other than when a parent/guardian initiates the Alternative Involuntary Assessment which must be to a Juvenile ARF.

The only problem is that a licensed substance abuse provider (other than another hospital under EMTALA) isn't required to accept the transfer of the patient from your hospital if any of a number of circumstances exist, as follows:

397.6751 Service provider responsibilities regarding involuntary admissions.--

- (1) It is the responsibility of the service provider to:
 - (a) Ensure that a person who is admitted to a licensed service component meets the admission criteria specified in s. 397.675;
 - (b) Ascertain whether the medical and behavioral conditions of the person, as presented, are beyond the safe management capabilities of the service provider;
 - (c) Provide for the admission of the person to the service component that represents the least restrictive available setting that is responsive to the person's treatment needs;
 - (d) Verify that the admission of the person to the service component does not result in a census in excess of its licensed service capacity;
 - (e) Determine whether the cost of services is within the financial means of the person or those who are financially responsible for the person's care; and
 - (f) Take all necessary measures to ensure that each client in treatment is provided with a safe environment, and to ensure that each client whose medical condition or behavioral problem becomes such that he or she cannot be safely managed by the service component is discharged and referred to a more appropriate setting for care.
- (2)(a) When, in the judgment of the service provider, the person who is being presented for involuntary admission should not be admitted because of his or her failure to meet admission criteria, because his or her medical or behavioral conditions are beyond the safe management capabilities of the service provider, or because of a lack of available space, services, or financial resources to pay for his or her care, the service provider, in accordance with federal confidentiality regulations, must attempt to contact the referral source, which may be a law enforcement officer, physician, parent, legal guardian if applicable, court and petitioner, or other referring party, to discuss the circumstances and assist in arranging for alternative interventions.
- (b) When the service provider is unable to reach the referral source, the service provider must refuse admission and attempt to assist the person in gaining access to other appropriate services, if indicated.
- (c) Upon completing these efforts, the service provider must, within one workday, report in writing to the referral sources, in compliance with federal confidentiality regulations:
 - 1. The basis for the refusal to admit the person, and

2. Documentation of the service provider's efforts to contact the referral source and assist the person, when indicated, in gaining access to more appropriate services.

(3) When, in the judgment of the service provider, the medical conditions or behavioral problems of an involuntary client become such that they cannot be safely managed by the service component, the service provider must discharge the client and attempt to assist him or her in securing more appropriate services in a setting more responsive to his or her needs. Upon completing these efforts, the service provider must, within 72 hours, report in writing to the referral source, in compliance with federal confidentiality regulations:

- (a) The basis for the client's discharge, and
- (b) Documentation of the service provider's efforts to assist the person in gaining access to appropriate services.

The model forms for the emergency admission application and physician's certificate are posted on the DCF website. These are recommended rather than mandatory forms so you are free to improve on them as long as the forms you come up with comply with the law. The DCF website has extensive information about the Marchman Act including the 2003 Marchman Act User Reference Guide (300+ pages). The website is at:

www.dcf.state.fl.us/mental_health/sa

Click on Marchman Act. Contents include:

2003 Marchman Act User Reference Guide includes among other issues:

- Statute & Rules
- History & Overview
- Marchman Act Model Forms
- Law Enforcement and Protective Custody
- Quick Reference Guide for Involuntary Provisions
- Flow Charts for Involuntary Provisions
- Admission & Treatment of Minors
- Where to Go for Help
- Marchman Act Pamphlet
- Substance Abuse Program Standards
- Common Licensing Standards
- Marchman Act PowerPoint Training Presentation

Q. If we cannot place a Marchman Act patient within 72 hours after medical clearance, do we have to release them since our hospitals are NON Marchman receiving facilities or do we have some strange responsibility because we are Baker Act Receiving facilities? Or is there a process to hold them longer if we cannot find placement? We are not sure of the process.

The hospital can initiate an emergency admission under the Marchman Act [397.679, FS]. As you can see below, you have only 72 hours to hold the person for examination. Within that time you either have to release the person, convert to voluntary, or file a petition with the court. See sections highlighted in yellow below:

397.679 Emergency admission; **circumstances justifying.**--A person who meets the criteria for involuntary admission in s. 397.675 may be admitted to a hospital or to a licensed detoxification facility or addictions receiving facility for

emergency assessment and stabilization, or to a less intensive component of a licensed service provider for assessment only, upon receipt by the facility of the physician's certificate and the completion of an application for emergency admission.

397.6791 Emergency admission; persons who may initiate.--The following persons may request an emergency admission:

- (1) In the case of an adult, the certifying physician, the person's spouse or guardian, any relative of the person, or any other responsible adult who has personal knowledge of the person's substance abuse impairment.
- (2) In the case of a minor, the minor's parent, legal guardian, or legal custodian.

397.6793 Physician's certificate for emergency admission.--

(1) The physician's certificate must include the name of the person to be admitted, the relationship between the person and the physician, the relationship between the applicant and the physician, any relationship between the physician and the licensed service provider, and a statement that the person has been examined and assessed within 5 days of the application date, and must include factual allegations with respect to the need for emergency admission, including:

- (a) The reason for the physician's belief that the person is substance abuse impaired; and
- (b) The reason for the physician's belief that because of such impairment the person has lost the power of self-control with respect to substance abuse; and either
 - (c)1. The reason the physician believes that the person has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or
 2. The reason the physician believes that the person's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the person is incapable of appreciating his or her need for care and of making a rational decision regarding his or her need for care.

(2) The physician's certificate must recommend the least restrictive type of service that is appropriate for the person. The certificate must be signed by the physician.

(3) A signed copy of the physician's certificate shall accompany the person, and shall be made a part of the person's clinical record, together with a signed copy of the application. The application and physician's certificate authorize the involuntary admission of the person pursuant to, and subject to the provisions of ss. 397.679-397.6797.

(4) The physician's certificate must indicate whether the person requires transportation assistance for delivery for emergency admission and specify, pursuant to s. 397.6795, the type of transportation assistance necessary.

397.6795 Transportation-assisted delivery of persons for emergency assessment.--An applicant for a person's emergency admission, or the person's spouse or guardian, a law enforcement officer, or a health officer may deliver a person named in the physician's certificate for emergency admission to a hospital or a licensed detoxification facility or addictions receiving facility for emergency assessment and stabilization.

397.6797 Dispositional alternatives after emergency admission.--Within 72 hours after an emergency admission to a hospital or a licensed detoxification or

addictions receiving facility, the client must be assessed by the attending physician to determine the need for further services. Within 5 days after an emergency admission to a nonresidential component of a licensed service provider, the client must be assessed by a qualified professional to determine the need for further services. Based upon that assessment, a qualified professional of the hospital, detoxification facility, or addictions receiving facility, or a qualified professional if a less restrictive component was used, must either:

- (1) Release the client and, where appropriate, refer the client to other needed services; or
- (2) Retain the client when:
 - (a) The client has consented to remain voluntarily at the licensed provider; or
 - (b) A petition for involuntary assessment or treatment has been initiated, the timely filing of which authorizes the service provider to retain physical custody of the client pending further order of the court.

Since you are a Baker Act receiving facility, if the person had a co-occurring psychiatric disorder and otherwise met the criteria for involuntary inpatient treatment, you could have filed a BA-32 petition with the court. There is no provision under the Baker or Marchman Act to hold the person longer than 72 hours for examination without involving the court. This time period doesn't stop for a medical emergency. If you attempted to refer the person to a licensed substance abuse treatment program within the 72 hour examination period and if none of the local facilities had the capability or capacity to manage the person's condition and the person no longer had an emergency medical condition, you would have had to release him.

Alternative Involuntary Admission for Minors

Q. I have a parent whose adolescent who is abusing substances; she is in desperate need of help. How can she get the paperwork to start the process of the Marchman Act? Where does she need to go here in our County?

You or the parent should contact the DCF Circuit Office in your county to find out what licensed service providers are available for this family. In the meantime, the Mom can initiate an involuntary assessment and stabilization of her minor child or can petition the court to order the adolescent's assessment. The sections from the Marchman Act are incorporated below:

397.675 Criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and **alternative involuntary assessment for minors**, for purposes of assessment and stabilization, and for involuntary treatment.--A person meets the criteria for involuntary admission if there is good faith reason to believe the person is substance abuse impaired and, because of such impairment:

- (1) Has lost the power of self-control with respect to substance use; and either
- (2)(a) Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; or
- (b) Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto; however, mere refusal to receive such

services does not constitute evidence of lack of judgment with respect to his or her need for such services.

397.6759 Parental participation in treatment.--A parent, legal guardian, or legal custodian who seeks involuntary admission of a minor pursuant to ss. 397.675-397.6977 is required to participate in all aspects of treatment as determined appropriate by the director of the licensed service provider.

397.6798 Alternative involuntary assessment procedure for minors.--

(1) In addition to protective custody, emergency admission, and involuntary assessment and stabilization, an **addictions receiving facility may admit a minor for involuntary assessment and stabilization upon the filing of an application to an addictions receiving facility by the minor's parent, guardian, or legal custodian.** The application must establish the need for involuntary assessment and stabilization based on the criteria for involuntary admission in s. 397.675. **Within 72 hours after involuntary admission of a minor, the minor must be assessed to determine the need for further services. Assessments must be performed by a qualified professional. If, after the 72-hour period, it is determined by the attending physician that further services are necessary, the minor may be kept for a period of up to 5 days, inclusive of the 72-hour period.**

(2) An application for alternative involuntary assessment for a minor must establish the need for immediate involuntary admission and contain the name of the minor to be admitted, the name and signature of the applicant, the relationship between the minor to be admitted and the applicant, and factual allegations with respect to:

- (a) The reason for the applicant's belief that the minor is substance abuse impaired; and
- (b) The reason for the applicant's belief that because of such impairment the minor has lost the power of self-control with respect to substance abuse; and either
 - (c)1. The reason the applicant believes that the minor has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or
 - 2. The reason the applicant believes that the minor's refusal to voluntarily receive substance abuse services is based on judgment so impaired by reason of substance abuse that he or she is incapable of appreciating his or her need for such services and of making a rational decision regarding his or her need for services.

397.6799 Disposition of minor client upon completion of alternative involuntary assessment.--A minor who has been assessed pursuant to s. 397.6798 must, within the time specified, be released or referred for further voluntary or involuntary treatment, whichever is most appropriate to the needs of the minor.

Two forms – one is for the parent to apply for the child's admission to a Juvenile Addiction Receiving Facility (a specialty secured facility if one is available) – although the facility may have modified this form. The other is for the parent to file with the court. If the court route is used, this form may be a guide for the parent, but a modified one may actually be used by the court. In any case, a licensed service provider isn't required to accept a person for assessment or treatment if staff doesn't believe the provider's admission criteria is met.

Court-Involved Involuntary Admission & Involuntary Treatment

Q. My husband is an alcoholic. If the magistrate agrees he needs help, how long is he detained? How is the treatment facility chosen? Who pays for the treatment?

A person can be court ordered for Involuntary Assessment and Stabilization for up to 5 days at a licensed substance abuse provider. If the provider isn't able to complete the assessment within the 5 days, it can file a written request for an extension of time to complete its assessment and the court may grant additional time, not to exceed 7 days after the date of the renewal order, for the completion of the involuntary assessment and stabilization of the client. If, depending on the outcome of the assessment, the court finds the person meets the criteria for involuntary Treatment, he/she can be ordered to treatment for a period of up to 60 days.

Generally, the person who files the petition for assessment or for treatment is responsible for identifying a licensed substance abuse provider agency to which the person can be ordered. The provider must agree that the person meets the criteria for admission prior to the court ordering the treatment. The provider will only approve if:

- The person is substance abuse impaired
- It is the least restrictive and most appropriate setting. Most persons with alcoholism receive their treatment on an outpatient basis.
- There is space available in the program
- The person's medical & behavioral condition can be safely managed
- It is within financial means of person to pay for the care

If the substance abuse provider is private, it is the obligation of the person or his/her family to pay for care from health insurance or private payment. If the substance abuse provider has a contract with the state DCF, it may also require payment for cost of care on a sliding scale based on a family's ability to pay. There are usually waiting lists for admission to publicly funded providers.

Q. While a resident was at our SRT, the doctor filed a petition for involuntary treatment under the Marchman Act and an order for up to 60 days was entered by the circuit court. However, no bed has been available in the substance program for him. Does the Baker Act expire when a Marchman Act is granted by the Court?

Generally, the Baker and Marchman laws are considered mutually exclusive since substance abuse is specifically excluded under the Baker Act definition of mental illness. Chapter 394.467(6)(c), FS states

If at any time prior to the conclusion of the hearing on involuntary inpatient placement it appears to the court that the person does not meet the criteria for involuntary inpatient placement under this section, but instead meets the criteria for involuntary outpatient placement, the court may order the person evaluated

for involuntary outpatient placement pursuant to s. 394.4655. The petition and hearing procedures set forth in s. 394.4655 shall apply. If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to s. 397.675, then the court may order the person to be admitted for involuntary assessment for a period of 5 days pursuant to s. 397.6811. Thereafter, all proceedings shall be governed by chapter 397.

Based on the appellate court case below, the Marchman Act order is still in force and will remain so until the man actually undergoes the 60 days of involuntary substance abuse treatment ordered by the court

S.M.F. v. Needle, 757 So. 2d 1265 (Palm Beach County 2000). The circuit court granted a petition for involuntary substance abuse treatment for a minor in response to a petition filed by her parent. The order was for 60 days of involuntary treatment, the maximum period permitted under law, commencing upon her admission to the facility. However, the minor ran away prior to commencing treatment and was returned to the program after the initial court order had expired. She filed a petition for a writ of habeas corpus arguing that she was entitled to immediate release because the law provides that “at the conclusion of the 60-day period of court-ordered involuntary treatment, the client is automatically discharged unless a motion for renewal of the involuntary treatment order has been filed with the court...” The Fourth District Court of Appeals decided that the original court order for 60 days of court ordered involuntary treatment was not merely 60-days after the entry of the order for treatment and that the 60-day period contemplated by the Marchman Act did not expire, because the petitioner ran away before commencing treatment. The petition for writ of habeas corpus was denied.

Q. We currently have an adult under a Marchman Act Involuntary Court Order for Treatment and we are petitioning for an extension. The County’s Marchman Act Court is stating that the initial 60 days of treatment begins the date of the court order, and not the date of admission to our hospital. The patient eluded pick up by the Sherriff's office for several weeks, and the court is telling us that that time still counted toward the 60 days. I can't find any language specific to when the 60 days begins (i.e., from the order or from time of admission into the program).

While the statute isn’t clear, the 4th District Court of Appeals determined that the 60 days begins with the first day of treatment, as follows:

S.M.F. v. Needle, 757 So. 2d 1265 (Palm Beach County 2000). The circuit court granted a petition for involuntary substance abuse treatment for a minor in response to a petition filed by her parent. The order was for 60 days of involuntary treatment, the maximum period permitted under law, commencing upon her admission to the facility. However, the minor ran away prior to commencing treatment and was returned to the program after the initial court order had expired. She filed a petition for a writ of habeas corpus arguing that she was entitled to immediate release because the law provides that “at the conclusion of the 60-day period of court-ordered involuntary treatment, the client is automatically discharged unless a motion for renewal of the involuntary treatment order has been filed with the court...” The Fourth District Court of

Appeals decided that the original court order for 60 days of court ordered involuntary treatment was not merely 60-days after the entry of the order for treatment and that the 60-day period contemplated by the Marchman Act did not expire, because the petitioner ran away before commencing treatment. The petition for writ of habeas corpus was denied.

This case is directly on point for the situation you describe. An appellate case has statewide applicability.

Q. Are there any Baker or Marchman Act appellate cases having to do with elopements after an order for involuntary placement has been entered?

There isn't any appellate case addressing elopements from facilities under the Baker Act. However, there is a Marchman case on point that is similar:

S.M.F. v. Needle, 757 So. 2d 1265 (Palm Beach County 2000). The circuit court granted a petition for involuntary substance abuse treatment for a minor in response to a petition filed by her parent. The order was for 60 days of involuntary treatment, the maximum period permitted under law, commencing upon her admission to the facility. However, the minor ran away prior to commencing treatment and was returned to the program after the initial court order had expired. She filed a petition for a writ of habeas corpus arguing that she was entitled to immediate release because the law provides that "at the conclusion of the 60-day period of court-ordered involuntary treatment, the client is automatically discharged unless a motion for renewal of the involuntary treatment order has been filed with the court..." The Fourth District Court of Appeals decided that the original court order for 60 days of court ordered involuntary treatment was not merely 60-days after the entry of the order for treatment and that the 60-day period contemplated by the Marchman Act did not expire, because the petitioner ran away before commencing treatment. The petition for writ of habeas corpus was denied.

Rights of Persons under the Marchman Act

Q. Chapter 397, FS (Marchman Act) requires that each person on involuntary status be represented by counsel "at every stage" in the proceeding. However, it doesn't designate what attorney is responsible for this representation as does the Baker Act. Who is responsible?

The Marchman Act includes the following provisions related to a person's right to counsel:

397.501 Rights of individuals.—

(8) RIGHT TO COUNSEL.--Each individual must be informed that he or she has the right to be represented by counsel in any involuntary proceeding for assessment, stabilization, or treatment and that he or she, or if the individual is a minor his or her parent, legal guardian, or legal custodian, may apply immediately to the court to have an attorney appointed if he or she cannot afford one.

397.681 Involuntary petitions; general provisions; court jurisdiction and right to counsel.--

(2) RIGHT TO COUNSEL.--A respondent has the right to counsel at every stage of a proceeding relating to a petition for his or her involuntary assessment and a petition for his or her involuntary treatment for substance abuse impairment. A respondent who desires counsel and is unable to afford private counsel has the right to court-appointed counsel and to the benefits of s. 57.081. If the court believes that the respondent needs the assistance of counsel, the court shall appoint such counsel for the respondent without regard to the respondent's wishes. If the respondent is a minor not otherwise represented in the proceeding, the court shall immediately appoint a guardian ad litem to act on the minor's behalf.

397.6955 Duties of court upon filing of petition for involuntary treatment.--Upon the filing of a petition for the involuntary treatment of a substance abuse impaired person with the clerk of the court, the court shall immediately determine whether the respondent is represented by an attorney or whether the appointment of counsel for the respondent is appropriate. The court shall schedule a hearing to be held on the petition within 10 days. A copy of the petition and notice of the hearing must be provided to the respondent; the respondent's parent, guardian, or legal custodian, in the case of a minor; the respondent's attorney, if known; the petitioner; the respondent's spouse or guardian, if applicable; and such other persons as the court may direct, and have such petition and order personally delivered to the respondent if he or she is a minor. The court shall also issue a summons to the person whose admission is sought.

The Office of Criminal Conflict and Civil Regional Counsel has primary responsibility for representing persons entitled to court-appointed counsel under the Marchman Act, as follows:

27.5304 Private court-appointed counsel; compensation.—

(7) Counsel entitled to receive compensation from the state for representation pursuant to court appointment in a proceeding under chapter 384, chapter 390, chapter 392, chapter 393, chapter 394, chapter 397, chapter 415, chapter 743, chapter 744, or chapter 984 shall receive compensation not to exceed the limits prescribed in the General Appropriations Act.

27.511 Offices of criminal conflict and civil regional counsel; legislative intent; qualifications; appointment; duties.-- 6)(a) Effective October 1, 2007, the office of criminal conflict and civil regional counsel has primary responsibility for representing persons entitled to court-appointed counsel under the Federal or State Constitution or as authorized by general law in civil proceedings, including, but not limited to, proceedings under s. 393.12 and chapters 39, 390, 392, 397, 415, 743, 744, and 984.

There are few appellate cases regarding the Marchman Act. However, the 2nd DCF had an interesting case, part of which addressed failure to advise the respondent of his right to counsel or to have counsel appointed for him. A summary of that opinion is below:

Steven Cole v. State of Florida. Case No. 98-01718 2nd DCA 1998. Appellate Judge Northcutt wrote the opinion with Appellate Judges Whatley and Altenbernd concurring. The Tenth Judicial Circuit court convicted Steven Cole of indirect criminal contempt for violating the court's order directing him to complete a program of treatment for substance abuse. The court sentenced Cole to serve 90 days in jail. Cole petitioned the 2nd DCA for a writ of habeas corpus and for other relief. The Second District Court of Appeals ordered his release, quashed his conviction and sentence for indirect criminal contempt, and prohibited the circuit court to enforce Cole's involuntary treatment order. The 2nd DCA based its decision on the failure to inform Cole of his right to counsel and that if could not afford an attorney, he could ask the court to appoint one to represent him. The Court noted that Cole was not given meaningful prior notice of the charges against him, the trial was not recorded as required by law, and the court order included directives and prohibitions that were beyond the judicial authority granted by the Marchman Act. Although the Act empowers the court to order a respondent's submission to involuntary substance abuse treatment and to enter such further orders as the circumstances may require, that authority does not extend to prescribing the specific modalities of the treatment. That authority is placed with the licensed service provider.

Q. I am with the Clerk of Court and have a question about the appointment of counsel for Marchman Act cases. The Court doesn't appoint counsel until a Petition for Involuntary Treatment is filed. At the point of the Ex Parte order for assessment/stabilization, counsel is not appointed. When does this application process occur...when the person arrives at the facility? There has been virtually no follow-up for these cases after the judge orders a person for examination. Our orders (we use the DCF recommended ones) do not contain any kind of provision for proof of compliance with the court order. The judge does not address this issue in the hearing. Unless the petitioner brings the noncompliance to the court's attention (via the State Attorney's office), there is no further activity on the case. It seems that the wind goes out of the sails once the hearing is over because it is up to the respondent to locate and pay for the treatment. Most petitioners believe that the court arranges for enrollment in a specific treatment program AND pays for it. Do you have an opinion in this respect?

With regard to appointment of counsel for the respondent, the Marchman Act has the following provisions:

397.501 Rights of clients.--Clients receiving substance abuse services from any service provider are guaranteed protection of the rights specified in this section, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

(8) RIGHT TO COUNSEL.--Each client must be informed that he or she has the right to be represented by counsel in any involuntary proceeding for assessment, stabilization, or treatment and that he or she, or if the client is a minor his or her parent, legal guardian, or legal custodian, may apply immediately to the court to have an attorney appointed if he or she cannot afford one.

397.681 Involuntary petitions; general provisions; court jurisdiction and right to counsel.--

(2) RIGHT TO COUNSEL.--A respondent has the right to counsel at every stage of a proceeding relating to a petition for his or her involuntary assessment and a petition for his or her involuntary treatment for substance abuse impairment. A respondent who desires counsel and is unable to afford private counsel has the right to court-appointed counsel and to the benefits of s. 57.081. If the court believes that the respondent needs the assistance of counsel, the court shall appoint such counsel for the respondent without regard to the respondent's wishes. If the respondent is a minor not otherwise represented in the proceeding, the court shall immediately appoint a guardian ad litem to act on the minor's behalf.

397.6814 Involuntary assessment and stabilization; contents of petition.--A petition for involuntary assessment and stabilization must contain the name of the respondent; the name of the applicant or applicants; the relationship between the respondent and the applicant; the name of the respondent's attorney, if known, and a statement of the respondent's ability to afford an attorney; and must state facts to support the need for involuntary assessment and stabilization, including:

397.6815 Involuntary assessment and stabilization; procedure.--Upon receipt and filing of the petition for the involuntary assessment and stabilization of a substance abuse impaired person by the clerk of the court, the court shall ascertain whether the respondent is represented by an attorney, and if not, whether, on the basis of the petition, an attorney should be appointed; and shall:

(1) Provide a copy of the petition and notice of hearing to the respondent; the respondent's parent, guardian, or legal custodian, in the case of a minor; the respondent's attorney, if known; the petitioner; the respondent's spouse or guardian, if applicable; and such other persons as the court may direct, and have such petition and notice personally delivered to the respondent if he or she is a minor. The court shall also issue a summons to the person whose admission is sought and conduct a hearing within 10 days; or

(2) Without the appointment of an attorney and, relying solely on the contents of the petition, enter an ex parte order authorizing the involuntary assessment and stabilization of the respondent. The court may order a law enforcement officer or other designated agent of the court to take the respondent into custody and deliver him or her to the nearest appropriate licensed service provider.

397.6818 Court determination.—

(2) If the court enters an order authorizing involuntary assessment and stabilization, the order shall include the court's findings with respect to the availability and appropriateness of the least restrictive alternatives and the need for the appointment of an attorney to represent the respondent, and may designate the specific licensed service provider to perform the involuntary assessment and stabilization of the respondent. The respondent may choose the licensed service provider to deliver the involuntary assessment where possible and appropriate.

(3) If the court finds it necessary, it may order the sheriff to take the respondent into custody and deliver him or her to the licensed service provider specified in the court order or, if none is specified, to the nearest appropriate licensed service provider for involuntary assessment.

397.6955 Duties of court upon filing of petition for involuntary treatment.--Upon the filing of a petition for the involuntary treatment of a substance abuse impaired person with the clerk of the court, the court shall immediately determine whether the respondent is represented by an attorney or whether the appointment of counsel for the respondent is appropriate. The court shall schedule a hearing to be held on the petition within 10 days. A copy of the petition and notice of the hearing must be provided to the respondent; the respondent's parent, guardian, or legal custodian, in the case of a minor; the respondent's attorney, if known; the petitioner; the respondent's spouse or guardian, if applicable; and such other persons as the court may direct, and have such petition and order personally delivered to the respondent if he or she is a minor. The court shall also issue a summons to the person whose admission is sought.

There is just one appellate case on this issue.

Steven Cole v. State of Florida. Case No. 98-01718 2nd DCA 1998. Appellate Judge Northcutt wrote the opinion with Appellate Judges Whatley and Altenbernd concurring. The Tenth Judicial Circuit court convicted Steven Cole of indirect criminal contempt for violating the court's order directing him to complete a program of treatment for substance abuse. The court sentenced Cole to serve 90 days in jail. Cole petitioned the 2nd DCA for a writ of habeas corpus and for other relief. The Second District Court of Appeals ordered his release, quashed his conviction and sentence for indirect criminal contempt, and prohibited the circuit court to enforce Cole's involuntary treatment order. The 2nd DCA based its decision on the failure to inform Cole of his right to counsel and that if could not afford an attorney, he could ask the court to appoint one to represent him. The Court noted that Cole was not given meaningful prior notice of the charges against him, the trial was not recorded as required by law, and the court order included directives and prohibitions that were beyond the judicial authority granted by the Marchman Act. Although the Act empowers the court to order a respondent's submission to involuntary substance abuse treatment and to enter such further orders as the circumstances may require, that authority does not extend to prescribing the specific modalities of the treatment. That authority is placed with the licensed service provider.

The Chief Judge of the 2nd DCA stated in the Cole case that:

"There appears to have been a systemic failure concerning the orderly implementation of the March Act. These circuit court judges may be, at least to some degree, responsible for that failure, but it doesn't not appear to me that they are the primary culprits. There is enough blame for Mr. Cole's difficulties to spread a thick coating across all branches and levels of government."

While the rights of persons under the Marchman Act refer to having access to an attorney at every stage of a proceeding, the Cole opinion specifically refers to the following:

397.6815 Involuntary assessment and stabilization; procedure.--Upon receipt and filing of the petition for the involuntary assessment and stabilization of a substance abuse impaired person by the clerk of the court, the court shall

ascertain whether the respondent is represented by an attorney, and if not, whether, on the basis of the petition, an attorney should be appointed; and shall:

(1) Provide a copy of the petition and notice of hearing to the respondent; the respondent's parent, guardian, or legal custodian, in the case of a minor; the respondent's attorney, if known; the petitioner; the respondent's spouse or guardian, if applicable; and such other persons as the court may direct, and have such petition and notice personally delivered to the respondent if he or she is a minor. The court shall also issue a summons to the person whose admission is sought and conduct a hearing within 10 days; or

(2) Without the appointment of an attorney and, relying solely on the contents of the petition, enter an ex parte order authorizing the involuntary assessment and stabilization of the respondent. The court may order a law enforcement officer or other designated agent of the court to take the respondent into custody and deliver him or her to the nearest appropriate licensed service provider.

The 2nd DCA notes that this absence of counsel for an ex parte process is in direct conflict with the requirement to have counsel "at every stage" of an involuntary admission proceeding. It also notes that the statute provides no authority for an ex parte order denying the petition. The court concluded that Cole's order to involuntary treatment was void because it was entered in violation of Cole's right to due process and his right to representation by counsel. While Cole was appointed a public defender to represent him in a criminal contempt prosecution, at no time at any stage of either Marchman Act proceeding was Cole furnished counsel, despite the Act's guarantee that he was entitled to representation at every stage of the involuntary proceedings.

Chapter 27.511(6)(a), FS states that effective October 1, 2007, the office of criminal conflict and civil regional counsel has primary responsibility for representing persons entitled to court-appointed counsel under the Federal of State Constitution or as authorized by general law in civil proceedings, including, but not limited to, proceedings under s.393.12 and chapters 39.390, 392, 397, 415, 743, 744, and 984. Therefore, Regional Counsel can be appointed to represent the respondents in Marchman Act cases, at least when a petition for involuntary treatment is filed. Due to the conflict between provision of the Marchman Act about provision of counsel when an ex parte order for involuntary assessment and stabilization is sought, your attorney may advise that appointment of counsel for ex parte purposes isn't necessary. However, should a hearing be scheduled, it is clear that an appointment of counsel would be required.

This may not answer the question of who is responsible for retaining counsel for the petitioner. Since the State Attorney isn't responsible for Marchman Act (some circuits do have state attorneys handle these cases) and most service providers don't have the resources to hire attorney's to represent them in Marchman Act cases, no petition is filed unless the family of the respondent hires an attorney for this purpose.

With regard to follow-up after the entry of a Marchman Act order, there isn't any statutory provision for a service provider to do so. The following provisions may apply:

397.6957 Hearing on petition for involuntary treatment.--

(3) At the conclusion of the hearing the court shall either dismiss the petition or order the respondent to undergo involuntary substance abuse treatment, with the respondent's chosen licensed service provider to deliver the involuntary substance abuse treatment where possible and appropriate.

397.697 Court determination; effect of court order for involuntary substance abuse treatment.--

(1) When the court finds that the conditions for involuntary substance abuse treatment have been proved by clear and convincing evidence, it may order the respondent to undergo involuntary treatment by a licensed service provider for a period not to exceed 60 days. If the court finds it necessary, it may direct the sheriff to take the respondent into custody and deliver him or her to the licensed service provider specified in the court order, or to the nearest appropriate licensed service provider, for involuntary treatment. When the conditions justifying involuntary treatment no longer exist, the client must be released as provided in s. 397.6971. When the conditions justifying involuntary treatment are expected to exist after 60 days of treatment, a renewal of the involuntary treatment order may be requested pursuant to s. 397.6975 prior to the end of the 60-day period.

(2) In all cases resulting in an order for involuntary substance abuse treatment, the court shall retain jurisdiction over the case and the parties for the entry of such further orders as the circumstances may require. The court's requirements for notification of proposed release must be included in the original treatment order.

(3) An involuntary treatment order authorizes the licensed service provider to require the client to undergo such treatment as will benefit him or her, including treatment at any licensable service component of a licensed service provider.

397.6971 Early release from involuntary substance abuse treatment.--

(1) At any time prior to the end of the 60-day involuntary treatment period, or prior to the end of any extension granted pursuant to s. 397.6975, a client admitted for involuntary treatment may be determined eligible for discharge to the most appropriate referral or disposition for the client when:

(a) The client no longer meets the criteria for involuntary admission and has given his or her informed consent to be transferred to voluntary treatment status;

(b) If the client was admitted on the grounds of likelihood of infliction of physical harm upon himself or herself or others, such likelihood no longer exists; or

(c) If the client was admitted on the grounds of need for assessment and stabilization or treatment, accompanied by inability to make a determination respecting such need, either:

1. Such inability no longer exists; or

2. It is evident that further treatment will not bring about further significant improvements in the client's condition;

(d) The client is no longer in need of services; or

(e) The director of the service provider determines that the client is beyond the safe management capabilities of the provider.

(2) Whenever a qualified professional determines that a client admitted for involuntary treatment is ready for early release for any of the reasons listed in subsection (1), the service provider shall immediately discharge the client, and must notify all persons specified by the court in the original treatment order.

397.6977 Disposition of client upon completion of involuntary substance abuse treatment.--At the conclusion of the 60-day period of court-ordered involuntary treatment, the client is automatically discharged unless a motion for renewal of the involuntary treatment order has been filed with the court pursuant to s. 397.6975.

397.6751 Service provider responsibilities regarding involuntary admissions.--

(1) It is the responsibility of the service provider to:

(a) Ensure that a person who is admitted to a licensed service component meets the admission criteria specified in s. 397.675;

(b) Ascertain whether the medical and behavioral conditions of the person, as presented, are beyond the safe management capabilities of the service provider;

(c) Provide for the admission of the person to the service component that represents the least restrictive available setting that is responsive to the person's treatment needs;

(d) Verify that the admission of the person to the service component does not result in a census in excess of its licensed service capacity;

(e) Determine whether the cost of services is within the financial means of the person or those who are financially responsible for the person's care; and

(f) Take all necessary measures to ensure that each client in treatment is provided with a safe environment, and to ensure that each client whose medical condition or behavioral problem becomes such that he or she cannot be safely managed by the service component is discharged and referred to a more appropriate setting for care.

(2)(a) When, in the judgment of the service provider, the person who is being presented for involuntary admission should not be admitted because of his or her failure to meet admission criteria, because his or her medical or behavioral conditions are beyond the safe management capabilities of the service provider, or because of a lack of available space, services, or financial resources to pay for his or her care, the service provider, in accordance with federal confidentiality regulations, must attempt to contact the referral source, which may be a law enforcement officer, physician, parent, legal guardian if applicable, court and petitioner, or other referring party, to discuss the circumstances and assist in arranging for alternative interventions.

(b) When the service provider is unable to reach the referral source, the service provider must refuse admission and attempt to assist the person in gaining access to other appropriate services, if indicated.

(c) Upon completing these efforts, the service provider must, within one workday, report in writing to the referral sources, in compliance with federal confidentiality regulations:

1. The basis for the refusal to admit the person, and
2. Documentation of the service provider's efforts to contact the referral source and assist the person, when indicated, in gaining access to more appropriate services.

(3) When, in the judgment of the service provider, the medical conditions or behavioral problems of an involuntary client become such that they cannot be safely managed by the service component, the service provider must discharge the client and attempt to assist him or her in securing more appropriate services in a setting more responsive to his or her needs. Upon completing these efforts, the service provider must, within 72 hours, report in writing to the referral source, in compliance with federal confidentiality regulations:

- (a) The basis for the client's discharge, and
- (b) Documentation of the service provider's efforts to assist the person in gaining access to appropriate services.

There are significant waiting lists for scarce publicly funded treatment beds throughout Florida. Because the Marchman Act allows a service provider to decline services to a person, even one under order of the court, some Clerks of Court require an applicant for such an order to furnish documentation from a licensed service provider of it's willingness to admit the person if so ordered by the court. You could modify the model order form to include a requirement that the court be notified when the person is released – either at end of the court ordered term or prior to that in Early Release situations

Transportation – Marchman Act

Q. Does it state anywhere in 397 about transportation for Marchman Acts as is does in the Baker Act? (nearest receiving or exception plan)?

No, there is no corresponding requirement for transportation in the Marchman Act as there is in the Baker Act. There is a presumption in the **Protective Custody** provisions that the law enforcement officer initiating will transport the person to any licensed detoxification center, Addiction Receiving Facility, or hospital. If the person is taken to jail because there is no available licensed facility, the law states:

Such detention is not to be considered an arrest for any purpose, and no entry or other record may be made to indicate that the person has been detained or charged with any crime. The officer in charge of the detention facility must notify the nearest appropriate licensed service provider within the first 8 hours after detention that the person has been detained. **It is the duty of the detention facility to arrange, as necessary, for transportation of the person to an appropriate licensed service provider with an available bed.** Persons taken into protective custody must be assessed by the attending physician within the 72-hour period and without unnecessary delay, to determine the need for further services.

The physician's certificate for **emergency admission** must include:

397.6793(4) The physician's certificate must indicate whether the person requires transportation assistance for delivery for emergency admission and specify, pursuant to s. 397.6795, the type of transportation assistance necessary.

397.6795 Transportation-assisted delivery of persons for emergency assessment.--An applicant for a person's emergency admission, or the person's spouse or guardian, a law enforcement officer, or a health officer may deliver a person named in the physician's certificate for emergency admission to a hospital or a licensed detoxification facility or addictions receiving facility for emergency assessment and stabilization.

Other than these provisions, the Marchman Act is silent as to transport responsibility

Responsibilities of Licensed Substance Abuse Providers

Q. Can a Marchman Act Receiving Facility refuse to accept clients? I know Baker Act receiving facilities cannot, but can they?

Yes, a Marchman Act facility, other than licensed hospitals subject to the federal EMTALA law, is permitted to refuse admission to voluntary or involuntary persons under the Marchman Act, as follows:

397.6751 Service provider responsibilities regarding involuntary admissions.

(1) It is the responsibility of the service provider to:

(a) Ensure that a person who is admitted to a licensed service component meets the admission criteria specified in s. 397.675;

(b) Ascertain whether the medical and behavioral conditions of the person, as presented, are beyond the safe management capabilities of the service provider;

(c) Provide for the admission of the person to the service component that represents the least restrictive available setting that is responsive to the person's treatment needs;

(d) Verify that the admission of the person to the service component does not result in a census in excess of its licensed service capacity;

(e) Determine whether the cost of services is within the financial means of the person or those who are financially responsible for the person's care; and

(f) Take all necessary measures to ensure that each individual in treatment is provided with a safe environment, and to ensure that each individual whose medical condition or behavioral problem becomes such that he or she cannot be safely managed by the service component is discharged and referred to a more appropriate setting for care.

(2)(a) When, in the judgment of the service provider, the person who is being presented for involuntary admission should not be admitted because of his or her failure to meet admission criteria, because his or her medical or behavioral conditions are beyond the safe management capabilities of the service provider, or because of a lack of available space, services, or financial resources to pay for his or her care, the service provider, in accordance with federal confidentiality regulations, must attempt to contact the referral source, which may be a law enforcement officer, physician, parent, legal guardian if applicable, court and petitioner, or other referring party, to discuss the circumstances and assist in arranging for alternative interventions.

(b) When the service provider is unable to reach the referral source, the service provider must refuse admission and attempt to assist the person in gaining access to other appropriate services, if indicated.

(c) Upon completing these efforts, the service provider must, within one workday, report in writing to the referral sources, in compliance with federal confidentiality regulations:

1. The basis for the refusal to admit the person, and

2. Documentation of the service provider's efforts to contact the referral source and assist the person, when indicated, in gaining access to more appropriate services.

(3) When, in the judgment of the service provider, the medical conditions or behavioral problems of an involuntary individual become such that they cannot

be safely managed by the service component, the service provider must discharge the individual and attempt to assist him or her in securing more appropriate services in a setting more responsive to his or her needs. Upon completing these efforts, the service provider must, within 72 hours, report in writing to the referral source, in compliance with federal confidentiality regulations:

- (a) The basis for the individual's discharge; and
- (b) Documentation of the service provider's efforts to assist the person in gaining access to appropriate services.

397.431 Individual responsibility for cost of substance abuse impairment services.

(1) Before accepting an individual for admission and in accordance with confidentiality guidelines, both the full charge for services and the fee charged to the individual for such services under the provider's fee system or payment policy must be disclosed to each individual or his or her authorized personal representative, or parent or legal guardian if the individual is a minor who did not seek treatment voluntarily and without parental consent.

(2) An individual or his or her authorized personal representative, or parent or legal guardian if the individual is a minor, is required to contribute toward the cost of substance abuse services in accordance with his or her ability to pay, unless otherwise provided by law.

(3) The parent, legal guardian, or legal custodian of a minor is not liable for payment for any substance abuse services provided to the minor without parental consent pursuant to s. 397.601(4), unless the parent, legal guardian, or legal custodian participates or is ordered to participate in the services, and only for the substance abuse services rendered. If the minor is receiving services as a juvenile offender, the obligation to pay is governed by the law relating to juvenile offenders.

(4) Service providers that do not contract for state funds to provide substance abuse services as defined in this chapter may establish their own admission policies regarding provisions for payment for services. Such policies must comply with other statutory and regulatory requirements governing state or federal reimbursements to a provider for services delivered to individuals. As used in this subsection, the term "contract for state funds" does not include Medicaid funds.

(5) Service providers that contract for state funds to provide substance abuse services as defined in this chapter must establish a fee system based upon an individual's ability to pay and, if space and sufficient state resources are available, may not deny an individual access to services solely on the basis of the individual's inability to pay.

It is reported that licensed substance abuse facilities "just say NO" and don't go through the other statutorily required attempts to assist in finding alternate programs or contact the referring agency. That's how folks often end up in ED's – they can't say "no", but then they want folks taken by LEO's from the ED to jail upon stabilization. This is a problem because if the person is truly stabilized, they don't need civil protective custody under Marchman Act. This leaves law enforcement with significant liability.

Q. Is a Marchman Act facility required to accept a person brought by law enforcement for involuntary admission?

Unlike Baker Act where a designated receiving facility must accept any person brought by law enforcement under involuntary status, chapter 397.6751(2) of the Marchman Act allows a detox facility or Addiction Receiving Facility (ARF) to refuse admission under any of the following conditions:

(a) When, in the judgment of the service provider, the person who is being presented for involuntary admission should not be admitted because of his or her failure to meet admission criteria, because his or her medical or behavioral conditions are beyond the safe management capabilities of the service provider, or because of a lack of available space, services, or financial resources to pay for his or her care, the service provider, in accordance with federal confidentiality regulations, must attempt to contact the referral source, which may be a law enforcement officer, physician, parent, legal guardian if applicable, court and petitioner, or other referring party, to discuss the circumstances and assist in arranging for alternative interventions.

(b) When the service provider is unable to reach the referral source, the service provider must refuse admission and attempt to assist the person in gaining access to other appropriate services, if indicated.

(c) Upon completing these efforts, the service provider must, within one workday, report in writing to the referral sources, in compliance with federal confidentiality regulations:

1. The basis for the refusal to admit the person, and
2. Documentation of the service provider's efforts to contact the referral source and assist the person, when indicated, in gaining access to more appropriate services.

(3) When, in the judgment of the service provider, the medical conditions or behavioral problems of an involuntary client become such that they cannot be safely managed by the service component, the service provider must discharge the client and attempt to assist him or her in securing more appropriate services in a setting more responsive to his or her needs. Upon completing these efforts, the service provider must, within 72 hours, report in writing to the referral source, in compliance with federal confidentiality regulations:

(a) The basis for the client's discharge, and

(b) Documentation of the service provider's efforts to assist the person in gaining access to appropriate services.

Q. We now have an Addictions Receiving Facility (ARF) licensed here at our receiving facility that we combined with our crisis stabilization unit. If we are the only addictions receiving facility in the area and law enforcement has a Marchman Act that they bring to an emergency room at a nearby hospital, are we (ARF) responsible for this patient if we have no beds available? Recently, a person was delivered to the ED of a nearby hospital with a very high BAL under Marchman Act Protective Custody initiated by the law enforcement officer. The ED stated it had no legal right to hold this patient against his will (even though the person was seriously impaired) and that responsibility was ours, as the ARF in the area. While we may have some obligation to aid in placement, I think some responsibility would be with the ED under the medical emergency act. Can a ED actually let the patient leave without any effort to restrain or hold them until such time as a bed is available or the client is no longer impaired? In this case, an ARF bed was not

readily available and the client was eventually baker acted to get around the dispute. Under the involuntary rules of the Marchman act, does the hospital have the legal right to restrain if necessary, similar to the Baker Act?

As an addictions receiving facility, you are not required to admit or retain a person under the Marchman Act. You do have an obligation if a person is brought to you for involuntary admission, as follows:

397.6751 Service provider responsibilities regarding involuntary admissions.

(1) It is the responsibility of the service provider to:

- (a) Ensure that a person who is admitted to a licensed service component meets the admission criteria specified in s. 397.675;
- (b) Ascertain whether the medical and behavioral conditions of the person, as presented, are beyond the safe management capabilities of the service provider;
- (c) Provide for the admission of the person to the service component that represents the least restrictive available setting that is responsive to the person's treatment needs;
- (d) Verify that the admission of the person to the service component does not result in a census in excess of its licensed service capacity;
- (e) Determine whether the cost of services is within the financial means of the person or those who are financially responsible for the person's care; and
- (f) Take all necessary measures to ensure that each individual in treatment is provided with a safe environment, and to ensure that each individual whose medical condition or behavioral problem becomes such that he or she cannot be safely managed by the service component is discharged and referred to a more appropriate setting for care.

(2)(a) When, in the judgment of the service provider, the person who is being presented for involuntary admission should not be admitted because of his or her failure to meet admission criteria, because his or her medical or behavioral conditions are beyond the safe management capabilities of the service provider, or because of a lack of available space, services, or financial resources to pay for his or her care, the service provider, in accordance with federal confidentiality regulations, must attempt to contact the referral source, which may be a law enforcement officer, physician, parent, legal guardian if applicable, court and petitioner, or other referring party, to discuss the circumstances and assist in arranging for alternative interventions.

(b) When the service provider is unable to reach the referral source, the service provider must refuse admission and attempt to assist the person in gaining access to other appropriate services, if indicated.

(c) Upon completing these efforts, the service provider must, within one workday, report in writing to the referral sources, in compliance with federal confidentiality regulations:

1. The basis for the refusal to admit the person, and
2. Documentation of the service provider's efforts to contact the referral source and assist the person, when indicated, in gaining access to more appropriate services.

(3) When, in the judgment of the service provider, the medical conditions or behavioral problems of an involuntary individual become such that they cannot be safely managed by the service component, the service provider must discharge the individual and attempt to assist him or her in securing more

appropriate services in a setting more responsive to his or her needs. Upon completing these efforts, the service provider must, within 72 hours, report in writing to the referral source, in compliance with federal confidentiality regulations:

- (a) The basis for the individual's discharge; and
- (b) Documentation of the service provider's efforts to assist the person in gaining access to appropriate services.

If you document that you don't have the capacity (space), capability (programming), or other factors enumerated in the Marchman Act to manage the person's condition, you have no obligation to accept the transfer. If a law enforcement officer brings an intoxicated person to your combined ARF/CSU under a Baker Act, you would have to accept the individual. If that individual had an acute physical condition beyond your facility's ability to manage, you could then arrange medical transport to a hospital.

However, if the law enforcement officer who takes the person into protective custody under the Marchman Act determines that a hospital is a more appropriate setting than a detox facility or an ARF, the officer has clear legal authority to take the person to a hospital, as follows:

397.6771 Protective custody with consent.

A person in circumstances which justify protective custody, as described in s. 397.677, may consent to be assisted by a law enforcement officer to his or her home, to a hospital, or to a licensed detoxification or addictions receiving facility, whichever the officer determines is most appropriate.

397.6772 Protective custody without consent.

(1) If a person in circumstances which justify protective custody as described in s. 397.677 fails or refuses to consent to assistance and a law enforcement officer has determined that a hospital or a licensed detoxification or addictions receiving facility is the most appropriate place for the person, the officer may, after giving due consideration to the expressed wishes of the person:

- (a) Take the person to a hospital or to a licensed detoxification or addictions receiving facility against the person's will but without using unreasonable force; or
- (b) In the case of an adult, detain the person for his or her own protection in any municipal or county jail or other appropriate detention facility.

397.6773 Dispositional alternatives after protective custody.

(1) An individual who is in protective custody must be released by a qualified professional when:

- (a) The individual no longer meets the involuntary admission criteria in s. 397.675(1);
- (b) The 72-hour period has elapsed; or
- (c) The individual has consented to remain voluntarily at the licensed service provider.

(2) An individual may only be retained in protective custody beyond the 72-hour period when a petition for involuntary assessment or treatment has been initiated. The timely filing of the petition authorizes the service provider to retain physical custody of the individual pending further order of the court.

A licensed hospital is required under the federal EMTALA law to accept any person for the purpose of conducting a medical screening examination to determine if the person has an emergency medical condition (EMC). An EMC includes a psychiatric emergency or a substance abuse emergency, even absent any other medical condition.

If the person has an EMC, the hospital's emergency department must either admit or transfer the person to another facility with the capability and capacity to meet the person's needs. Such a transfer is appropriate only when all medical records are provided in advance to the proposed destination facility and prior approval has been provided by that facility.

There is no conflict for hospitals between the Marchman Act and the EMTALA law -- both require the hospital to accept and examine. The Marchman Act permits the hospital to retain the person for up to 72-hours if meeting the involuntary admission criteria. The ARF and the hospital have the same rights and responsibilities under the law.

Until the person is documented by a qualified professional to no longer meet the legal criteria for detention under one of the protective statutes, the liability for a hospital releasing such a person can be enormous. There are many methods hospital EDs routinely use to divert persons from leaving AMA. This is especially important since the law permits any hospital to retain the person under the circumstances described above.

Use of mechanical and chemical restraints is more likely governed by the federal Conditions of Participation. Restraints cannot be used for behavioral purposes except as permitted under documented situations of imminent danger. The Marchman Act also limits use of restraints "to control aggressive behavior that poses an immediate threat..."

397.501(3) RIGHT TO QUALITY SERVICES.—

(a) Each individual must be delivered services suited to his or her needs, administered skillfully, safely, humanely, with full respect for his or her dignity and personal integrity, and in accordance with all statutory and regulatory requirements.

(b) These services must include the use of methods and techniques to control aggressive behavior that poses an immediate threat to the individual or to other persons. Such methods and techniques include the use of restraints, the use of seclusion, the use of time-out, and other behavior management techniques. When authorized, these methods and techniques may be applied only by persons who are employed by service providers and trained in the application and use of these methods and techniques. The department must specify by rule the methods that may be used and the techniques that may be applied by service providers to control aggressive behavior and must specify by rule the physical facility requirements for seclusion rooms, including dimensions, safety features, methods of observation, and contents.

Q. In the recent past this hospital has received 3 Law Enforcement Marchman Act patients, and we are not very clear on how to handle them. The mental health unit here is locked and patients cannot just leave when they are ready, most Marchman Act receiving facilities are not locked and patients can leave are we violating someone rights by making them stay?

On the one hand, you are required by the federal EMTALA law to accept all persons brought to your ED and assess them for an emergency medical condition. Federal CMS defines such an emergency medical condition to include emergency psychiatric and substance abuse condition, even absent any other medical issues on pre-admission status. If you confirm that the person has an emergency substance abuse condition and you don't have the capacity or capability to provide for the person's special needs, you would need to seek out an appropriate hospital that has such capability and capacity.

Your unit is titled "Mental Health Addiction Recovery Unit". If your hospital has beds that are separately licensed by AHCA for substance abuse from those that are licensed for psychiatric purposes, you would have an obligation to provide care for person's emergency condition. You would be able to lawfully retain the person for up to 72 hours for evaluation prior to release or petitioning the court for further stay.

As you may know, non-hospital substance abuse service providers aren't subject to the EMTALA law and would not be required to accept the transfer for any variety of reasons, including inability to pay the cost of care.

The criteria for involuntary admission under the Marchman Act is as follows:

397.675 Criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment.--A person meets the criteria for involuntary admission if there is good faith reason to believe the person is substance abuse impaired and, because of such impairment:

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

A qualified professional who can perform the examination and authorize the person's release is defined as follows:

397.311(25) "Qualified professional" means a physician licensed under chapter 458 or chapter 459; a professional licensed under chapter 490 or chapter 491; or a person who is certified through a department-recognized certification process for substance abuse treatment services and who holds, at a minimum, a bachelor's degree. A person who is certified in substance abuse treatment services by a state-recognized certification process in another state at the time of employment with a licensed substance abuse provider in this state may perform the functions of a qualified professional as defined in this chapter but must meet certification requirements contained in this subsection no later than 1 year after his or her date of employment.

Staff at DCF HQ have indicated that a person held under the Marchman Act who doesn't have a co-existing mental illness can't be held in a Baker Act receiving facility. The reason for this is that voluntary and involuntary admissions under the Baker Act require that the person have a mental illness, but that legal definition excludes intoxication and substance abuse impairment, among others. However, if your hospital has beds separately licensed by AHCA for substance abuse, this may be different.

Most hospitals have the person examined by an ED physician to rule out any medical complications associated with the substance abuse impairment. They then make efforts to refer the person to local licensed substance abuse providers and provide persons with information how to follow-up should there not be current availability of service. They are then released for outpatient follow-up. Whether this is fully compliant with EMTALA needs to be determined by your hospital's Compliance Officer.

Q. I understand that an LCSW can initiate a Baker Act or Marchman Act. Can an LCSW also rescind one?

An LCSW can initiate a Baker Act involuntary examination, but only a physician or psychologist can conduct the examination once initiated. Only a psychiatrist, psychologist or ED physician can approve the release of a person from a receiving facility after an involuntary examination.

Regarding the Marchman Act, requirements are quite different. A law enforcement officer can initiate Protective Custody, a circuit court can initiate Involuntary Assessment and Stabilization, a parent/guardian can initiate Alternative Admission for Minors to a JARF. An Emergency Admission of an adult however can only be initiated by a physician, spouse, guardian, relative or other responsible adult, but it requires the certification of a physician. Without the written accompanying certification of a physician containing the required elements, an emergency admission under the Marchman Act wouldn't be valid.

Once admitted under the Marchman Act, an LCSW is one of the professionals statutorily defined as a "Qualified Professional" to approve the person's release or to provide an assessment to the court as part of a petition for involuntary treatment.

Provisions under the Baker Act are entirely different than those under the Marchman Act. The only thing in common is the federal EMTALA law that recognizes psychiatric and substance abuse emergencies as emergency medical conditions even absent any other medical conditions.

Q. Regarding the Marchman Act and some new interpretations of the law, I am being told that I can not use my Marchman Act Detox status to hold a person under the Marchman Act against their will. What does that mean? Under current practice, a person comes here under the Marchman Act for detox and we have either 72 hrs or 5 days – depending on the type to evaluate and discharge or change to voluntary. We know we can not use restraints and or seclusion. We know that if their behaviors are a problem, we can change to Baker Act if they meet the criteria or discharge. Now I am told that if they want to leave while still under the Marchman we have to let them go even if they meet the involuntary

criteria. I am told that the only way we can hold is if we are a Addictions Receiving Faculty. Is this correct?

You absolutely may use a detox facility to accept and hold a person for involuntary admission under the Marchman Act. There are only a few adult Addiction Receiving Facilities licensed throughout the state – other locations use inpatient hospitals and residential or outpatient detox facilities for this purpose. The law and rules haven't changed on this issue to my knowledge. However, you can't lock or otherwise physically secure a detox facility – usually the "protective custody" by a law enforcement officer or an order of the court for involuntary assessment and stabilization is sufficient to convince the individual to stay for the 72 hour period allowed by law for inpatient settings.

The following provision of the Marchman Act governs your duty to release a person:

397.6758 Release of client from protective custody, emergency admission, involuntary assessment, involuntary treatment, and alternative involuntary assessment of a minor.--A client involuntarily admitted to a licensed service provider may be released without further order of the court only by a qualified professional in a hospital, a detoxification facility, an addictions receiving facility, or any less restrictive treatment component. Notice of the release must be provided to the applicant in the case of an emergency admission or an alternative involuntary assessment for a minor, or to the petitioner and the court if the involuntary assessment or treatment was court ordered. In the case of a minor client, the release must be:

- (1) To the client's parent, legal guardian, or legal custodian or the authorized designee thereof;
- (2) To the Department of Children and Family Services pursuant to s. 39.401; or
- (3) To the Department of Juvenile Justice pursuant to s. 984.13.

The Marchman Act states that the timely filing of a petition for involuntary treatment following involuntary admission authorizes the service provider to continue to retain physical custody of the client pending further order of the court.

Q. I'm wondering if many people have insurance coverage for substance abuse. Do you know if it is covered in the Parity Act or is that only for mental illness? After detox, how do people get treatment immediately if they can't pay? We had always referred them to the County Central Intake to be placed on a waiting list. Is the Marchman Act primarily for detox or for ongoing treatment as well? A local hospital has a well known Addiction Treatment Center.

...

Many people do have coverage for substance abuse treatment, but unfortunately, many have lost their jobs due to the economy or to their addiction. Further, many employer sponsored health policies only cover the employee, but not their dependents. Many plans have a lot of exclusions, limitations, and pre-certification requirements. Finally, some employees don't want their employers to know of their diagnosis and need for substance abuse treatment. All these can be barriers. However, substance abuse treatment is covered in the federal parity law, but there continue to be many exclusions to Parity.

Ability to pay for care is a condition for acceptance to a licensed substance abuse provider under the Marchman Act. This applies in any setting except for state funded substance abuse programs that have the capacity and capability within their funded beds. The only other exception is for hospitals that have beds licensed for substance abuse treatment. They would have to accept any person, regardless of ability to pay, if they have the capability / capacity to meet a person's emergency medical condition. The Federal Centers for Medicare and Medicaid define a substance abuse or psychiatric emergency as an emergency medical condition under the EMTALA law. If a person has no method of paying for care and there isn't a hospital with available licensed substance abuse beds, you should continue to refer to the county's program.

Substance abuse withdrawal may be a medical issue, rather than a substance abuse treatment issue. If a person has a potentially life-threatening condition, it would clearly fit under one of the other medical consent laws. However, if the intervention is intended to treat the substance abuse impairment, it would fit under the Marchman Act.

Marchman Act Records & Forms

Q. Our in-house attorney has researched issues related to having "original" Marchman Act documents, but would like to know your thoughts and if you know of any case law that speaks directly to the issue. Once we have determined how best to proceed, we will instruct our staff accordingly.

You should be commended for consulting with your agency's legal counsel. The only references to "originals" in the Marchman Act relate to court orders and one reference to treatment orders. The law makes no reference to the law enforcement officer's Protective Custody form having to be the original and the rules don't address this issue at all. The model state LEO Protective Custody form is recommended, but is not a required form. Some locales use locally developed forms for this purpose.

There is no reference in the Baker Act to requiring originals of any documents. In fact, the Florida Administrative Code governing the Baker Act was revised in 2005 to eliminate any reference to "originals" and the Baker Act forms also were revised to omit such references.

The Department of Children and Families strongly supports the development of electronic medical records in which there is no hard copy available at all. Even the court system throughout the state is rapidly phasing in electronic filings that will have no hard copy and no original signatures.

You were correct in accepting the person to your ARF via medical transport for Protective Custody / involuntary admission initiated by law enforcement even though the officer had forgotten to sign the form. You were going to ask the officer to sign a copy of the form and fax it to you for your records, but not require the officer to travel to your program to provide an original signature. This is respectful of the valuable time of the officer and protective of the client's safety by expeditiously accepting him into a safe setting.

Unless you have suspicion that a copy of a form has been altered in some way, insistence on an original may be an artificial barrier to acceptance of an otherwise appropriate client.

Q. I had a call from a court clerk in our MH Division. He is asking for some guidance about Baker Act and Marchman Act records. Apparently the office has always considered the cases / records protected / confidential, but the clerk wasn't able to locate anything in 394 or 397 that clearly stated this. He hadn't reviewed the administrative rules, but I told him that I'd contact you in case you could provide a quick answer. Apparently a newspaper reporter is asking whether a particular person has been petitioned under the Marchman Act. There has not been a petition on the person, but the clerk wants to be sure about what he should/shouldn't say/release now and in the future.

Federal and state laws are very restrictive on what can be released about persons concerning their mental health and substance abuse treatment. The Baker Act and Marchman Act allow, after a good cause hearing, for a circuit judge to release information about a person. This good cause hearing – usually is an in camera inspection of the record by the judge. The Marchman Act reads as follow:

397.501 Rights of clients.

(7) Right to Confidentiality of Client Records.--

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

5. Upon court order based on application showing good cause for disclosure. In determining whether there is good cause for disclosure, the court shall examine whether the public interest and the need for disclosure outweigh the potential injury to the client, to the service provider-client relationship, and to the service provider itself.

The Florida Attorney General has several opinions related to the clerk and such records, including the following summaries of these opinions:

AGO 91-10 Regarding the inspection and copying requirements of Baker Act and Marchman Act records possessed by the clerk of court. 1991 WL

528139 (Fla. A.G.) Attorney General Robert A. Butterworth advised the Clerk of the Court for Lee County, FL that Baker Act patients' clinical records produced pursuant to section 394.459(9), Fla. Stat. are specifically made confidential and are exempt from being inspected and copied by the public pursuant to section 119, Fla. Stat. Generally, when materials are filed with the clerk of court, such records are open to the public. AGO 89-94 concluded that in the absence of a specific statutory provision or court rule making a record confidential or dictating the manner of its release and absent a court order closing a particular court record, probate records filed with the clerk of court are subject to Ch. 119, F.S. The records created pursuant to the Baker and Marchman Acts are confidential

and exempt from s. 119.07(1), F.S., when placed in the possession of the clerk of court.

AGO 97-67 Regarding the clerk's authority to maintain confidentiality of confidential information contained in the official records. It is the clerk's responsibility to devise a method to ensure the integrity of the Official Records while also maintaining the confidential status of information contained within. Nothing in the Public Records Law or the statutes governing the duties of the clerk authorizes the clerk to alter or destroy Official Records. However, the statute does impose a duty on the clerk to prevent the release of confidential material that may be contained in the Official Records. There is nothing that precludes the clerk from altering reproductions of the Official Records to protect confidential information. The manner in which this is to be accomplished rests within the sound discretion of the clerk.

The federal and state laws governing the subject as well as the Attorney General Opinions should be very persuasive. Perhaps the county attorney that advises the Clerk of Courts could use the above and attached information to give legal advice to the Clerk. Open Government is a critical issue, especially to the media.

Confidentiality

Q. What information does the Marchman Act law and rules permit a facility to share with law enforcement, including the reference to the Code of Federal Regulations that also deal with the issue?

Assuming that the person refuses to allow the facility to acknowledge his presence in the substance abuse facility, you may need to file a petition for a good cause hearing to get a court order. Law enforcement general has no interest in a person's clinical records – they just want to serve a warrant or arrest him. Hopefully the HIPAA information you already have will suffice.

397.501, FS Rights of individuals.

(7)RIGHT TO CONFIDENTIALITY OF INDIVIDUAL RECORDS.—

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

- 1.To medical personnel in a medical emergency.
- 2.To service provider personnel if such personnel need to know the information in order to carry out duties relating to the provision of services to an individual.
- 3.To the secretary of the department or the secretary's designee, for purposes of scientific research, in accordance with federal confidentiality regulations, but only upon agreement in writing that the individual's name and other identifying information will not be disclosed.
- 4.In the course of review of service provider records by persons who are performing an audit or evaluation on behalf of any federal, state, or local

government agency, or third-party payor providing financial assistance or reimbursement to the service provider; however, reports produced as a result of such audit or evaluation **may not disclose names or other identifying information and must be in accordance with federal confidentiality regulations.**

5. Upon court order based on application showing good cause for disclosure.

In determining whether there is good cause for disclosure, the court shall examine whether the public interest and the need for disclosure outweigh the potential injury to the individual, to the service provider and the individual, and to the service provider itself.

(b) The restrictions on disclosure and use in this section do not apply to communications from provider personnel to law enforcement officers which:

1. Are directly related to an individual's commission of a crime on the premises of the provider or against provider personnel or to a threat to commit such a crime; and

2. Are limited to the circumstances of the incident, including the status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

(c) The restrictions on disclosure and use in this section do not apply to the reporting of incidents of suspected child abuse and neglect to the appropriate state or local authorities as required by law. However, such restrictions continue to apply to the original substance abuse records maintained by the provider, including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.

(d) Any answer to a request for a disclosure of individual records which is not permissible under this section or under the appropriate federal regulations must be made in a way that will not affirmatively reveal that an identified individual has been, or is being diagnosed or treated for substance abuse. The regulations do not restrict a disclosure that an identified individual is not and has never received services.

(f) An order of a court of competent jurisdiction authorizing disclosure and use of confidential information is a unique kind of court order. Its only purpose is to authorize a disclosure or use of identifying information which would otherwise be prohibited by this section. Such an order does not compel disclosure. A subpoena or a similar legal mandate must be issued in order to compel disclosure. This mandate may be entered at the same time as, and accompany, an authorizing court order entered under this section.

(g) An order authorizing the disclosure of an individual's records may be applied for by any person having a legally recognized interest in the disclosure which is sought. The application may be filed separately or as part of a pending civil action in which it appears that the individual's records are needed to provide evidence. An application must use a fictitious name, such as John Doe or Jane Doe, to refer to any individual and may not contain or otherwise disclose any identifying information unless the individual is the applicant or has given a written consent to disclosure or the court has ordered the record of the proceeding sealed from public scrutiny.

(h) The individual and the person holding the records from whom disclosure is sought must be given adequate notice in a manner which will not disclose identifying information to other persons, and an opportunity to file a written response to the application, or to appear in person, for the limited purpose of

providing evidence on the statutory and regulatory criteria for the issuance of the court order.

(i) Any oral argument, review of evidence, or hearing on the application must be held in the judge's chambers or in some manner which ensures that identifying information is not disclosed to anyone other than a party to the proceeding, the individual, or the person holding the record, unless the individual requests an open hearing. The proceeding may include an examination by the judge of the records referred to in the application.

(j) A court may authorize the disclosure and use of records for the purpose of **conducting a criminal investigation or prosecution of an individual only** if the court finds that all of the following criteria are met:

1. The crime involved is extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury, including but not limited to homicide, sexual assault, sexual battery, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect.
2. There is reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution.
3. Other ways of obtaining the information are not available or would not be effective.
4. The potential injury to the individual, to the physician-individual relationship, and to the ability of the program to provide services to other individuals is outweighed by the public interest and the need for the disclosure.

65D-30.004, FAC Common Licensing Standards.

(28) Confidentiality. Providers shall comply with Title 42, Code of Federal Regulations, Part 2, titled "Confidentiality of Alcohol and Drug Abuse Patient Records," and with subsections 397.419(7) and 397.501(7), F.S., paragraphs 397.6751(2)(a) and (c), F.S., and Section 397.752, F.S., regarding confidential client information.

The following information is used in the policies and procedures of a major substance abuse treatment agency and may be helpful:

Disclosures to law enforcement officers possessing arrest warrants

If a law enforcement officer comes to the agency with an arrest warrant and are seeking a patient on premises, staff must not interfere with or impede the said patient's arrest. The law enforcement officer is allowed to enter the facility. Staff, however, is prohibited by federal regulations from aiding or identifying the patient unless the law enforcement officer is in possession of a court order. The officer is allowed to stand on the premises and serve the arrest warrant on anyone he/she believes is the person sought. The officer should be directed to serve the subpoena on the Chief Administrative Officer rather than the staff and patients.

Disclosures related to the initiation or substantiation of a crime

Information from alcohol and drug abuse patient records shall not be disclosed for the purpose of initiating or substantiating any criminal charges against a patient. Patient records or other identifying information shall not be disclosed in response to a law enforcement request that is related to the investigation of prosecution of a crime unless such disclosure is authorized by a court order. If the request is accompanied only by a compulsory process (e.g. court order).

Employees are prohibited from disclosing the requested information, including

whether the patient currently is in treatment or ever has received treatment from the agency.

This allows law enforcement officers to do their job while preventing staff from providing information protected by law. Assuming that the person refuses to allow the facility to acknowledge his presence in the substance abuse facility, the only alternative you may have is to file a petition for a good cause hearing to get a court order.

Appellate Cases

Q. We have a situation where a mother filed a Marchman Act on her adult daughter. The daughter was ordered to treatment and walked out of the treatment center. The mother hired an attorney to petition the court and hold the daughter in contempt for not following the treatment order. The judge has asked if I know of any other case similar to this one and what was the outcome so he'll know what options there are for this situation. I've never seen the court follow through holding the patient in contempt for not following through with a treatment order, but don't know any other options to force someone to attend treatment since most facilities can't detain the patient. Have you seen or heard of a situation in any other county similar to this or any input would be helpful.

Several summaries of cases below might have some interest to you and the judge:

Steven Cole v. State of Florida. Case No. 98-01718 2nd DCA 1998. Appellate Judge Northcutt wrote the opinion with Appellate Judges Whatley and Altenbernd concurring. The 10th Judicial Circuit court convicted Steven Cole of indirect criminal contempt for violating the court's order directing him to complete a program of treatment for substance abuse. The court sentenced Cole to serve 90 days in jail. Cole petitioned the 2nd DCA for a writ of habeas corpus and for other relief. The 2nd DCA ordered his release, quashed his conviction and sentence for indirect criminal contempt, and prohibited the circuit court to enforce Cole's involuntary treatment order. The 2nd DCA based its decision on the failure to inform Cole of his right to counsel and that if could not afford an attorney, he could ask the court to appoint one to represent him. The Court noted that Cole was not given meaningful prior notice of the charges against him, the trial was not recorded as required by law, and the court order included directives and prohibitions that were beyond the judicial authority granted by the Marchman Act. Although the Act empowers the court to order a respondent's submission to involuntary substance abuse treatment and to enter such further orders as the circumstances may require, that authority does not extend to prescribing the specific modalities of the treatment. That authority is placed with the licensed service provider.

S.M.F. v. Needle, 757 So. 2d 1265 (Palm Beach County 2000). The circuit court granted a petition for involuntary substance abuse treatment for a minor in response to a petition filed by her parent. The order was for 60 days of involuntary treatment, the maximum period permitted under law, commencing upon her admission to the facility. However, the minor ran away prior to commencing treatment and was returned to the program after the initial court order had expired. She filed a petition for a writ of habeas corpus arguing that

she was entitled to immediate release because the law provides that “at the conclusion of the 60-day period of court-ordered involuntary treatment, the client is automatically discharged unless a motion for renewal of the involuntary treatment order has been filed with the court...” The 4th DCA decided that the original court order for 60 days of court ordered involuntary treatment was not merely 60-days after the entry of the order for treatment and that the 60-day period contemplated by the Marchman Act did not expire, because the petitioner ran away before commencing treatment. The petition for writ of habeas corpus was denied.

However, there was one Baker Act related case from 1983 regarding an individual’s non-compliance with a court order for involuntary outpatient treatment:

C.N., Appellant v. STATE of Florida, Appellee, 433 So. 2d 661 (Fla. App. 3 Dist. 1983). Contemnor appealed from a contempt judgment entered against her by the Dade Circuit Court for contemnor’s alleged noncompliance with an earlier order, on a petition for involuntary hospitalization, that she obtain outpatient psychiatric treatment as the “least restrictive means of intervention.” The DCA held that (1) exercise of court’s contempt power to compel hospitalization and treatment was inappropriate, and (2) where court proceeding under the Mental Health Act has, consistent with legislative intent, ordered outpatient care by private mental health professional as alternative involuntary hospitalization, such least restrictive intervention can be revoked and patient deprived of her liberty only in proceedings which substantially meet requirement of the Baker Act for involuntary hospitalization. Testimony of physicians at the contempt hearing was essentially that contemnor had “basic personality problem” related to psychiatric disorder which gave her “difficulty in following directions,” and thus evidence presented did not support finding of contemptuous intent. A willful disregard of, or disobedience to, an order of the court is the essence of contempt.

For court to order involuntary hospitalization, it is not sufficient that patient merely failed to follow plan for outpatient treatment; there must be clear and convincing proof that individual is dangerous to herself or others before state may deprive her of her freedom on basis of mental illness alone.

The order provided that should appellant fail to comply with outpatient psychiatric treatment as the “least restrictive means of intervention...” “this cause shall recur for further proceedings”, and the court “retains jurisdiction of the subject matter of this proceeding and the parties to enter...further orders...” The appellate court found there is no statutory authority for court to retain jurisdiction for purpose of modifying action taken on earlier petition for involuntary hospitalization; imposition of more restrictive intervention, i.e., involuntary placement, requires, at minimum, new petition for involuntary hospitalization, notice of hearing and hearing on petition.